Family Based Mental Health Services

Magellan Behavioral Health of Pennsylvania (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:

Referral Process – clarifies county specific requirements for referrals
Treatment or Service Plan – updated to include requirements for crisis plan
Expectations of Service Delivery – expanded information related to Family Support Services funds and non-billable services
Outcomes – expanded to include additional POMS information

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is a Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) expectation that providers apply these Performance Standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews; but also share with providers as needed to communicate expectations and best practices. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania regulations and requirements, including but not limited to The Pennsylvania Code Title 55, Chapter 1101 General Provisions and proposed Family-Based Mental Health Services Regulations Chapter 5260 as well as all associated Medical Assistance (MA) Bulletins, licensing requirements and any contractual agreements made with Magellan in order to be eligible for payment for services.

Please routinely visit the link below to stay up to date on Compliance Alerts:
https://www.magellanofpa.com/for-providers/

Level of Care Description

Family Based Mental Health Services (FBMHS) are voluntary behavioral health treatment services that are provided in the home and community setting. FBMHS has the philosophy that youth achieve best outcomes when treatment is provided in a home environment. The family is a critical partner in the treatment process. FBMHS utilizes the strengths of the youth and family to address areas of need. FBMHS must provide coordination with other natural and community-based supports. FBMHS follow CASSP principles and philosophy.

FBMHS is utilized for youth with serious emotional disturbance and who are at risk of out-of-home placement or who have recently returned home from an out-of-home placement. FBMHS' treatment philosophy is based on the Eco-Systemic Structural Family Therapy (ESFT) model. The treatment services include individual therapy, family therapy, parent training, and case management services. FBMHS includes 24/7 crisis support for youth and families involved with the service.

Scope of Services

FBMHS are available for eligible HealthChoices members up to age 21. A recommendation for FBMHS must be made by a psychiatrist or licensed psychologist.

FBMHS is a team delivered service provided by a minimum of one Master's level clinician and one Bachelor's level staff. FBMHS typically provide 25 hours of treatment per month. FBMHS should provide, at minimum, one individual therapy session per week and one family therapy session per week. FBMHS should incorporate natural supports into the treatment services in a way that best meets the youth and family's treatment needs. FBMHS are designed to be flexible and mobile, meeting the youth and family where they are. Treatment sessions are scheduled at times that best meet the needs of the youth and their family, including evenings and weekends.

Sessions should align with the ESFT model with priority given to weekly sessions with the entire family - all involved caregivers and the identified child. This can be adjusted for each family, with the number and type of session aligning with current needs, stage of treatment, and treatment goals.

FBMHS are provided for up to 32 weeks. Additional authorization is based on medical necessity criteria for continued stay and requires an updated evaluation. The FBMHS team must collaborate with all involved services and supports around the recommendation for additional authorization.

Engagement is critical to success with the goal to allow families to maintain their role as the primary caregivers for their children. FBMHS partners with families to collaborate with community supports and provide valuable tools to manage, advocate, and link natural resources to maintain children in their homes and community. FBMHS values the individual culture of each family.

Service Description

FBMHS are delivered by a team of two clinicians who can have a maximum caseload of 8 families. The FBMHS agency uses a crisis/on-call line to provide mobile crisis support 24 hours a day, 7 days a week. The FBMHS team provides crisis prevention and intervention to the youth and families in the program.

Case Management services are a component of the FBMHS treatment model. FBMHS should coordinate with other services and systems on behalf of the youth and family, and function in a role of treatment team leader.

Overall supervision of the FBMHS program must be provided by a director who is employed full-time by the FBMHS program. FBMHS clinicians receive 1.5 hours of individual clinical supervision and 1.5 hours of group supervision per week. All staff (therapists and clinical supervisor) are required to attend the Department of Human Services (DHS) approved FBMHS Eco-Systemic Structural Family Therapy (ESFT) training from an approved training center. Staff must obtain 18 training hours during the first year. In addition, staff must obtain 255 hours of Core ESFT FBMHS training provided at the rate of 85 hours annually over a 3-year time frame. Staff will be required to pass an established competency

assessment to graduate from the training program. Both bachelor's and master's level clinical staff who have graduated from the training program will need to obtain 30 hours of ESFT Booster training annually. Clinical supervisors will need to attend 30 hours of ESFT Supervisor Core training annually and attend CORE ESFT FBMHS training when their staff is presenting a case. Both bachelor's and master's level clinical staff are required to pass the FBMHS exam.

