Federally Qualified Health Centers

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 a goal to promote the utilization and progress toward providing best practice 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 then comply with all applicable federal and Pennsylvania laws, including Title 55, General Provisions 1101 as well as the FQHC PROMISe Handbook, all associated Medical Assistance (MA) Bulletins, licensing requirements and any contractual agreements made with Magellan Behavioral Health of Pennsylvania, Inc. 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

A Federally Qualified Health Center (FQHC) provides comprehensive primary health care and behavioral health services (mental health and substance use disorder) to all individuals regardless of their ability to pay or their health insurance status and are usually located in medically underserved areas. FQHCs offer screening for medical, dental, and mental health conditions. The goal of the service is to increase access to behavioral health services.

Behavioral health consultants (BHC) located within the FQHC are responsible for one-on-one screening and assessments (including assessments of risks, strengths and supports) as well as facilitating and coordinating treatment for behavioral health symptoms including depression, anxiety, substance abuse, and family issues. This may also include support and education around lifestyle behavior changes as part of disease management. The BHC works with an individual's primary care provider to furnish evidenced-based interventions, including referral services when needed.

Scope of Services

FQHCs offer **brief** solution-focused treatment, assessment, and referral services when clinically indicated. FQHCs offer same day appointments with the BHC when necessary, and offer ongoing support and interventions as needed. Hours of service vary depending on the FQHC. FQHCs offer services to persons with psychiatric and co-occurring diagnosis, as well as general wellness support, including health management and education.

Both adults (persons over the age of 21) and children (persons under the age of 21) are eligible for FQHC services and can receive screenings, assessments, and brief treatment with a BHC in

coordination with the primary care physician including, but not limited to, family stress, loss of loved ones, weight management, tobacco cessation support. Providers should reference the regulations for rules and requirements regarding consents needed for treatment of youth under the age of 14. FQHC services are provided in an approved setting; providers are expected to follow standards and expectations set forth by the Department of Human Services (DHS) regarding covered and non-covered services, approved settings, licensure, facilities, staffing patterns and ratios, requirements for types of service offered and to whom, and supervision.

Service Description

Behavioral health encounters within an FQHC can only be performed by a psychiatrist, psychiatric CRNP, doctoral level psychologist, or a licensed clinical social worker (LCSW). Substance Use Disorder treatment may be provided by a psychiatrist, licensed psychologist, or an individual licensed by the Department of Drug and Alcohol Programs (DDAP). A certified addictions counselor can serve as a BHC if they also meet these requirements. The BHC is clinically supervised by the FQHC practitioner. Services rendered by the BHC must be face to face. There is no timeframe associated with the visit. The lowest frequency of treatment sessions that supports symptom improvement and prevention of worsening of symptoms is expected. Providing linkage to community providers for longer term treatment needs is appropriate.

The FQHC may also have access to a psychiatric consultant who is a medical professional trained in psychiatry qualified to prescribe medications, but they do not prescribe or provide treatment directly to individuals.

Per MA Bulletin 08-20-03, FQHCs are permitted to provide group services. Group therapy is a form of psychotherapy provided to no less than two persons with diagnosed mental illness or emotional disturbance. Group therapy is sometimes used alone, but it is also commonly integrated into a comprehensive treatment plan that also includes individual therapy and medication. Both mental health and substance use disorder group therapy sessions may be provided by FQHCs.

Service Exclusions

Behavioral health services offered by the FQHC may be considered a duplication of services if a member is receiving other behavioral health services. Best practices include implementing protocols for inquiring about current engagement in the behavioral health system to prevent duplication of behavioral health services.

Referral Process

An individual must have a face-to-face initial visit with a PCP (medical practitioner) before a referral is made to the BHC. The practitioner determines if the individual meets the Medical Necessity Criteria for a behavioral health referral and consent must be obtained and documented. The BHC can

recommend to the PCP that an individual may benefit from BHC services but only a PCP/practitioner can make the eligibility determination.

Admission Process

Medical Necessity Criteria for admission to BHC services includes a member who has, or is suspected of having, a behavioral health condition; an individual who is entering or reentering the service system; needs assessment due to a change in clinical/functional status; or assessment is required to make specific recommendations regarding additional treatment or services required by the individual.

Any behavioral health or psychiatric condition being treated by the PCP, including substance use disorders, that in the clinical judgement of the PCP warrants BHC services. The individual's record is to contain documentation of a preliminary working diagnosis, a final diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
The initial visit with the PCP can occur no more than one year prior to BHC services. The BHC has ongoing collaboration with the individual's PCP during treatment.

At initiation of service, a Member Bill of Rights is signed, or the refusal to sign is documented. Appropriate releases for communication with the PCP and other providers are signed, or an individual's refusal is documented. Informed consent for medications is signed, or the refusal to sign is documented. Education related to Psychiatric Advance Directives for mental health is signed, or refusal to sign is documented in the individual's record.

