Recovery Support Services

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

Performance Standards are intended to give guidance for contracted services as part of the 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. Service Exclusions – clarified that RSS services can be provided on the day of admission to inpatient and residential programs and within 30 days of discharge, including the day of discharge
2. Referral Process – addition of requirement that recommendation from LPHA is valid for 1 year
3. Documentation – additional information related to Encounter Form requirements included
4. Quality Management – Incident Reporting requirements updated to include information about electronic submission of reports

Use of Performance Standards

Disclaimer: The Recovery Support Services (RSS) Performance Standards issued from Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) have been designed to function as a reference for Certified Recovery (CRS) Specialists, CRS Supervisors, provider agencies and other stakeholders in order to support their commitment to optimal service delivery. The RSS Performance Standards provide an overview of best practice considerations and outcomes measurements. The development of this document was led by the Recovery and Resiliency Department to create a dialogue around quality of care in RSS. Please note that this document is designed to be a helpful guide to the provision of Recovery Support Services but does not replace or supersede the Recovery Support Services Minimum Program Requirements issued by Magellan with approval from our County Partners. The RSS Performance Standards refer specifically to the provision of community-based, Medicaid reimbursable Recovery Support Services, but may additionally be a helpful reference for recovery support that is embedded in other programming, such as in Opioid Centers of Excellence (COE).

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

RSS provides opportunities for individuals living with a substance use disorder diagnosis or co-occurring disorder to partner with a Certified Recovery Specialist (CRS) and receive support in the process of achieving their wellness and recovery goals. CRSs are individuals living in recovery and willing to share their own knowledge and experience to facilitate resiliency, promote positive personal change, and support the development of new skills. Recovery support is built on the foundational knowledge that recovery is not only possible, but probable. The CRS understanding of recovery and resiliency is inherently hopeful, trauma-informed, and strengths-based. RSS are person-centered, flexible, and designed with the understanding that those being served are experts in their own lives. In a member's

recovery journey, CRSs center the importance of self-direction, self-advocacy, natural supports, and community integration.

Scope of Services

RSS are available to Magellan members over the age of 18 who are living with a substance use disorder diagnosis or co-occurring disorder. RSS are typically offered individually but may also include participation in CRS run group services. Most RSS occur in a community-based setting, but there may be occasions where it is appropriate to engage with a CRS in a residential or inpatient setting. The frequency and duration of RSS is determined by the needs and goals of the member in collaboration with their RSS provider.

Service Description

To offer HealthChoices reimbursable recovery support, providers must obtain a certificate and state approval through the Supplemental Services Review Committee (SSRC) and enroll in the Medical Assistance program as a provider of Recovery Support Services. Recovery support may be a distinct department within a provider agency that offers other services, or it may be offered by an agency that provides only Recovery Support Services. Recovery support programs may additionally have areas of specialization. All recovery support programs should be administered according to their state and MCO approved Service Descriptions.

Certified Recovery Specialists must meet the educational (high school diploma/GED) and training (54 hours of education in specified areas) requirements, have passed the PCB's written exam and be certified by the PCB as Certified Recovery Specialists (CRS). Each CRS must maintain his/her certification by meeting PCB requirements of 30 credits for re-certification every two years. In order to be eligible for re-credentialing through the PCB, CRSs must complete 30 hours of training, of which 6 hours must be specific ethics and boundaries, and 3 hours must be in confidentiality. Newly hired CRS staff must receive six (6) hours of supervised field work from the CRS Supervisor before working independently.

Supervisors of CRSs should adhere to the PCB published guidance for CRS Supervision titled, RECOVERY SPECIALIST SUPERVISOR CORE COMPETENCIES. This document is "intended for organizations or persons to use as an outline for development of trainings for those individuals who are providing supervision to substance use disorder recovery specialists." CRS Supervisors must complete the Department-approved CRS supervisory training within six months of assuming the position of CRS supervisor. Face-to-face supervision, for a minimum time of 1 hour, is required weekly for CRSs. Group supervision is strongly recommended as an adjunct to individual supervision.

