Substance Use Disorder Outpatient and Intensive Outpatient

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

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

Current Version Information

Substantive changes in most recent update:

1. Quality Management – incident reports are required to be submitted electronically

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is Magellan's expectation that providers apply these Performance Standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews. Entities providing services as part of the Pennsylvania (PA) HealthChoices Program must first be enrolled in the PA Medical Assistance Program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania laws, including Title 28 Part V & Title 55 Chapters 1101 & 1223 of the PA Code, as well as all associated MA Bulletins, The Department of Drug and Alcohol Programs (DDAP) licensing requirements and any contractual agreements made with Magellan in order to be eligible for payment for services.

Please routinely visit the link below and look for the "Compliance Alerts" accordion *to stay up to date on compliance email blasts: https://www.magellanofpa.com/for-providers/*

Level of Care Description

Outpatient treatment centers are community-based programs, allowing the recovering member to keep going to work or school. Members are able to remain at home while receiving treatment, allowing for a more normal daily routine. Support of family and friends is imperative at this level of care. Outpatient care consists of individual and/or group sessions. Intensive outpatient care entails a larger time commitment of at least 12 hours per week, comprising of both individual and group therapy.

Scope of Services

Substance Use Disorder (SUD) Outpatient (OP) and Intensive Outpatient (IOP) Services will be delivered to adults and/or adolescents, depending upon the provider's service license approved program description. There is not a set length of stay for OP care, however, the American Society of Addiction Medicine (ASAM) Continued Stay Criteria should be used to make length of stay determinations for level 1.0. IOPs are expected to follow the ASAM criteria for number of treatment hours per week for 2.1 level of care. A member must have a primary diagnosis of a Substance Use Disorder in order to participate in OP or IOP treatment. All Substance Use providers licensed by the Department of Drug and Alcohol Programs (DDAP) must be capable of

identifying and delivering services to members who have been diagnosed with both a SUD and a Mental Health (MH) disorder, where the MH diagnosis is not symptomatic. This aligns with the ASAM delivery of care that necessitates that providers are co-occurring capable.

Programs will follow their DDAP license(s) for allowable maximum number of members served. Independent practitioners cannot provide SUD OP or IOP services.

Service Description

Outpatient and Intensive Outpatient Services include the implementation of the most promising approaches for an individual who is diagnosed with a Substance Use Disorder (SUD). The individual's potential for growth and recovery should be emphasized. Intervention strategies should attempt to improve the individual's quality of life as well as alleviate symptoms. The issues identified in the biopsychosocial evaluation and goals of the individual should drive the treatment plan.

It is best clinical practice for these services to be provided by a Substance Use professional. Accordingly, clinic-based OP and IOP SUD services should be delivered by a licensed, certified, or master's prepared individual as per facility policy and the Pennsylvania Code. SUD professionals should be supervised in their practice by a senior clinician, or other appropriately trained clinicians. Per the regulations, services within a licensed outpatient clinic may also be provided by SUD counselors and counselor assistants and must meet the ASAM Criteria for delivery of services. 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.

All clinicians who may have direct contact with children/adolescents under age 18 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 facility must also have a policy in place that requires Act 33/34 clearances and FBI Background Check for employees working with children/adolescents under age 18. Clinicians who may be providing services to older (60+) or care-dependent adults are required to obtain Act 34 clearances upon initial hiring. The Child Protective Services Law which outlines when clearances must be obtained and how often they need to be updated must be followed.

Service Exclusions

While active in SUD IOP, members may also receive:

- Case Management and Recovery Support Services (RSS), unless individuals are also active in an Opioid Center of Excellence, where these services are embedded as required by the Department of Human Services.
- Assertive Community Treatment (ACT)
- Peer Support Services

All other services may be duplicative.

While active in an SUD OP Program, members may receive (some of these may require prior authorization):

- Halfway House services
- Case Management and RSS, unless individuals are also active in an Opioid Center of Excellence where these services are embedded.
- Family Based
- Intensive Behavioral Health Services (IBHS)
- Intensive Behavioral Health Services -Applied Behavior Analysis (IBHS-ABA)
- Multi-Systemic Therapy (MST)
- Functional Family Therapy (FFT)
- Assertive Community Treatment (ACT)

Referral Process

Referrals may come from a variety of sources, including the member.