Service Exclusions

Family Based Services should address the behavioral health treatment needs of the youth and their family. While receiving FBMHS, youth should not receive other behavioral health services, including, but not limited to, case management services, school-based partial hospitalization programs, Intensive Behavioral Health Services (IBHS), and other outpatient therapy services. Family Based Services teams should request a clinical review with a Magellan Care Manager to discuss any proposed service overlaps.

Referral Process

The referral process for FBMHS starts with a Psychological or Psychiatric Evaluation. The doctor will assess the youth's strengths and needs and will prescribe a service based on which level of care the youth meets medical necessity criteria for.

CASSP principles state that behavioral health treatment should be least restrictive and least intrusive. FBMHS should not be recommended if the youth and their family have not tried other less restrictive, less intrusive levels of care first. FBMHS should not be prescribed to youths who are without an adult caregiver who is willing and able to participate in treatment.

Components of an initial referral packet include:

1. Magellan Treatment Authorization Request Cover Sheet (TAR)
2. Magellan FBMHS Referral Form
3. Psychological/Psychiatric Evaluation
    a. Evaluations are to be typed and written in the Life Domain format
    b. Evaluations can be submitted within 60 days from the date of the face-to-face evaluation but are considered expired after 60 days.

Once the initial FBMHS referral is submitted for authorization, Magellan has two days to review for completeness and medical necessity. If there is missing information that is needed to make the medical necessity decision, Magellan will submit a Request for Additional Information to the submitting provider. Once the packet is determined to be "complete", Magellan has two business days to render a medical necessity decision.

If a youth and family need services urgently, an expedited FBMHS referral process may be used. In these situations, the FBMHS staffing provider submits a Magellan Referral Form. The form must be signed by a licensed psychologist or psychiatrist. The FBMHS provider must submit the remaining

required documentation (Psychological/ Psychiatric Evaluation in Life Domain Format and TAR) to Magellan within 30 days of opening the expedited case.

For members in an acute level of care, such as Acute inpatient or acute partial hospital programs, , referrals can be submitted without an identified provider and Magellan's referral team will aid in finding a provider. A valid Authorization to Use and Disclose (AUD) form should be included in the referral packet to support the referral process.

Referrals for Magellan members in Lehigh, Northampton, and Cambria Counties must be made directly to the accepting FBMHS provider. Magellan can provide guidance with this referral process.

Admission Process

Initial referrals for FBMHS should incorporate CASSP principles. Recommendations for FBMHS must meet medical necessity criteria for that level of care. Medical necessity criteria for FBMHS includes severe functional impairment and a risk of out-of-home placement. FBMHS medical necessity guidelines can be found at Appendix T, Part B [3] HealthChoices Behavioral Health Services Guidelines for Behavioral Health Medical Necessity Criteria.

Youth and families should be referred to Family Based Services providers within Magellan's network. The family has voice and choice about what agency will be providing their behavioral health treatment services, pending the provider is licensed by The Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) as a FBMHS provider and enrolled in the PA Medical Assistance Program. If the provider accepts the referral and the family agrees, the provider will submit required documentation to Magellan.

Treatment or Service Plan

FBMHS teams must develop a treatment plan that is individualized and centers around the youth and family's own goals. Treatment plans must be strengths-based and grounded in recovery concepts. They must be informed by a case formulation that includes predisposing, precipitating, perpetuating, and protective factors. Treatment plan goals must be measurable, attainable, and appropriate for the youth's developmental stage and stage of change. When behavioral descriptions are incorporated, they must include information about the function of the behavior and describe the proposed replacement behaviors. Treatment plans developed by the FBMHS must adhere to all applicable ethical standards.

Treatment plan development must be an interactive and evolving process that includes input from the youth, their family, and treatment team. Treatment plans must not place blame on the youth when there is no progress. The youth has not failed, rather it is the plan that has failed. Treatment plans

must address the behaviors that led to the need for FBMHS by building on the inherent strengths of the youth and their family and should reflect the four pillars of the ecosystem family therapy treatment model. Treatment plans must be culturally competent.