Certified Recovery Specialist supervision should account not only for the functional work responsibilities of the CRS role, but also for the emotional labor associated with routinely discussing personal recovery with peers. This should include the implementation of trauma informed supervision practices that address the possibility of vicarious trauma and/or re-traumatization. Supervision should

allow for the development of self-care strategies within the framework of transparently set boundaries between the CRS and supervisor. CRS Supervisors are encouraged to enhance the DDAP core competencies by familiarizing themselves with the supervision practices outlined by Shery Mead in "Intentional Peer Support (IPS) Co-Reflection Guide." Co-reflection as defined within IPS allows for mutual and purposeful supervisory engagements that promote shared growth.

CRSs should have the opportunity for professional development and networking opportunities with other peers such as participation in workgroups and community recovery meetings. The Recovery Support Coordination (RSC) Team at Magellan can provide information to providers on these opportunities.

Service Exclusions

Recovery Support Services may often serve as an adjunct to clinical treatment and therefore can overlap with both substance use and mental health community-based services including: Halfway House, Substance Use Disorder (SUD) Partial Hospital; SUD Outpatient and Intensive Outpatient (IOP); SUD Case Management; Crisis Residential; Mental Health (MH) Case Management; Psych Rehab; MH Partial; MH Outpatient and IOP; and Dual Diagnosis Treatment Team (DDTT). Recovery Support Services can also be provided on the day of admission to inpatient and residential programs and within 30 days of discharge, including the day of discharge.

Community-based Recovery Support Services cannot be offered in conjunction with programming or services that include embedded Recovery Support Services, such as Center of Excellence (COE) services as this would be considered duplicative.

An individual may not receive RSS, CFRS (Certified Family Recovery Specialist) and/or Peer Support Services at the same time as all are forms of peer support services. The primary diagnosis of the individual would determine which peer service would best suit the needs of the individual at a given point in time. Members with a SUD or co-occurring disorder with a primary diagnosis of a Substance Use Disorder are eligible for RSS Services.

Referral Process

Anyone, including the individual, may make a referral to Recovery Support Services; however, unless exempt by the member's county of eligibility, RSS must be recommended as a medically necessary service by a licensed practitioner of the healing arts (LPHA). A LPHA is defined as a Physician, Licensed Psychologist, Certified Registered Nurse Practitioner, Physician's Assistant, Licensed Professional Counselor, Licensed Marriage and Family Counselor or Licensed Clinical Social Worker. For an individual to receive RSS, there must be a written recommendation including a substance use diagnosis and identified functional impairment of the individual from an LPHA acting within the scope of professional practice. Magellan policy dictates that the recommendation from the LPHA will no longer be valid 1 year after the date of signature and an updated prescription would be necessary to initiate services. In cases

where the ability to obtain a recommendation by an LPHA is a barrier to access, engagement units may be utilized for up to 60 days.

A functional impairment for RSS is defined as difficulties that substantially interfere with or limit one or more of the following:

- A person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills;
- Role functioning in one or more major life activities including basic daily living skills;
- Instrumental living skills (maintaining household, managing money, getting around in the community, taking prescribed medication);
- Functioning in social, family, and vocational/educational contexts.

Admission Process

As Recovery Support Services are voluntary, the intake process must include a consent to participate in services. After intake, an individual engaged in RSS must complete, in collaboration with their CRS, a strengths-based assessment and an Individual Recovery Plan (IRP) within 60 days.

The strengths-based assessment should provide the foundation for the development of the IRP and should be completed prior to the IRP. RSS providers are able to determine the structure of the strengths-based assessment process, but should include information on:

- The individual's skills, strengths, resources, and needs, including in the living, educational, working and social domains;
- Cultural considerations and preferences;
- Identified and needed supports (both natural and formal).