ASAM Admission Criteria must be used in order to determine the appropriate level of care. Outpatient programs follow Level 1.0 criteria while Intensive Outpatient Program follow level 2.1 criteria. Authorization is not required for these two levels of care, however, the ASAM form must be in the member's chart. This will be monitored by Magellan during regular oversight activities.

Admission Process

Members must have timely access to appropriate behavioral health services from an in-network provider 24 hours a day, seven days a week. Members should be able to obtain behavioral health services from an in-network provider within the timeframe that reflects the clinical urgency of the situation. Providers are to offer immediate emergency services, when necessary, to stabilize a potentially life-threatening situation. Services should be provided within six hours of referral from Magellan in an emergent situation that is not life-threatening, within 48 hours of referral in an urgent clinical situation, and within 7 business days of referral for routine clinical situations. Additionally, Outpatient and IOP appointments must be provided within seven days after discharge from a 24-hour level of care stay.

Providers are expected to offer appointment times that will meet the member's

needs, including evening appointment times to accommodate the member who works, attends school or is otherwise unable to attend appointments offered during traditional office hours. Network providers must offer hours of operation to Pennsylvania HealthChoices' members that are no less than the hours of operation they offer to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.

The assessment process is a collaborative process between the member and the provider. A member's support system (family/significant other) should be included in the assessment and ongoing treatment when clinically indicated and with the member's agreement. In additional to behavioral health needs, assessments should be inclusive of both Social Determinants of Health (SDOH) factors and physical health factors, as well as how these factors may impact treatment.

It is expected that a member and family members/significant others receive education and information about the member's illness. The member and family members/significant other should be provided with information in order to assist the member and their families in the management of symptoms and behaviors that may occur with behavioral health disorders.

Diagnostic Admission Criteria

Level 1: Co-Occurring Capable Programs
At Level 1, some members have co-occurring mental health disorders that meet the stability criteria for a co-occurring capable program. Other members have difficulties in mood, behavior, or cognition as the result of other psychiatric or substance-induced disorders, or the member's emotional, behavioral, or cognitive symptoms are troublesome but not sufficient to meet the criteria for a diagnosed mental health disorder.

Level 1: Co-Occurring Enhanced Programs
In contrast to the diagnostic criteria described above for co-occurring capable programs, the member who is identified as in need of Level 1 co-occurring enhanced program services is assessed as meeting the diagnostic criteria for a mental health disorder as well as a substance use or induced disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission (ASAM pg. 90).

Level 2.1: All Programs
The member who is appropriately placed in a Level 2.1 program is assessed as meeting the diagnostic criteria for a substance use and/or other addictive disorder as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission. If the member's presenting alcohol and/or other drug use and other addictive behavior history is inadequate to substantiate such a diagnosis, the probability of

such a diagnosis may be determined from information submitted by collateral parties (such as family members, legal guardians, and significant others).

Level 2.1: Co-Occurring Enhanced Programs
The member in need of Level 2.1 co-occurring enhanced program services is assessed as meeting the diagnostic criteria for a mental health disorder as well as a substance use disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission (ASAM pg. 201).

Treatment or Service Plan

An individual treatment and rehabilitation plan must be developed with a member within 15 days following intake. This plan shall include, but not be limited to, written documentation of:

- Short and long-term goals for treatment as formulated collaboratively by staff and the member
- Type and frequency of treatment and rehabilitation services
- Proposed type of support services

Within 15 days following intake, the clinic's supervisory physician shall review and verify each patient's level of care assessment, psychosocial evaluation, and initial treatment plan, prior to the provision of any treatment beyond the 15th day following intake. The clinic's supervisory physician shall verify the patient's diagnosis. The clinic's supervisory physician shall sign and date the patient's level of care assessment, psychosocial evaluation, treatment plan and diagnosis in the patient's record.

Treatment and rehabilitation plans must be reviewed and updated at least every 60 days. Each review and update shall be dated, signed and documented in the patient's record. Counseling must be provided to a client on a regular and scheduled basis.

