

Magellan Health Services of Arizona RBHA Frequently Asked Questions For Provider Scopes of Work

Crisis Providers

- 1. Are the cultural competency and standard service requirements needed in the Scope of Work as it is already defined in the ADHS Provider Manual – Magellan Edition?**

Yes. This can be referred to in CLAS standards 4-7, which are mandated by federal regulations. These standards are part of a cultural competency plan. This language will remain in the Scope of Work.

- 2. Can you please provide clarification as to why laws prohibiting discrimination are needed in the Scope of Work?**

This is to ensure and monitor the proper delivery of services.

- 3. The Scope of Work states, “The contractor is responsible for ensuring the availability of Medicare licensed clinical staff to conduct assessments and ensure services are appropriately billed to Medicare. Contractor shall submit evidence of Medicare licensure to Magellan annually.” To my knowledge, Medicare does not license master level clinical staff. Medicare will certify an agency to provide a service, but will not certify a master level staff to provide a service.**

Magellan expects that services provided to individuals with Medicare will be billed to Medicare and providers will take the necessary steps to ensure staff members delivering services are able to bill Medicare for covered services.

- 4. The Scope of Work states, “Contractor will ensure all written materials shall be made available in alternative formats for the visually impaired. Contractor will inform all behavioral health recipients that information is available in alternative formats and how to access those formats.” Is this something that the RBHA should do to set a single standard and a single source for the information?**

No. Providers must have materials available in alternative formats to meet the needs of persons receiving services. There are several alternative formats that can be used and contractors can utilize any format they deem best for their agency. The RBHA is held to this requirement as well (this is a federal requirement).

Children's Providers

- 1. Under Appointment Standards and Timely Transfer of Care, what mechanism will be put in place for closures when a recipient transfers between providers?**

A system/RBHA disenrollment is not required when an individual transfers from one agency to another.

- 2. How can a service recipient obtain his/her medication while a transfer is in process?**

The clinical liaison is responsible for ensuring services are secured to meet the needs.

- 3. If a PNO has a referral after 5 p.m., can the referral be faxed to the QSP and follow-up within 24 hours?**

As stated under The Management of Referrals, "If there is not a live answer, the PNO will fax the referral to the QSP. The QSP must return the fax referral to PNO Call Center with confirmation of the appointment date and time offered and the actual scheduled appointment date and time within 24 hours of the date and time sent by PNO."

- 4. Is there a standard format for the monthly progress notes?**

For direct support providers, there is not a standard format for the monthly progress notes. There is the expectation that the information in the note has the following elements: child's presence/absence with appointments, evidence of active intervention toward goals and evidence of change in intervention when no progress toward goals has been met.

- 5. Many other codes are needed beyond the support and rehabilitation services codes to successfully operate a generalist direct support agency. These include case management, assessment, travel transportation, screening and other codes.**

As defined in the service description, in order to operate as a generalist support provider, the provider must be prepared to configure its program operations to the needs of the child and family team without arbitrary limits on frequency, duration, type of service, age, gender, population, or other factors associated with the delivery of support and rehabilitation services. This would include providing case management, assessment, travel transportation, screening and other codes.

Adult Providers

A. Outpatient Services

A1. Can psychiatric services be included in the Scope of Work?

This is included in the Scope of Work.

A2. The Scope of Work states, “Facilitate/participate in service planning that actively addresses recovery goal(s), including psychosocial rehabilitation and employment or the vocational rehabilitation needs of behavioral health service recipients if applicable.” Does this apply to all outpatient providers?

The expectation is that psychosocial rehabilitation and employment/vocational rehabilitation needs are addressed in service planning as applicable to the needs of recipients.

A3. The Scope of Work states, “Develop and execute a written discharge plan consistent with the recipient’s ISP no later than the third day following a recipient’s admission to an inpatient facility.” Why would an outpatient facility be responsible for completing a discharge plan for an inpatient facility?

The agency serving as the clinical liaison needs to work collaboratively with the hospital on discharge planning in order to identify and establish service needs upon discharge. To reduce the number of unnecessary hospital days, the outpatient provider must have an active plan in place to accommodate/support the recipient's return to the community.

A4. Do all outpatient providers need to offer evening and weekend appointments?

This is a contractual requirement that needs to be addressed based on the needs of the people served by the agency.

A5. Is a physician required to provide oversight of medical treatments, medications, including methadone and Buprenorphine, and detoxification for recipients with substance use disorders?

Magellan has revised the language from “physician” to “medical professional.”

A6. Regarding the clause: “Assess and treat mental health and substance use disorders in adults, adolescents, and their families through competent staff.” Are GMH/SA providers who are not licensed to provide services to individuals who are under 18 required to add this to their license?

If family history indicates a need for assessment and treatment for someone under the age of 18, the provider is responsible to coordinate services with other agencies to meet the needs

of the family. To clarify the language, Magellan has added “as applicable” after adolescents or “consistent with the contractor’s scope of practice.”