Upon completion, the strengths-based assessment must be signed by both the CRS and the member, indicating joint understanding of the elements of the assessment.

Service Plan

As mentioned above, an IRP will be developed by the individual with support from the CRS within 60 days of consent and will be reviewed at a minimum of every 6 months thereafter. The IRP will also be updated upon any major changes in goals or events in the individual's life. As with the strengths-based assessment, the IRP will be signed by both the individual and the CRS. Dual signatures indicate joint understanding of the individualized goal and action steps pertinent to the individual's recovery. Goals should be self-directed, strengths-based, outcome oriented, and measurable. Goals should be integrated into the individuals' overall treatment plan.

IRPs will also identify interventions directed at achieving the individualized goals and objectives, as well as specifying the Certified Recovery Specialist's role in supporting the individual and the frequency by which the services will be delivered.

With the consent of the member, the CRS works with family members, service and treatment providers, and other programs and natural supports to assist in the achievement of these goals.

Expectations of Service Delivery

The Values of Recovery Support

Recovery Support Services are inherently individualized, flexible, and include a creative process based on the strengths and needs of the member. Magellan believes that the adoption of the best practices outlined below provides invaluable structure in the development of optimal peer programming.

Magellan endorses the National Practice Guidelines for Peer Supporters published by the International Association of Peer Supporters (iNAPS) in 2013 as a framework for providing ethical and effective peer services, including RSS. The National Practice Guidelines link 12 core values of peer support, as identified by peer supporters across the United States, to actionable steps providers and CRSs should practice ensuring the provision of high-quality programming. The 12 core values are:

1. Peer support is voluntary
2. Peer supporters are hopeful
3. Peer supports are open minded
4. Peer supporters are empathetic
5. Peer supports are respectful
6. Peer supporters facilitate change
7. Peer supporters are honest and direct
8. Peer support is mutual and reciprocal
9. Peer support is equally shared power
10. Peer support is strengths-focused
11. Peer support is transparent
12. Peer support is person-driven

The full National Practice Guidelines document, including the associated recommendations for each of the core values, can be reviewed at:
https://na4ps.files.wordpress.com/2012/09/nationalguidelines1.pdf

Considerations for Service Provision

In order to ensure that the provision of Recovery Support Services are tangibly and measurably improving the lives of members, Magellan strongly recommends a goal-driven and outcomes-oriented approach. This begins with the development of an IRP that is driven by the member's own goals and supported by the CRS to ensure it meets the tenets of the SMART methodology. SMART is an acronym

that stands for: Specific, Measurable, Attainable, Relevant, and Time-Bound. Utilizing SMART goals allows the member and peer to create a focused framework and build expectations of their time together, including process and appropriate activities. Setting expectations is an important element of providing a trauma informed service, ensuring understanding and trust in the peer relationship. Recovery support goals and associated action steps should incorporate wellness and recovery elements, including strategies for supporting the development of a coping mechanism and community integration efforts. An essential element of RSS goal planning is the transfer of skills so that peers can implement strategies and skills they have obtained following discharge from the program. Goals should be consistent with and align with the individual's treatment goals.

Support Groups

While most recovery support takes place individually, it may be appropriate for peers to participate in group services when they have aligned IRPs. Magellan encourages providers to consider the provision of appropriate support groups as a way of encouraging skill development, community integration, and promoting the importance of natural supports. The curriculum of group services should be pre-approved by Magellan.

Integration of Wellness and Recovery Modalities

Magellan additionally supports the integration of wellness and recovery modalities in RSS. As an evidence-based practice, WRAP (Wellness and Recovery Action Planning) groups support members in identifying personalized support strategies. WRAP principles can also be implemented in individual meetings. Other examples include Psychiatric Advanced Directives, WHAM (Whole Health Action Management), and Shared Decision Making, etc. Utilization of tools and recovery support modalities should be documented in progress notes.