The initial treatment plan should be reviewed and approved by the program director/supervisor within 5 days of the initial service and a comprehensive treatment plan must be completed within 30 days. Updated treatment plans must be revised and updated monthly.

Treatment Plans should avoid generic problem descriptions such as "noncompliance" and goals such as "youth will follow directions." These terms and phrases do not address the individual needs of the youth, identify the tasks/contexts that the youth find challenging, or the skill the youth must learn or strengthen to improve their functioning. The youth's voice in goal development is critical to success in treatment.

Treatment plans must include a crisis plan and/or safety plan. The goals and interventions must be individualized to the youth and family and must focus on growth and development of self-regulation and management skills. The initial crisis plan should be developed within five days of starting to provide services to a youth and family.

The criteria for discharge from the FBMHS program must be identified in the treatment plan. Treatment plan goals and interventions must work towards helping the youth and family meet the criteria needed for discharge. Discharge criteria must be individualized, measurable and attainable. A tentative or projected discharge date must be included in the plan.

In addition to the rendering FBMHS team, the parent or guardian of the identified child or youth under 14 years of age should sign the treatment plan and updates. Adolescents receiving FBMHS who are 14 years of age and older shall sign the treatment plan and updates. The FBMHS team must be honest and transparent with the youth and family about what it means to sign the treatment plan. The signature on the plan means that the youth and family agree with the plan and are consenting to participate fully in the treatment.

All progress notes must clearly record the delivery of services and how the services relate to the attainment of the goals set forth in the treatment plan.

Expectations of Service Delivery

Considerations for Service Provision

FBMHS is a combination of team-delivered and individual-delivered behavioral health treatment services that provides multiple treatment episodes per week. OMHSAS recommends a ratio of 43 percent team-delivered and 57 percent individual services. Treatment services can be provided to all members of the family. Treatment services include Individual Therapy, Family Therapy, Case Management, Crisis Support, and collaboration with involved natural and community supports.

FBMHS uses the Eco-Systemic Structural Family Therapy Model (ESFT). This model is focused on 4 pillars of treatment: attachment, executive functioning, co-caregiver alliance, and emotion regulation. The FBMHS treatment model includes 4 stages of treatment: Constructing the Therapeutic System, Establishing a Meaningful Therapeutic Focus, Creating Growth-Promoting Interpersonal Expression, and Solidifying and Extending Changes.

The FBMHS program also includes Family Support Services (FSS) funds. Family-Based Family Support Services are defined by the HealthChoices Program Standards & Requirements (PS&R), Appendix T as: formal and informal services or tangible goods which are needed to enable a family to care for and live with a child who has a serious emotional disturbance. The expectation is that use of FSS is sustainable and connected to the family's treatment goals. FSS can include concrete services or tangible goods such as food, furniture, clothing, and utilities. FSS can also include funding for: self-help advocacy groups; sibling and/or parent support groups; education & training; respite care; memberships related to a specific treatment plan goal; supports to generic community programs; supports to families utilizing informal systems; special recreational programs; and day care. The FBMHS budget identifies administrative and program costs which include Family Support Services. A cost component for FBMHS/FSS is built into the HealthChoices capitation rate and incorporated into each provider's contracted rate. Providers must have an account system that identifies revenue sources and expenditures.

Family Support Service (FSS) dollars are to be tied to a specific goal on the identified member's treatment plan; but can also be used for material things that are needed for assisting with the child's well-being (such as clothing, groceries or paying a utility bill). Though treatment plans may indicate "socialization activities," these activities should be ones that the family can sustain, as well as teach families to use support systems such as food banks and or local church charities. FSS funds should not be used to keep families engaged in treatment. Use of FSS funds for routine dining out with families is not allowed. Routine dining out is neither sustainable, nor does it teach a skill. Magellan encourages agencies to be cautious in their use of FSS funds for meals related to socialization goals. FSS funds may never be used to pay for staff meals or non-family members.

Provider staff meetings, supervision, recordkeeping activities, writing of treatment plans and progress notes, and other non-direct services, may **not** be billed as Family Based Mental Health Services units (thus, administrative functions related to FSS funds and the management of these dollars are **not** directly reimbursable).

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 peer support provider.
- 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 Individual Recovery Plan 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.

