Level 3.1: Clinically Managed Low-Intensity Residential Services (Halfway House)

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.

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is a Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) expectation that providers apply these Performance Standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews; but also share with providers as needed to communicate expectations and best practices. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania laws, including Title 55, Chapter 1101; Title 28, Part V Department of Drug and Alcohol Program requirements; the American Society of Addiction Medicine (ASAM) guidelines; as well as 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 and look for the "Compliance Alerts" accordion to stay up to date on Compliance Alerts:
https://www.magellanofpa.com/for-providers/

Level of Care Description

ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services are a combination of clinical and recovery services offered in a residential program that includes a Halfway House. This level of care is appropriate for members who require additional time in a structured residential setting to assist with improving essential daily living skills and prepare them for a successful transition to a lower level of care, including Intensive Outpatient or standard Outpatient Services. Halfway House level of care is often an appropriate treatment option for members who struggle to apply recovery skills, lack self-efficacy, and lack connections to community, education, or vocational activities.

Scope of Services

3.1 level of care is a 24-hour supervised residence that exists to provide a safe, secure environment where members can develop and practice early recovery skills, experience professional and peer support in a recovery-oriented setting and prepare for a successful transition to the community. Halfway House services are usually, but not exclusively offered in a freestanding facility; however, all are required to be licensed. Support systems, including the ability to collaborate with a physician and emergency services, should be available internally or via program affiliation with other levels of care 24/7. The Halfway House level of care is also designed to be able to assist members with arranging medical appointments, and laboratory and toxicology tests to facilitate a member's overall health and wellness. Linkage to a Psychiatrist or Medical Doctor to support pharmacotherapy is also an expectation of services offered in the 3.1 level of care. These services will be provided by a team of credentialed medical, addiction, and mental health professionals who have knowledge about the biological and psychological dimensions of substance use disorders.

3.1 Provider Performance Standards

It is also expected that the clinical team can identify signs and symptoms of psychiatric distress or decompensation. Allied health professionals, such as counselor aides or group living workers who are available on site 24 hours a day are also an important part of the staffing available in a 3.1 level of care. 3.1 programs are to include a range of evidenced-based therapies and therapeutic modalities to support members in their recovery. A minimum of five hours per week of professionally directed treatment is required in a 3.1 level of care. Clinical services should be available at various hours of each day, including weekends and holidays, to accommodate the residents' work schedules.

Service Description

Halfway House treatment is comprised of both clinical services and a recovery residence component. The recovery residence component of a Halfway House is designed to minimize relapse or continued problem use potential. Clinical and therapeutic services offered are designed to address readiness to change as well as coping and functional skills within the member's environment. Services include group therapy, family sessions, and vocational rehabilitation. Interpersonal skills are promoted through community living and house meetings.

Additionally, medication education and management, and life skills are available in 3.1 programs. Therapies offered in a halfway house are evidence-based, and include the following components:

- Improve a member's ability to structure and organize daily living tasks;
- Offer planned personalized activities to address the member's substance use disorder and apply recovery skills;
- Addiction pharmacotherapy;
- Random drug screening to monitor and reinforce treatment gains;
- Offer motivational interviewing and enhancement as opposed to confrontation;
- Counseling and clinical monitoring to support successful involvement in daily activity;
- When appropriate, treatment would include collaboration with members' community supports;
- Monitoring of member medication adherence;
- Access to recovery support services such as CRS, BCM, support groups etc;
- Services for family and loved ones; and
- Education and linkage to addiction pharmacotherapy as a treatment tool

Service Exclusions

While receiving treatment at a 3.1 level of care members are not eligible for following services: Acute Inpatient Psychiatric Services, Extended Acute Care, Substance Use Disorder (SUD) Detoxification, SUD Rehabilitation, SUD Partial Hospitalization programs, SUD Intensive Outpatient treatment, SUD Case Management, Crisis Residential programs, Community Residential Rehabilitation, Adult Residential programs, Family Based Therapy, Intensive Behavioral Health Services, Applied Behavior Analysis,

Multi-Systemic Therapy, Functional Family Therapy, Psychiatric Rehabilitation programs (site-based and mobile), and Dual Diagnosis Treatment Team services.