Documentation

The documentation in an individual's record allows behavioral health professionals to evaluate and plan for treatment, monitor progress 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 CRS.
- Alterations of the record must be signed and dated.
- The record must contain the diagnosis from the Licensed Practitioner of the Healing Arts at time of referral.

- The IRP must be entered in the record.
- The record must indicate the progress towards goal at each session, change in support and response to interventions.
- 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 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 individual service plan – specifically, any goals, objectives, and interventions.
    - Progress at each session, changes in support and response to support;
    - The actual clock hours that services were rendered.

It is critical that progress towards the goal identified in the IRP be documented in a progress note. For recovery support, collaborative documentation is considered best practice. Collaborative documentation refers to the CRS and the member writing the progress note together and facilitates a collective understanding of what was accomplished. Like all elements of RSS, collaborative documentation is voluntary, and the member must consent to participate. It is also not appropriate for all members and in every session. Please refer to the Department of Human Services' Collaborative Documentation Guidelines as well as Magellan's most recent Compliance communication on the topic.

Regardless of whether a progress note is written collaboratively, in addition to the above requirements, RSS documentation should include:

- The activities of the RSS appointment and the ways those activities support the IRP.
    - If an RSS appointment deviates from the IRP, it is important to document the reason why that may be the case (such as an unexpected crisis situation).
- Relevant details of discussion, including goal related and wellness conversation.
- Continuity of care, such as planning information that includes concrete next steps.
- The role of the CRS in supporting the member, and reference to the strategic sharing of the CRS's recovery story.
- Documentation of referrals, resources, partnerships, and collaboration with other supports including natural supports.
- Evidence of discharge planning should be present in the narrative.
- Enough detail to justify the units of time spent in the RSS process.
- Clear documentation and rationale of services provided during transit with an individual including:
    - Services provided in transit must include the specific interventions that relate back to the specific goal in the member's ISP.
    - Recovery Support Services should only be provided during transit if it is safe and appropriate.

- The CRS should only transport a member when it is necessary and appropriate. The CRS should be mindful not to create dependence. Other methods of transportation should be explored and utilized whenever possible. If an individual needs assistance with acquiring a specific skill such as riding the bus to roster independence, it would be appropriate to include this as a time-limited goal on the ISP.
- Providers must document how much time is spent in transit with a member while providing an intervention from the ISP, in addition to other non-billable time in transit. If services provided during transit are not billable, the time spent in transit should be clearly deducted from the overall time billed and this distinction should be clearly documented.
- Providers should have policies and procedures in place that clearly outline their expectations and guidelines for staff around the general transportation of individuals as well as rendering services while in transit.

Encounter Forms

Encounter forms offer an extra check and balance for an agency to ensure that services delivered in the community are done so as documented. As such, this mechanism for oversight and control is best enforced by obtaining pertinent information which can verify the provision of services.

In accordance with Medical Assistance (MA) Bulletin 99-89-05, a recipient signature is required for MA services unless the service is signature exempt (please reference details in the bulletin). If a provider is unable to obtain a signature on the encounter form (including refusal), it must be documented why, and attempts should be made to obtain a signature the following session.

Per MA Bulletin 99-89-05, the following information must be recorded on the encounter form:

- Certification Statement: "I certify that the information shown is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements or documents, or concealment of material facts may be prosecuted under applicable federal and state laws."
- Provider Name and MA ID
- Recipient Name and MA ID
- Date of service
- Member/ guardian signature

Magellan requires providers of community-based services (which includes RSS) to obtain a signed encounter verification form for each face-to-face contact that results in a claim being submitted to Magellan. In addition to the requirements outlined in MA Bulletin 99-85-05, the start and end time of the session (the actual time in clock hours, not the duration; i.e. '2:00 PM-4:00 PM', not '2 hours') must be included on the encounter form for all face-to-face community-based services.