Specific Expectations for Documentation in FBMHS

- Progress Notes:
    - must clearly record the delivery of services and what occurred in the session.
    - should indicate the goal(s) for the session.
    - should reflect the stage of treatment.
    - include all usage of FSS funds when utilized during a clinical treatment session and how they relate back to the treatment goal.
    - should document the progression of treatment from one session to the next, including evidence of movement towards attaining/sustaining treatment goals.
    - should include the clinician's interpretation of the session, how this relates to their overall case formulation, and promotes treatment progress
    - should include treatment team's clinical rational for use of interventions and observations of response to those interventions.
    - should include specific plans for the next session. Plan should include anticipated interventions to be used in the next session based on what occurred in this session.
    - should also include following up on any homework given to the family.

- Crisis Plans:

- should be developed within the first 5 days of treatment.
- include the youth and family's definition of crisis.
- are individualized to the youth and family's needs.
- address precipitants, interventions to varying levels of precipitants, access to intervention, alternatives to be tried.
- correlate to stage of treatment.
- are reviewed regularly and revised as needed to reflect new coping skills and supports.

Care Coordination

Engagement is critical to success. A youth's caregivers or family must be included in treatment. FBMHS also partners with youth and families to collaborate with natural and community supports. This includes tools to manage, advocate, and link resources to maintain children in their homes and community.

Coordination must occur with any other systems that the youth is involved with, including, but not limited to: Juvenile Probation Office (JPO), Children and Youth Services (CYS), Mental Health Department and Developmental Programs, Psychiatry, Physical Health providers, Substance Use providers, and the School District. Communication must occur between the Family Based Services team and the system partners for coordination of care. Appropriate releases of information must be obtained when needed to allow for this coordination.

Discharge Planning and Transition

Comprehensive discharge planning prepares youth and their families for discharge success. The discharge planning process should begin at the onset of treatment and continue throughout the treatment authorization. The FBMHS team should collaborate with the youth and family about specific aftercare needs for all members of the family, not just the individual.

Some best practices for discharge planning include:

- Starting discharge planning immediately.
- Giving families voice and choice.
- Understand the family's language preferences, obtain language assistance for the youth/family as needed, schedule aftercare services with providers who have appropriate linguistic and cultural competence.
- Consideration of Social Determinants of Health and other potential barriers the youth and family could experience after discharge.
- Providing clear information about medications and having a plan for continued medication management support.

- Collaboration with involved providers and systems, that may include: Physical Health, Substance Use, Trauma, CYS, JPO, etc.
- Consideration of community-based supports including: Case Management, Certified Peer Support, HiFi Wraparound, etc.
- Consideration of natural resources: connections to community organizations, food banks, activities, sports, music, faith-based, etc.
- Making sure Medical Necessity Criteria is met for the level of care the youth/family is being referred to.
- Utilization of up to a 30-day overlap of services to allow for active collaboration with the aftercare providers that includes providing the next treatment provider with a discharge summary.
- Revisiting the crisis plan with the youth and family and revising as needed to reflect new coping skills and supports. List the names and phone numbers of people that the youth/family can call for help and include information about local crisis services and toll-free hotlines/text lines.
- Create a calendar for the 1st month after discharge that includes dates/times of all appointments, as well as special dates for the youth/family.
- Provide a typed discharge plan to the youth/family, written in their preferred language.

In the event of a family discharging from FBMHS prior to the end of the authorized treatment span, Magellan requires the FBMHS provider to complete a telephonic early discharge review. Magellan also requires notification in the event of a family declining services after the provider has submitted for authorization. Notification of these events is required in a timely fashion.

Outcomes

All providers of Family Based Services should have policies and procedures in place to evaluate outcomes for the program. All providers are required to use the Modified Family Assessment Form (M-FAF) with members to gather outcome information. Additional indicators that could be considered include:

- Number of higher levels of care admissions.
- Number of crisis contacts.
- Participant satisfaction.
- Frequency of contact with members and families.
- Community tenure.
- Community linkages addressing SDOH needs.

Performance Outcome Management System (POMS) is a tool that DHS established to continuously evaluate the effectiveness of the HealthChoices' program. POMS allows DHS to identify members with a serious illness or risk of illness; establishes a data baseline for member functioning at registration or entry into the HealthChoices' system; updates member data as the course of treatment evolves; and finalizes member data at closure of treatment.