Referral Process

In order to begin the referral process for the 3.1 level of care, a member needs to obtain an ASAM assessment. This can be arranged through a current provider if a member is enrolled in other services or by locating the closest ASAM assessment site (a list of providers can be found on the Magellan website, www.Magellanofpa.com, or by calling 1-866-780-3368). A member may also call a provider directly to get instructions on how to access services at their facility. Once the ASAM assessment has been conducted and this level of care, is deemed appropriate for the member, the individual or provider conducting the ASAM assessment will make the appropriate referrals.

Admission Process

Medical Necessity Criteria (MNC) for ASAM 3.1 Level of care is determined by ASAM Dimensions 1-6:

- Dimension 1: No withdrawal risk, or minimal or stable withdrawal.
- Dimension 2: None, stable, or receiving concurrent medical monitoring.
- Dimension 3: None or minimal; not distracting to recovery. If stable, a co-occurring enhanced program is required.
- Dimension 4: Open to recovery but needs a structured environment to maintain therapeutic gains.
- Dimension 5: Understands relapse but needs structure to maintain therapeutic gains.
- Dimension 6: Environment is dangerous, but recovery is achievable if level 3.1 24-hour structure is available.

Other services that members should be able to access while at 3.1 LOC include:

- Telephone or in-person access to a physician and emergency services are available 24/7
- Programs that have direct affiliation with other levels of care or close coordination through referral to more and less intensive levels of care and other clinical and support services.
- Member has the ability to arrange for needed procedures, such as dental care, lab testing, or toxicology, as appropriate to the severity of the member's conditions.
- Member has the ability to arrange for pharmacotherapy for psychiatric and anti-addiction medications.

Treatment or Service Plan

A standardized multidimensional assessment and treatment planning process must be used. The goal is to establish and maintain relevance with respect to the member's status as it changes during the course of treatment. The focus is on the member's overall progress on goals and objectives rather than the confines of a treatment episode. Services are regularly updated to ensure relevance and appropriateness for Level 3.1.

3.1 Provider Performance Standards

An individualized, comprehensive biopsychosocial assessment of the patient's substance use disorder (SUD) and history is conducted or updated by staff who are knowledgeable about addiction treatment. This assessment is used to confirm the appropriateness of placement at Level 3.1 and to help guide the individualized treatment planning process, which is focused on the member's strengths, needs, abilities, preferences, and desired goals. Through a comprehensive assessment of the member's biopsychosocial status and SUD needs, appropriateness for the 3.1 LOC is established, and a foundation is laid for an individualized treatment plan.

An individualized treatment plan is developed with the member to achieve identified goals. In addition to identified clinical treatment goals, other components of treatment planning include case management conducted by on-site staff, healthcare, mental health, social, vocational, or housing services. Treatment is patient-directed based on assessment, with the clinician in the role of guide and facilitator. The individualized plan features measurable objectives to be addressed during the course of treatment and reflects the member's stated goals.

Expectations of Service Delivery

Level 3.1 program services may be offered in a freestanding, appropriately licensed facility located in a community setting. The 3.1 provider will notify Magellan, in a timely manner, about changes in the member's medical or psychiatric status resulting in a provider pursuing a higher or lower level of care.

Per ASAM guidelines, treatment providers should provide a holistic approach for determining individualized and outcome-driven treatment plans for members. Using the criteria as a guide, practitioners can:

- Assist a patient from assessment through treatment.
- Work with the patient to determine goals.
- Help rank and rate all the patient's risks, using the criteria's multidimensional approach to determine where to focus treatment and services.
- Determine the intensity and frequency of services needed using the criteria's detailed guides of levels of care.