Treatment or Service Plan

Per the FQHC handbook, although treatment is typically brief, FQHC providers are required to have a documented treatment plan. A comprehensive treatment plan includes assessment of medical, functional, and psychosocial needs. Behavioral health care planning is developed in relation to behavioral/psychiatric health problems. The individualized, strengths-based treatment plan is to be completed within 30 calendar days of intake. The individual's signature (or parent/guardian if under 14) and physician's signature must be present on the treatment plan.

The treatment plan includes an initial assessment or follow-up monitoring with measurable goals/objectives with timeframes for achievement. The plan includes the use of applicable validated assessment tools. Assessments include identification of member risks, strengths and supports. Goals align with individual identified areas for improvement and interventions align with goals. The treatment plan includes revisions for individuals who are not progressing or whose status changes.

Facilitating and coordinating treatment along with ongoing collaboration with the FQHC practitioner is expected. Interventions provided may include individual therapy, medication, and group therapy sessions. The BHC may provide brief solution-focused intervention with ongoing collaboration with PCP (practitioner). The BHC should facilitate linkage to community behavioral health providers if longer

term treatment is needed. An individualized crisis plan also needs to be developed with the member and included in the treatment plan.

In cases where an individual may be engaged in prolonged treatment at the FQHC, best practice is to review and update treatment plans every 180 days. Treatment plans should be reviewed with and signed by the member and physician when updated.

Expectations of Service Delivery

It is strongly recommended that providers utilize best practices when providing services. Best practices include implementing protocols for inquiring about current engagement in the behavioral health system to prevent duplication of services. The member should have an appointment with the physical health and the behavioral health provider during the same visit to the FQHC. The PCP should utilize a standardized assessment tool to screen for the need for services with the BHC, and the BHC should utilize a standardized assessment tool at admission, during services, and at discharge to determine health improvements resulting from the provision of services. A formalized consultative or coordinated relationship with both mental health and substance use disorder service providers should be included.

Medication Management documentation is expected of current psychotropic medication, dosages, date(s) of dosage changes, quantities, allergies and adverse reactions, or no known allergies (NKA) or sensitivities, to foods, drugs, and other substances. Member education is provided regarding reason for the medication, benefits, risks, and medication side effects, including effect of psychotropic medication in women of child-bearing age. DEA scheduled drugs are avoided in treatment of members with a history of substance abuse/dependency (if applicable). Documentation is made of member's adherence to or non-adherence with medications, and if non-adherent, interventions are considered as appropriate. Assessments by prescribers are to include screening for metabolic syndrome for individuals taking antipsychotic medication. Metabolic screening documentation includes data such as BMI, height and weight, and waist circumference, and lab work including fasting blood glucose, lipids, and blood pressure, with reassessments as needed.

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 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 the responsible licensed provider.
- Alterations of the record must be signed and dated.
- The record must contain a preliminary working diagnosis, a final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments, as well as the treatment plan, must be entered in the record. Drugs prescribed as part of the treatment, including the quantities and dosages, must be entered in the record. If a prescription is telephoned to a pharmacist, the prescriber's records require a notation to this effect.
- The record must indicate the progress at each visit, 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 that the service was provided.
- The name(s) of the individuals(s) who rendered the services.
- The place where the services were rendered.
- The relationship of the services to the treatment/ service plan—specifically, any goals, objectives, and interventions.
- Progress at each visit, any change in diagnosis, changes in treatment, and response to treatment.
- The actual time in clock hours that services were rendered. For example: the recipient received one hour of psychotherapy. The medical record should reflect that psychotherapy was provided from 10:00 a.m. to 11:00 a.m.

Care Coordination

Care coordination is to include involvement of family and natural supports in an individual's treatment, ongoing and continued coordination with PCP, and other providers involved in individual's care. There should be discussion of considering linkage to community-based behavioral health providers and facilitated as indicated if a member presents with symptoms requiring higher level of care. Also, consideration of preventive services such as peer support and intensive care management available within community behavioral health service provider network is recommended. Service overlap may be permitted to make a smooth transition when facilitating referral to a community-based behavioral health provider.

Discharge Planning and Transition

When it is determined that the member has either met the criteria for discharge, presents with unstable mental health symptoms, is intoxicated or in withdrawal, the member will be referred by the BHC to the appropriate behavioral health provider for continued care. Criteria for discharge include, the member has withdrawn, been discharged from service or goals for the member's treatment have been substantially met.

Outcomes

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

- Member satisfaction
- Utilization of higher levels of care
- Community tenure
- Linkages with other programs
- Follow up after discharge from higher levels of care
- Member engagement in services
- Use of one or more validated outcomes tools appropriate to the members served

Performance Outcome Management System (POMS) is a tool 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).
- 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 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 PA 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 Magellan delivers, 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.