A7. Does the goal of “symptom management/self-determination – recipients manage their own illness” apply to all recipients?

This goal applies to all populations. For example, related to substance abuse services, this applies to trigger identification and developing a plan to address triggers/relapse prevention. An important aspect of treatment is to have people identify the ways they will be able to deal with triggers (in treatment and outside of treatment). In addition, it is critical to link people with community/natural supports to address symptoms/relapse prevention.

A8. Who is responsible for notifying the behavioral health recipients that they have a choice in choosing contractors within the RBHA/PNO network and ensuring choice in providers?

Providers need to assist in the education of persons about services that are available; choice is not a one-time event. The QSP and the PNO should reinforce to the consumer that choice is available.

A9. How are advanced directives coordinated/updated to avoid a person from having multiple advance directives at the same time?

All providers have a role in educating recipients about advanced directives. The clinical liaison is a point of contact to discuss whether or not there is an executed (developed) advanced directive. If a provider assists a person in executing an advance directive, this must be coordinated with the clinical liaison.

B. Adult Residential Services

B1. The Scope of Work states, “A Standardized Referral Packet can be delivered seven (7) days after the recipient is admitted, the provider must not deny a recipient for lack of documentation.” It is absolutely critical for Level II and Level III providers to have the following pieces of information PRIOR to admission (OBHL guidelines, legal standards and professional coordination of care standards): 1. Documentation of guardianship. 2. Documentation of the need for Special Assistance. 3. Current medication orders. 4. Written evidence of freedom from TB (aka TB tests) within 7 days of admission. Given the complexities of coordinating these tests with PCPs, etc., it has been our experience that it is next to impossible to meet this 7-day time frame unless the clinical team has either collected the documentation or initiated the process BEFORE intake. It has also been our experience that when clients are admitted without this information, and subsequently test positive for exposure to TB (whether or not they are symptomatic), it becomes extremely problematic for everyone – especially the client – to arrange an alternative treatment location.

Providers and clinical teams need to work collaboratively to ensure that all necessary documentation is provided within the established timeframe. A potential compromise may be that the provider provisionally accepts a recipient in the absence of this information, but must have certain documentation prior to physically admitting the recipient to the program.

B2. The Scope of Work states, “If a service recipient is absent from treatment for 24 hours (unless the recipient has a planned/agreed-upon absence that supports larger recovery goals), the contractor will process this as an Absence from Scheduled Activities /Absent without Leave (AWOL) discharge, complete an incident report and notify the Clinical Liaison and Magellan Health Services Adult Residential Coordinator immediately.” Can 24 hours be changed to 72 hours? It takes longer than 24 hours to process a discharge. Providers have a responsibility to coordinate these actions not only with the clinical teams, but also with family members, guardians, ancillary treatment providers, etc. There are also facility-related tasks involved in a discharge of this nature (re-keying locks, removing and storing client belongings, etc.).

The intent is to ensure that there is timely communication about an absence from treatment. Magellan has revised the language to 48 hours.

B3. Please change the language around placing individuals on a waiting list.

The intent is to ensure that timely services are provided. In accordance with federal requirements each state must ensure that all services covered under the state plan are available and accessible to enrollees. Please refer to the Provider Manual sections 3.2 and 3.19 for further information.

B4. Why are peer support services only to be provided through outpatient clinics?

Peer services can be delivered by various provider types in accordance with the ADHS/DBHS allowable procedure code matrix. For 24 hour residential services, peer support cannot be billed by the residential provider in addition to the residential service code as residential is an all-inclusive code.

B5. The requirement that the contractor must demonstrate annual continuing education in CPR and first aid is unusual since official CPR and first aid certification is good for a two year period.

Not all certifications expire in the same year. For example, John’s staff certification may expire in 2009; whereas, Jane’s staff certification expires in 2010. This is why it is required to demonstrate annual continuing education.

B6. Upon receipt of a complete Standardized Referral Packet from the RBHA, an intake appointment with the recipient must occur within one calendar day of the referral. What happens when background checks that are required by the landlord exceed the 48 hour timeframe?

This is in the Scope of Work to ensure the timely delivery of services. Magellan understands that there may be extenuating circumstances that would delay an admission related to landlords requiring background checks. Due to fair housing laws, Magellan understands that in certain instances, this requirement may be out of the provider’s control. This will be addressed on a case-by-case basis between the residential director and the provider.

B7. Admission must occur within 48 hours, two calendar days, of the intake appointment except in cases when extended transition is required. What happens when background checks that are required by the landlord exceed the 48 hour timeframe?

This is in the Scope of Work to ensure the timely delivery of services. Magellan understands that there may be extenuating circumstances that would delay an admission related to landlords requiring background checks. Due to fair housing laws, Magellan understands that in certain instances, this requirement may be out of the provider's control. This will be addressed on a case-by-case basis between the residential director and the provider.