Although a requirement for in-person community-based/ mobile services, Magellan also considers the inclusion of start and end times on telehealth encounter forms to be a best practice. Per OMHSAS-22-02, signatures for telehealth service verification may include hand-written or electronic signatures,

unless prohibited by other laws. Consistent with Act 69 of 1999 Electronic Transactions Act, an electronic signature is an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. Providers using electronic signatures must have systems in place to ensure that there is an audit trail that validates the signer's identity. Physical signatures may be obtained through a variety of different mechanisms including: in-person with the member; US Mail; or e-mailed forms to a member who has the capability to print and return the hard copies; or print, scan and e-mail copies. Signatures can also include an audio recording of voice consent (i.e., the "sound") stored within a HIPAA-compliant telehealth platform. Recording means that the member's voice consent is stored within the medical record system. Signatures are to be obtained as soon as possible and no later than 90 days after the service.

Magellan does permit encounter signatures on multiple dates of service, for example, a weekly/ monthly encounter form for all services rendered during the prior week/ month, as long as the minimum requirements outlined above are met. Signed encounter forms should be available at the time of a Magellan audit or review. The signed encounter form must match all other supporting documentation of the session (i.e., progress note).

Care Coordination

It is an expectation that the CRS work in collaboration with a member's natural supports and professional services, provided that the member agrees to coordination and signs the appropriate release forms. Natural supports, such as friends and family members, can and should be incorporated in support planning and other wellness activities. Collaboration with professional supports is often necessary to ensure that RSS goals and activities are complimentary to the work of other service providers. This may include partnership and information sharing with case management, outpatient providers, crisis services, etc. If a member prefers that this coordination does not occur, this preference should be noted in progress notes. If a member requires inpatient treatment, the assigned CRS should participate in discharge planning and plan to meet with the member within seven days of discharge. Additionally, recovery support should address the integrated health needs of members through partnership with physical health providers such as primary care physicians.

CRSs are invaluable educators in the process of navigating resources, not only providing linkages but also practical support and modeling of self-advocacy strategies. Recovery support should include referral supports if a member's needs are not being effectively addressed in their current level of care. If CRSs continue to be involved, coordination during the transition process should be documented. If a CRS needs to refer the member and discharge (for instance, if the higher level of care includes embedded peer services) than the CRS should facilitate a "warm hand-off," where a member is introduced to the new level of care and programming with CRS support.

Discharge Planning and Transition

Criteria for discharge should be defined by each provider's Service Description, and a formal discharge plan should be established for all individuals. Successful graduation from recovery support upon

completion of goals is the anticipated outcome from programming. Upon discharge, a summary must be completed to include:

- a report of participation and services provided;
- progress made;
- what services/supports the individual is connected with after discharge (or recommendations if declining future support);
- and the reason for discharge.

Discharge planning should take place from the onset of services and be reflected in documentation, as a central tenet of peer services is the focus on the transfer of skills and supporting independence.

Discharge is appropriate when a member has met their goals or no longer benefits from RSS. Discharge would also be appropriate for members who no longer wish to continue in RSS. Disengagement from the peer support process might also indicate that the service is not appropriate at the current moment and result in discharge as well. Signs of disengagement might include lack of response to peer outreach, last minute cancellations or "no-shows" to appointments, and unwillingness to either work on identified goals or identify new goals.

Outcomes

All RSS providers are expected to have procedures identified to evaluate outcomes for peer programs. Program outcomes should include member feedback and satisfaction but should not be limited to these measures alone. Some of the indicators that could be considered include:

- Percentage of members who graduate due to successful completion of goals in the ISP;
- Increase in community tenure/decrease in hospitalization;
- Increased stability in housing;
- Vocational and educational activities;
- Decreased involvement in the justice system;
- Increased community linkages;
- Strengthened connection to OP providers and other support services.

RSS programs have flexibility in identifying outcomes procedures. Some providers have found that the annual self-assessment can be leveraged into outcomes measurements. Others have developed internal measurement tools or utilized existing tools such as the FACIT (Fidelity Assessment Common Ingredients Tool) developed by SAMSHA for consumer-operated services.

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 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 the 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.