The treatment plan and updates shall be based upon the psychosocial evaluation and diagnoses. All co-occurring enhanced programs must include both mental health and substance use issues identified in the assessment process when developing a treatment plan with members. Treatment shall be provided in accordance with the treatment plan and updates and under the supervision and direction of the clinic's supervisory physician. Goals are to be concrete, specific, realistic, measurable, stage-of-change specific, and based on the strengths of the member. Providers are encouraged to include recovery principles in the treatment planning process.

Expectations of Service Delivery

Magellan supports a targeted and focused approach to member care. Clinical and support needs are to be identified using behavioral descriptions that explain the reason a member requires treatment. All treatment is expected to have a clear direction toward one or more goals.

Treatment services should be delivered within models supported as evidence-based practices in behavioral health literature.

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 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.
- The record must contain all relevant diagnoses inclusive of mental health, substance use, and physical health, and be reflected on claims submissions.
- 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.

Risk Assessment

Outpatient providers should have a standard suicide risk assessment that is utilized with members routinely throughout the course of treatment. If a member indicates as high risk for suicide, a crisis plan should be created to support the member's needs. Both risk assessments, relapse prevention plans and crisis plans should be updated periodically to best meet the member's needs. Members who experienced an acute inpatient admission should have risk assessments completed at their return to outpatient services.

Relapse Prevention Plan

Providers must develop, in coordination with members, a thorough relapse prevention plan that identifies areas of risk for the member and specific interventions to address each risk identified. The plan must include contacts and numbers to aid with interventions, if necessary.

In addition to the documentation standards described above, co-occurring capable and co-occurring enhanced programs must document the member's mental health problems, the relationship between the mental and substance-related disorders, and the member's current level of mental functioning.

Co-occurring Capable and Enhanced Service Delivery

While Magellan supports a targeted and focused approach to member care, we expect that all of our SUD providers are co-occurring capable in their delivery of services. Per the ASAM Criteria, 3rd Edition, all Substance Use providers must have an approach to treatment with a recovery-oriented co-occurring capability that necessitates that all care is welcoming and

person-centered. Although all SUD providers must be co-occurring capable in their delivery of clinical services, some providers have been designated as a co-occurring enhanced system of care based on their state licenses, staff credentials, and staffing patterns. Enhanced Providers must be dually licensed by both the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) and the Department of Drug and Alcohol Programs (DDAP). These providers must address the complicated needs of individuals with co-occurring disorders of Mental Health and Substance Use within a single outpatient setting.

Co-occurring Enhanced

1. In order to be considered a provider of enhanced and therefore truly integrated Substance Use and Mental Health Co-occurring (COD) services, the agency must be dually licensed through DDAP and OMHSAS to provide drug and alcohol as well as mental health treatment services, respectively.
2. The agency's philosophy, mission statement and policies must incorporate an understanding of co-occurring disorders and treatment of individuals with co-occurring disorders.
3. The agency will ensure a welcoming, "no wrong door" environment.
4. Evidence-based medication-assisted treatments will be offered to individuals, as appropriate. Enhanced COD treatment providers must ensure that individuals have access to MAT, either through direct service or by affiliative agreement with another provider(s).
5. Recognition that medication-assisted treatment is most effective in conjunction with psycho-social treatment and is expected of MAT treatment providers.
6. The agency will display, distribute and utilize literature on COD-related topics for individuals and families, including information on medication-assisted treatment.
7. The agency will implement best practices for DDAP priority populations, and recognizing the unique needs of these populations.
8. The agency will develop a group schedule to include COD-related topics.

Care Coordination

Providers are expected to encourage the member to permit communication with primary care physicians (PCPs) and other behavioral health providers. It is expected that a release of information will be obtained from the member for both the PCP and other behavioral health providers who may be co-treating the member. It is expected that there will be documented evidence of this discussion in the treatment record and of patient refusal if this action is not completed.

If upon initial assessment physical health factors are identified, it is best practice to assess for the stability of the identified physical health factors and the member's perceptions as to their ability to self-manage their physical health needs. The impact that behavioral and physical health factors have on each other should be discussed along with how these factors may

influence treatment. If barriers are identified in managing one's physical health needs, the barriers and possible resolution to identified barriers should be reviewed with member and may be considered for inclusion in goal planning discussions. Physical health diagnoses, medications and treating providers should be documented within a member's treatment record. Providers should encourage members to receive annual physicals. Any lab results obtained that may impact treatment, such as psychiatry, should be included in care discussions.

