Magellan HEALTHCARE®

Opioid Centers of Excellence

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

Significant changes made to several sections to align with Pennsylvania Department of Human Services Center of Excellence Fidelity Guidelines published in August 2024. Sections with changes should be reviewed in their entirety. These sections are:

1. Service Description
2. Identification and Enrollment
3. Scope of Services
4. Admission Process
5. Expectations of Service Delivery
6. Service Exclusions
7. Documentation
8. Care Coordination
9. Discharge Planning and Transition

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 comply with all applicable Pennsylvania regulations and requirements, including but not limited to The Pennsylvania Code Title 55, Chapter 1101 General Provisions, The Department of Human Services Centers of Excellence Fidelity Guidelines, Appendix G of The HealthChoices Program Standards and Requirements, 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. Opioid Centers of Excellence services must be provided by a Department of Drug and Alcohol Programs (DDAP) licensed drug and alcohol facility.

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/

Service Description

Opioid Centers of Excellence (COE) are specialized programs within the Magellan Provider Network. COEs are tasked with engaging members with an active Opioid Use Disorder (OUD) and connecting them with treatment, community, and health services. COE services are intended for members who are **newly diagnosed** with an OUD and therefore, are not familiar with resources available to assist them with their recovery efforts.

A COE provides services which include professionally directed Case Management (CM) services and Certified Recovery Specialist (CRS) services. A COE must demonstrate its ability to employ a community-based care management team, **which must include a CRS credentialed by the Pennsylvania Certification Board** (or working towards certification within 6 months of hire), and may include peer navigators, nurses, social workers, and other provider types.

The COE program is established to connect members with vital community services and resources to combat the opioid epidemic in Pennsylvania. Services do not need to occur within the confines of the physical location of the COE as the CM and CRS staff are expected to be mobile in the community in which the COE serves. Service delivery is centered on the member's needs, both clinical and nonclinical. A complete list of core competencies required for CRS and CMs is available in Appendix V of the Fidelity Guidelines.

COE care management services may include activities such as supporting clients with reducing substance use, assisting clients in accessing or re-engaging with services, enhancing recovery capital (e.g., social support), removing deficits in health-related social needs (HRSN)/ social determinants of health (SDOH), working with family members to support the client, enrollment and/or recertification of Medicaid benefits, or assessing clients' needs for an American Society of Addiction Medicine (ASAM) Level of Care Assessment (LOCA).

A COE **must also demonstrate its ability to accept referrals 24 hours per day, 7 days per week, through mobile engagement teams that facilitate warm hand-offs** by traveling to the location where an individual in need of COE services presents. Examples of these locations are emergency departments, jails or prisons, sites where an overdose occurred, client's home, etc. Warm hand-offs can occur from an emergency department to treatment services, from treatment services to non-treatment recovery support services, or between levels of care for treatment services.

A COE must provide **at least** one form of Medication-Assisted Treatment (MAT) approved by the Food and Drug Administration at the enrolled service location in which COE services are offered and schedule clients for MAT induction within 24 hours of the member's initial encounter with the COE provider (includes weekends and holidays).

A COE must refer and connect individuals as clinically appropriate to all ASAM levels of care

within the timelines prescribed by the HealthChoices Program's Service Access Standards for emergency, urgent, and routine situations. All levels of care must be accessible to members within the required timelines.

- ASAM levels of care can be found at: https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/
- Timeliness standards can be found on page 59 at: https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/2023%20Updated%20Documents/HC%20BH%20PSR%201-1-23.pdf

For any of these services not provided on-site, the COE must demonstrate its ability to make warm hand-offs to providers of these services through documentation such as letters of support, memoranda of understanding, etc. A COE must demonstrate its ability to provide naloxone to COE members for overdose prevention purposes. The COE itself does not need to provide naloxone to clients but must be able to help a client obtain a prescription using the Physician General's standing order or a free dose through the county coordinating entity.

COEs are encouraged to offer a variety of visit frequencies and venues based on clients' needs, goals and preferences. An individualized approach should be reflected in care management notes and data. Services are provided in 15-minute unit intervals and the billable service for the month must include active case management. One brief check-in with the identified member does not meet the expectations to support the Per Member Per Month (PMPM) COE payment rate.