Care Coordination

Coordination of care at a 3.1 level of care may focus on helping individuals prepare for a smooth transition to a less intensive level of care. Such coordination may include working with an individual's family if appropriate, working with a psychiatrist if needed, education and access to medication-assisted treatments, access to a medical physician, and help with obtaining any specialty appointments such as dentist, etc.

At times, a situation may arise when an individual will require a higher level of care at which time the member should be assessed using appropriate assessment tools and referred to necessary treatment.

Coordination with community recourses such as Certified Recovery Specialist, Intensive Case Management, psychiatric services, Medication Assisted Treatment, etc. is critical to successful outcomes for members. It is the expectation that the 3.1 provider will secure consents for community and natural supports upon admission in efforts to increase communication between all supportive parties of the member and insure further stability inside and outside of the treatment facility.

Discharge Planning and Transition

When a member is no longer assessed as meeting ASAM criteria for 3.1 level of care, the expectation is that member is offered a clinical recommendation as to what level of care would be most appropriate for them according to ASAM criteria. Examples would be 2.5 (Partial Hospitalization Services), 2.1 (Intensive Outpatient Services), or Level 1 (Outpatient Services.) Throughout this process it is the expectation that Magellan members are actively involved in discharge and aftercare planning process and are agreeable to all locations, dates and times of scheduled appointments. These appointments would include but are not limited to medication management, physical health, behavioral health, medication assisted therapy, etc.

Aftercare appointments for behavioral health are expected to be within 7 days of discharge. Walk-in appointments do not meet Magellan expectations of adequate discharge planning. If a member chooses a walk-in appointment, this should be documented. If an outpatient provider declines to offer a scheduled appointment, assertive efforts should be attempted to secure one with other outpatient providers. If this is not successful or the member declines aftercare appointments, document and inform Magellan Care Manager of this barrier.

All discharges should be reported to Magellan via a telephonic review as soon as the treatment episode is complete or within 24 -48 hours of discharge. This includes, AMA (Against Medical Advice Discharges) whereby offering a discharge appointment within the standard of seven days remains a provider's responsibility.

For all unplanned discharges, it is the expectation of the provider to communicate with Magellan what efforts the clinical team made in order to motivate member to remain in treatment. Furthermore, it is a state regulation that providers notify member’s emergency contacts upon any unplanned discharge, when provider has a signed consent from the member to do so.

Documentation

The documentation in an individual’s record allows mental health and substance use 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 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 plans, 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 into 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. 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.

Magellan has also established some documentation guidelines for providers and services that are reimbursed under an all-inclusive daily rate. Specifically:

- A completed American Society of Addiction Medicine (ASAM) Summary Form (https://www.magellanofpa.com/media/5448/ddap-efm-1002-asam-placement-summary-sheet.pdf) must be present in a member's record prior to or at the start of a level of care/program to receive payment.
- Daily progress notes must be present for all dates of service billed. Clear and concise documentation is required for substantiating payments made to the provider and must meet the required standards as set forth above.

3.1 Provider Performance Standards

- Progress Notes must document the interventions used, the individual's response, and relate to the treatment plan goals. Interventions should be individualized and specific; use of vague language such as "listened and provided positive feedback" or "watched a video" would not be considered sufficient.
- Group therapy notes should include a brief description of the group. They must also include individualized information for each participant including their behavior during the group session, level of participation and response to interventions/ information discussed.
- Staffing patterns must align with all DDAP Regulations, ASAM Requirements and any applicable MA Bulletins to allow for meaningful treatment to be provided 5 hours per week.

Each date of service must have corresponding documentation in the member's record. This documentation should include all interventions, both formal and direct treatment (i.e. structured individual and group sessions) as well as those interventions that are less traditional.

Outcomes

All providers of Level 3.1 services should have policies and procedures in place to evaluate outcomes for the program. Some of the indicators that could be considered include:

- Average length of stay
- Member satisfaction
- Follow up with aftercare services following discharge
- Re-admission within 30 and 90 days after discharge

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. 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.

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.

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.

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.

3.1 Provider Performance Standards

- 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, and Other.

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

3.1 Provider Performance Standards