Magellan may be engaged for assistance in referring members to specialized integrated health programs, either funded by Magellan or through physical health managed care organizations, in which behavioral health and physical health coordination is supported.

The outpatient provider must ensure linkage with the member's PCP, other behavioral health providers including case management, community treatment team, prescribing physician, and other community support services. It is expected that when a member has case management services, that the case manager will be the linkage point with all other levels of care. Housing stability must be considered when treating the member at any level of care, and appropriate referral to support systems outside of the behavioral health system may need to occur if housing is inappropriate or at risk. Referral to peer support groups, a Certified Recovery Specialist or drop-in centers should be considered.

Magellan is committed to the principles of recovery and resiliency for all members and believes that a high level of functioning within the community is possible for all individuals, provided they have access to appropriate services and supports. Magellan is committed to working together with providers, members, families, and counties to achieve this reality. Its philosophy of care also recognizes that full participation of the member and/or family member in the treatment process maximizes the likelihood of a successful recovery intervention. Magellan Care Managers work together with providers and members, to address both treatment and environmental factors impacting recovery.

Magellan supports providers in ensuring that treatment for all individuals is recovery- and/or resiliency-oriented, stage-of-change specific, strengths-based, and member/family-centered. Treatment will be family-focused and involve significant others to the extent desired by the member. Community-based treatment, using natural supports and extensive community support, will be standard. Additionally, treatment will be multi-systemic in nature; culturally competent; flexible and accountable; coordinated; provided in the most appropriate, least-restrictive and least-intrusive setting; evidence-based and reflective of best practices. Magellan supports providers' efforts to foster resilience in individuals and their families, through the promotion of protective factors and reduction of risk factors.

Discharge Planning and Transition

A member must have a clearly stated discharge plan. If the member continues to need community supports and medication management, the provider is expected to solidify plans for those activities. The member should be informed of crisis services or how to reengage in outpatient services if the member believes there might be a need in the future. Discharge plans should be inclusive of resources and/or plans to support a member's physical health and Social Determinants of Health factors, as applicable. If a member has a case manager, he/she should solidify plans for post discharge services and supports for the member. Coordination with the case manager should be pursued in order to ensure that necessary referrals are made.

Provider staff must notify a member, in writing, of a decision to involuntarily terminate the member's treatment. The notice shall include the reason for termination. The member must have an opportunity to request reconsideration of a decision terminating treatment.

Transfer/ Discharge Criteria

It is appropriate to transfer or discharge the member from the present level of care if he or she meets at least one of the following criteria:

- The member has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care. Continuing the chronic disease management of the member's condition at a less intensive level of care is indicated;
- The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. The member is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care (more or less intensive) in the same type of service, or discharge from treatment, is therefore indicated;
- The member has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve his or her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated;

The member has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care. (ASAM pg. 303)

Outcomes

Substance Use Disorder Outpatient 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 tools appropriate to the members served

1. Magellan's branded, clinically driven care model, eMbraceCare, uses a person-centered approach that is designed to support an individual's achievement of improved personal health outcomes and wellness, by encouraging positive living, along with the provision of services that meet individual needs in a whole health manner. Positive living, the ultimate goal of eMbraceCare, is a lifelong process for individuals experiencing behavioral and substance use disorders that includes incorporating all of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Eight Dimensions of Wellness into their lives. These Eight Dimensions of Wellness (http://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness) include the following: Emotional - Coping effectively with life and creating satisfying relationships.
2. Environmental - Achieving good health by occupying pleasant, stimulating environments that support well-being.
3. Financial - Satisfaction with current and future financial situations.
4. Intellectual - Recognizing creative abilities and finding ways to expand knowledge and skills.
5. Occupational - Achieving personal satisfaction and enrichment from one's work.
6. Physical - Recognizing the need for physical activity, healthy foods, and sleep.
7. Social - Developing a sense of connection, belonging, and a well-developed support system.
8. Spiritual - Expanding a sense of purpose and meaning in life.

Through Magellan's person-centered and predictive clinical model, we address the care of the complete individual using *e*MbraceCare, which reflects our commitment to personalized care. This approach begins with the assurance that our clinical staff honors self-determination, direction, and control over an individual's recovery planning process, as part of the treatment paradigm.

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 (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 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.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).

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