Mobile engagement is encouraged based on client need and preference. It is recommended to follow your COE's organizational policies; but consider incorporating strategies to engage with clients in the community which could help prevent client disengagement. Clients who prefer office-based care management visits are not required to complete them in the community. However, mobile engagement is an important component of the COE program as the intention of COE is to engage individuals who do not respond to the traditional SUD system and therefore may require more proactive engagement to remain engaged in services. COEs should have a documented mobile engagement policy that indicates how they will provide this service based on need and preference of the client.

Identification and Enrollment

In order to receive COE services, a member should not be currently enrolled or have been enrolled in a substance use treatment program, including but not limited to Medications for Opioid Use Disorder (MOUD) treatment, Office-based Opioid Treatment (OBOT), Outpatient Treatment Program (OTP) or other outpatient providers, in the prior 30 days.

Exception(s):

- The individual has been enrolled in a MOUD program beyond 30 days but shows reasonable harm, including a recent increase in substance use (verified by more than two urine drug screens [UDS]), recent overdose or other opioid-related medical event or a treatment episode in an inpatient or residential level of care in the past 30 days (psychiatric or SUD treatment);
- The individual experiences a change or continuation of significant HRSN/ SDOH needs which could impact recovery (the specific HRSN/SDOH needs to be identified in the client's chart, including what has changed that could risk the client's ability to avoid opioids);
- The individual is a transfer from another COE and continues to submit positive UDS and/or have significant HRSN/ SDOH needs.

This service is intended to support individuals in the community that are struggling with active opioid use and in need of connection to substance use disorder treatment, medical treatment, and other services to promote recovery. Individuals who are being served in existing programs for substance use disorder treatment, such as Methadone Maintenance Treatment (MMT) programs, Substance Use Disorder Outpatient (SUD OP), or Intensive Outpatient Programs (IOP) should not be automatically enrolled into the COE.

COEs are expected to develop a documented outreach process (i.e., referral arrangements with an active MOU, a formal written referral agreement, a systematic process for checking for eligible clients within specified organizations or a systematic case finding outreach process) that involves actively recruiting clients from the treatment and non-treatment communities, not just from their internal programs and referral processes.

Each COE must develop a process for warm handoffs that includes a process for accepting new clients within 24 hours (WHO) from:

- emergency departments
- crisis services (EMS, police, crisis response teams)
- hospitals (psychiatric & medical)
- residential programs
- incarceration (jails & prisons)

Enrolling clients in the COE requires a formal, interactive process that cannot be automated, (i.e., assigning clients to the COE) and must include the following requirements:

- All clients who are eligible for the COE ***must be*** provided with a brief description of the program (verbal or in writing).
- All clients ***must sign*** a formal consent to enrollment in the COE before they can be enrolled which represents an acknowledgement and acceptance to receive COE services.

- COE consent forms should include language that indicates the COE as the client's choice of provider of COE services.

The COE must also have a written strategy for identifying as well as reducing disparities (e.g., racial, ethnic, cultural, language, gender) in client identification or enrollment processes.

Admission Process

Referrals may come from a variety of sources, including the member. A program participant must be enrolled in HealthChoices and must have an opioid diagnosis.

Admission to a COE occurs on a 24/7 basis, including weekends. Providers are expected to offer appointment times that will meet the member's needs, including evening appointment times to accommodate the member who works or is otherwise engaged.

The COE must either provide a substance use assessment, inclusive of an ASAM level of care recommendation which is a collaborative process between the member and the provider. If the COE is unable to provide the assessment, they must make arrangements for the member at an assessment site. 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.

Admission to a COE is appropriate when a member with an OUD is unstable. Those members who are already engaged in the community and who are stable in their recovery are not appropriate for admission. Instability includes a member who is at risk of relapse due to isolation or inability to access services, a member who is newly diagnosed with an opioid use disorder, a member who requires active case management in order to connect with medical services, OBGYN services, dental care, etc.