HealthChoices' providers are ***mandated*** by DHS to collect priority population data and submit POMS data on every HealthChoices' member receiving mental health services at certain points during treatment. These include the following:

- When you are seeing the member for the first time (initial registration);
- When you are seeing the member for the first time under HealthChoices (the member may have seen you as a fee-for-service patient and subsequently converted to HealthChoices);
- When you are seeing the member for the last time (either termination from your care, if the member is moving to another provider; or closure, if the member is ending all mental health treatment); and
- Whenever there is a change in any POMS element.

Magellan has an online web tool for collecting the data required for the HealthChoices mandated reporting of POMS. Online entry includes user friendly access and search functions allowing for a time efficient data entry process by providers. Individuals submitting POMS data on behalf of a provider must have a log-in for the Magellan Provider Portal (magellanprovider.com). After successful log-in, users should look for "PA Outcomes Measurement" under "My Practice."

Complaint Process

Magellan provides a formal mechanism for all members to express a complaint related to care or service, to have any complaints investigated and resolved, and to receive a timely and professional response to their complaint in compliance with the HealthChoices Program Standards and Requirements Appendix H. This Complaint process is managed by Magellan's Quality Improvement Team. Complaint information is integrated as a key indicator for informing patient safety, credentialing, quality improvement activities, and analyzed for trending and opportunities throughout the network.

When a member files a complaint directly with Magellan, Magellan partners with the provider to address the concern. A member's decision to file a complaint with Magellan should not compromise their care or services. Providers are expected to adhere to their Facility and Program Participation Agreement with Magellan regarding cooperation with appeal and grievance procedures. The identified provider will receive an acknowledgement letter summarizing the complaint items and requesting documentation to be submitted for the review. The response and documentation should be faxed to 888-656-2380 on or before the deadline listed in the letter. Additional information and follow up activities might be requested.

The information that is collected through Magellan's investigation is presented to a first level complaint review committee, which makes the first level complaint decision. HealthChoices standards and regulations, contractual standards, and generally accepted standards of care apply those standards to the issue at hand. Magellan is required to make a decision and send a letter to the member

explaining the findings and the reasons for the decision within 30 calendar days of receipt of the Complaint.

Magellan uses information gained from member complaints to identify areas where opportunity for improvement may exist. Magellan may request corrective action of a provider in response to supported complaints and identified trends in complaints. If Magellan identifies a supported (substantiated) complaint involving an agency, Magellan staff will collaborate with providers to develop a Complaint Resolution Plan to address the concern. Please review the Provider Communication shared with network providers here about this important and collaborative process.

Viewing complaints from the member's perspective is critical. If the member feels the concern is sufficient enough to raise it, the matter should be taken seriously and treated accordingly. If the member is still active with provider's services, attempts to resolve the member's issue or concerns and an internal review of the concerns should occur. As opportunities for improvement are identified, corrective action(s) should be implemented in accordance with provider's internal policies, procedures, and protocols.

Service providers should also have internal written policies and procedures for filing and resolving complaints within their organization. These policies and procedures must comply with state and federal regulations, as well as applicable accreditation standards. Staff should be trained to listen effectively and manage a member's expectations and employ a proactive approach to customer service. Organizations should always try to resolve the member's concerns immediately and informally whenever possible. Complaints/concerns involving minor issues might not require a formal written response. However, even if the matter is addressed quickly and informally, documentation of the member's complaint/concern and actions taken to resolve it should be documented and recorded.

If the member (or their family members or representatives) feel that their concerns have not been addressed, the matter might require a more formal review involving designated staff within provider's organization. Because these reports might be received by a variety of staff, clear definitions, and clearly defined procedures for submission of verbal or written complaints/grievances are essential. The information must be forwarded promptly to the designated staff or department for investigation and follow up.

Persons receiving services should be provided with information explaining the agency's complaint/grievance policies and procedures. Programs often provide this information upon admission to the service; however, it should also be readily accessible throughout the duration of services. Physicians and staff should have adequate training on helping individuals as needed to report, address, and resolve a complaint or grievance.

Grievance Process

Magellan and the 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).

Appendix A to the Pennsylvania HealthChoices Supplement to the Magellan National Provider Handbook offers an updated Incident Reporting Form, Provider Instructions and Definitions. Magellan also provides an electronic format for incident reporting for submission to ease provider paper burden.