B8. For the statement, "Develop and execute a written discharge plan consistent with the recipient's ISP no later than the third day following a recipient's admission to an inpatient facility." It is our understanding that the inpatient facility is responsible for the facility discharge plan and the outpatient provider is responsible for the step-down care.

The outpatient provider agency, in collaboration with the inpatient provider and clinical liaison agency are responsible for coordinating discharge planning in order to identify and establish service needs on discharge.

B9. The Scope of Work States, "Provide a copy of a behavioral health recipient's executed advance directive, or documentation of the refusal, to the behavioral health recipient's Acute Care Primary Care Physician/Practitioner for inclusion in the behavioral health recipient's medical record." Does the acute care primary care physician offer a medical advance directive to the behavioral health recipient?

Yes. Medicaid law requires this and it is an expectation of the AHCCCS health plans. In the event a BHR develops (executes) an advance directive, the provider must provide a copy to the acute care primary care physician/practitioner for coordination.

B10. The Scope of Work States, "Assess and treat mental health and substance use disorders in adults, adolescents, and their families through competent staff." Are providers being asked to provide outpatient treatment services to adolescents?

No. If the provider is not licensed to serve children/adolescents or families, the provider is responsible for coordinating services with other agencies to meet the identified needs of the family.

B11. The Scope of Work States, "Contractors will document progress towards the four recovery outcomes that are consistent with the goal(s) of the service recipient's ISP." These are geared toward SMI consumers in general irrespective of the type of program the agency is operating. Does this apply to GMH/SA providers?

The four recovery outcomes apply to all populations served, not just the SMI population.

C. Community Living Services

C1. Requiring the ability to provide evening and weekend appointments to meet the needs of people being served has a financial Impact.

This is a contractual requirement that needs to be addressed based on the needs of the people served at every agency.

C2. The Scope of Work states that the service contractor will provide a monthly service report to the RBHA's Care Management Department, to include: name of person receiving Services, service provided and number of units Provided. The RBHA already has this information in its claims and demographic system. This manual level of reporting is redundant and burdensome. Why are providers required to report on this?

Magellan has deleted this reporting requirement.

D. Inpatient Level I Sub-Acute Services

D1. The Scope of Work states, "Inpatient services and crisis beds are provided in a subacute facility to a recipient who is experiencing acute and severe behavioral health and/or substance abuse symptoms. Services may include emergency reception and assessment; crisis intervention and stabilization." Has Magellan considered the outpatient evaluation and prescribing functions that occur in the lobby and how these are addressed in an inpatient scope? For these individuals, we become the clinical liaison.

This is addressed in the ADHS/DBHS Covered Services Guide on page 123 - Crisis Stabilization.

D2. The Scope of Work states, "Seriously Mentally Ill recipients must have a documented contact with the clinical team prior to leaving the contractor and cannot be placed in homeless shelters or supervisory care unless supervisory care is the recipient's home." For SMI individuals, the requirement is to coordinate the discharge with the clinical team/DCC. Placement after discharge for these individuals is by the DCC, not the inpatient unit.

The intent is to ensure that persons with SMI are not discharged to a homeless shelter or supervisory care home without the clinical team involvement.

D3. Agreement from the outpatient team and recipient must be obtained for a seriously mentally ill recipient to be placed in a halfway house. After hours and weekends, contact the responsible on-call party. The inpatient facility does not place an individual with SMI. This is through the clinical team/DCC, Why is this in the scope of work?

The inpatient and outpatient teams must coordinate a recipient's discharge with one another.

D4. The requirement that a contractor must ensure that police, recipients and

family members receive immediate attention when they enter the facilities has a financial impact. What does “immediate attention” mean?

People must be greeted and timely services must be provided based on need.

D5. The requirement that a provider must “not deny, suspend, or terminate services to a behavioral health recipient without prior notification to Magellan or the PNO” is not realistic and very confusing as applied to a crisis environment.

This refers to a prior authorized service.

D6. Regarding the clause “Recipients will not be put on a waiting list. Should the occasion arise when facility is at capacity, every attempt will be made to utilize another agency’s facility or an inpatient hospital setting.” Subacutes cannot admit more than three new individuals past licensed capacity due to health, safety, and space reasons. Can we recommend rephrasing this to: “The provider will make every effort not to place recipients on a waiting list for inpatient services.”

Magellan revised the language to read: “The contractor will demonstrate that attempts were made to transfer affected recipients to another facility or inpatient hospital setting.”

D7. What does “contractor will ensure ongoing recruitment and retention strategies to increase and maintain a multilingual and multiculturally trained workforce” look like?

The providers will identify the number of bilingual (all languages) staff and explore best practices for hiring and training staff. Workforce diversity should be representative of and reflect the community served by the provider. This includes language.

D8. Why must the contractor ensure that materials for recipients of service are translated into all languages that meet the following population thresholds: spoken language (3,000 or 10%), vital materials (1,000 or 5%), and written notices (1,000 or 5%)?

This is an AHCCCS requirement. Please reference section 3.23 of the Provider Manual.