To determine whether OUD-COE care management services are appropriate for a member, the COE shall utilize the inclusion and exclusion criteria established in the OUD-COE Fidelity Checklist.

Scope of Services

A COE does not provide treatment; however, they must be able to offer at least one form of Medication for Opioid Use Disorder (MOUD) within their program. Rapid access to MOUD treatment is encouraged as a parallel process to the COE and not after the following steps are completed. COE clients are not required to be on MOUD to receive COE services, MOUD is client choice. COE staff should encourage the use of MOUD as an evidence-based best practice.

After acquiring consent for COE services, the following additional steps for enrollment should be completed:

- A meeting with a COE team member, preferably face-to-face, but may occur by telehealth; this will likely be the same person acquiring the consent and providing the overview of the COE program (if during WHO, it may require more than one meeting); Selection of face-to-face meeting vs. telehealth meeting should be based on client need and preference.
- Telehealth meetings should follow all organizational, PA Office of Medical Assistance Programs (OMAP) and Office of Mental Health and Substance Abuse Services (OMHSAS) policies and requirements.
- Face-to-face meetings can occur in the office or in the community via mobile engagement.
- Client receipt of contact information for their COE team should they need to contact them for support prior to the next scheduled appointment.
- Determine that the person resides in or is going to reside in the service catchment area and can receive care management services.
- COE-specific enrollment paperwork to include the completion of Releases of Information (ROIs) for providers in the area to allow for coordination of care and ROIs to release de-identified data to Managed Care Organizations (MCOs), Department of Human Services (DHS), and the Program Evaluation and Research Unit (PERU). COEs should document in the client's chart the outreach to other COEs, MOUD, and care management providers in the area to avoid client duplication.
- A rapid assessment of needs following the fidelity guidelines below (can be brief to cover basic requirements including review of immediate HRSN/SDOH needs, referrals to address these immediate needs, suicide risk screening, and provision of MOUD education – more detailed data collection can be collected over days or weeks).
- If any screening tool (C-SSRS, GAD-7, etc.) was completed by staff outside the COE (an outside agency, an SUD treatment department of the facility, etc.) on the same day as COE enrollment, COE staff should obtain and review those results with the client and determine if an assessment is needed. COE staff should document in the client's chart that these screening results were reviewed and updated as needed. If clinically appropriate, the screening should be repeated at COE enrollment.
- A rapid care management plan which should focus on helping the person stay engaged in COE services and substance use, mental health, and/or medical treatment services (a more detailed plan can evolve over time). A rapid care management plan is intended to reduce the risk of disengagement during the initial 30 days of COE enrollment.
- It is recommended that COE staff focus on the highest indicated needs (e.g., transportation; housing; harm reduction).
- It is recommended that the rapid care plan and strategies for preventing disengagement be documented in the client's intake note in their electronic record.

Contracted COE providers in the Magellan HealthChoices network must follow their Pennsylvania Department of Drug and Alcohol Programs (DDAP) license(s) for allowable maximum number of members served.

Per Appendix G of the HealthChoices Program Standards and Requirements; as well as Magellan's expectations, the following services, when provided as clinically appropriate and included reflected in the individual member's care plan constitute community-based care management services:

- Face-to-face encounters with the member that meets the standards established below.
- Telemedicine encounters with the member in accordance with OMHSAS-22-02 Revised Guidelines for the Delivery of Behavioral Health Services Through Telehealth.
- Telephonic engagement with the member that meets the standards established below.
- Transportation with the member that meets the standards established below.

Assessment

Rapid Assessment of Needs:
All COEs will need to provide a health-related social needs (HRSN)/ social determinants of health (SDOH) assessment for immediate health-related social needs/ social determinants of health needs using a validated tool. Immediate needs should be assessed during enrollment, with full HRSN/SDOH assessment completed within 7 days of COE enrollment.

All COEs will need to identify HRSN/ SDOH needs in the client's chart and REDCap. In REDCap this can be indicated in the interactions under "Need Identified" (PA Navigate will be available as a hub that can be utilized by COEs to share referrals and assess closed loops of service).

A rapid care management plan is developed on the day of intake to decrease risk of overdose and substance using behaviors and to address immediate needs that could create barriers to consistent attendance within the first month after COE enrollment. An extended care management plan around HRSN/ SDOH gaps should be implemented by the second month and updated throughout an individual's enrollment in COE via monthly monitoring. If substance use behaviors appear to be constant with no reduction, the COE should maintain focus on harm reduction (if appropriate to programming with which the client is involved) and reducing substance use with a focus on pressing HRSN/ SDOH needs, until substance use behaviors decrease.

The following screenings should be conducted as indicated:

- A risk screening is applied by a COE staff member using the Columbia Suicide Severity Rating Scale (CSSS-RS) or other validated screening/assessment tool.
- A full comprehensive suicide assessment should be completed by licensed clinical staff if indicated in the screening that it is needed.
- Suicide screenings should occur annually unless otherwise indicated by institutional protocols.
- Screening scores and follow-up screening timeframes should be documented in the client's electronic record.

A medical team or trained COE staff member must be available on the first day of COE enrollment to provide an overview of MOUD options. The medical team or trained COE staff member does not need to be on the campus; however, all individuals should have access to the medical team or trained COE staff member (e.g. via telehealth) to review the MOUD options and the individual's preference about MOUD. This review includes any concerns around stigma and MOUD. All clinical questions regarding medication should be documented and discussed with licensed medical provider during the individual's first visit with the medical team.

Within 72 hours of COE enrollment:
An ASAM Level of Care Assessment (LOCA) is applied by a trained person to each individual within 72 hours of their enrollment, unless an ASAM LOCA was completed within 6 months prior. It is recommended that the ASAM LOCA is reviewed and updated (if needed) by the COE during enrollment. An ASAM level of care assessment will assist the COE staff in determining the level of care the individual should be referred to for substance use treatment. If the ASAM was completed prior to COE enrollment, the date of completion should be documented in the electronic health record. If the ASAM was completed at an outside agency, it is recommended that a Release of Information be signed by the individual to obtain a copy of the most recent ASAM LOCA.

Within 7 days of COE enrollment:
All COEs will need to provide an HRSN/ SDOH assessment for health-related social needs/social determinants of health needs using a validated tool. Individuals can be assessed using a rapid HRSN/ SDOH assessment at least monthly for the first two months, with the full HRSN/SDOH screening repeated and every six months thereafter while they are enrolled in the program. Care plans should be updated every six months or sooner if there is a new need identified.

Within 30 days of COE enrollment:
All individuals should receive the Brief Assessment of Recovery Capital (BARC-10) in the first 30 days. BARC-10 scores must be utilized by COE staff to assist clients in building recovery capital.

Optional Additional Screenings to Include within Assessment/Screening Process:
The MOUD placement guide may be applied by the COE medical team to each individual within 48 hours of their enrollment.

Care Planning

The member's plan of care should clearly outline how the COE is supporting the member in connecting to treatment, community, and health services. Per Appendix G, development of integrated, individualized care plans should include, at a minimum:

- The member's treatment and non-treatment needs.
- The member's preferred method of care management, such as face-to-face meetings, phone calls, or through a secure messaging application.

- The identities of the member’s community-based care management team, as well as the names of the member’s support system.
- Care coordination with a member’s Primary Care Physician (PCP), mental health service provider, drug & alcohol treatment provider, pain management provider, obstetrician or gynecologist, and Behavioral Health Managed Care Organization (BH-MCO), as applicable.
- In the COE records, the COE should maintain copies of release of information permissions from member to coordinate care with those involved in the member’s care and recovery plan(s).

In addition to the above, Magellan would expect the following to be included in the COE’s care plan:

- Signatures from the member and COE staff member supporting the care plan.
- Notation of the expected frequency of contact with member.

Referrals for Services

Magellan expects that COE staff will actively facilitate referrals and coordinate responses of social service needs. This includes providing support to members that extends beyond sharing resource information (e.g., providing a list of phone numbers for resources). The COE should actively assist members with ongoing communications including but not limited to filling out applications, contacting resources on behalf of members, etc.

COE staff should facilitate referrals to necessary and appropriate entities, including but not limited to clinical services according to the member’s care plan:

- Primary care, including screening for and treatment of positive screens for: HIV, Hepatitis A (screening only); Hepatitis B; Hepatitis C; and Tuberculosis
- Perinatal Care and Family Planning Services
- Mental Health Services
- Forms of medication approved for use in MAT not provided at the OUD-COE Provider’s enrolled service location(s)
- MAT for pregnant women, if the OUD-COE Provider does not provide MAT to pregnant women
- Drug and Alcohol Outpatient Services
- Pain Management
- Facilitating referrals to any ASAM Level of Care that is clinically appropriate according to a Level of Care Assessment

COE staff should also facilitate referrals to necessary and appropriate non-clinical services in accordance with the member’s needs identified through a SDoH screening. This includes, but is not limited to:

- Stable housing
- Employment

- Re-establishing family/community relationships

Monitoring

COE staff should conduct ongoing monitoring to include:

- Individualized follow-up with members and monitoring of members' progress per the care plan, including referrals for clinical and non-clinical services.
- Continued and periodic re-assessment of a member's SDoH needs.
- Performing urine drug screenings at least monthly.
- Documentation should be evident in the chart that confirms the referrals made, the provider delivering the MAT service, and the type of MAT that the member is receiving.
- BARC-10 must be re-administered at six-month intervals.
- Making and receiving warm hand-offs. In the event of a warm hand-off from an overdose event, the OUD-COE must provide education related to overdose risk and naloxone.

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

Service Exclusions

While active in a COE, members may not receive community-based CRS or SUD case management services from another provider. Of note, when a member is enrolled in community-based services and maintaining their recovery, it is not always necessary to enlist the services of the COE and/or continue services in the COE once those community connections are established. Certified Peer Specialist (CPS) services may also be seen as duplicative of CRS services provided by the COE and documentation must be present in chart to support the need for both peer services.

Documentation

The documentation in the individual's behavioral health record allows clinicians 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.

A COE **must utilize electronic records to document care management activities**. Ideally, this should be an Electronic Health Record (EHR) or Electronic Medical Record (EMR) system. Paper records are not acceptable. COEs must comply with relevant federal and state confidentiality laws concerning protected health information. The COE must document all care management service encounters including the following information:

- Date of encounter.
- Location of encounter.
- Identity of the individual employed by the OUD-COE with whom the member met.
- Duration of encounter.
- Description of service provided during the encounter.
- Next planned activities that the OUD-COE and the member will undertake.

In addition, the following are important to follow and align with the minimum Medical Assistance documentation requirements:

- The record must be legible throughout.
- The record must identify the member on each page.
- Entries must be signed and dated by the responsible provider.
- Alterations of the record must be signed and dated.
- The record must contain a preliminary working diagnosis, as well as final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments, as well as the recovery plan, must be entered in the record. Medications 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 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 recovery plan – specifically, any goals, objectives and interventions.
- Progress at each session, any change in diagnosis, changes in treatment and response to treatment.
- The actual time in clock hours that services were rendered.

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 COE) to obtain a signed encounter verification form for each face-to-face contact that results in a claim/ encounter 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

Care Coordination is the prime objective of a COE Case Manager. Providers are expected to encourage the member to permit communication with PCPs and other behavioral health providers. It is expected that a release of information (consent to release information or Authorization to Use & Disclose Form) 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 or refusal if this action is not completed. Depending on the makeup of the care management team and provider type, some physical or mental health needs can be addressed on-site without a referral.

If upon initial assessment physical health factors are identified, it is best practice to assess for the stability of those 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 the member and considered for inclusion in care 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.

COEs should encourage individuals to integrate family members in the program during the engagement phase and provide family members with education on the client's service options and needs (e.g., benefits of MOUD, need for long-term care). The COE can obtain the appropriate releases for family members and/or natural supports once the individual is agreeable to involving these individuals in their care.

Housing stability must be considered when treating the member at any level of care, and appropriate referrals to support systems outside of the behavioral health system may need to occur if housing is inappropriate or at risk.

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. Our 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.

Discharge Planning and Transition

Discharge from enhanced care management at the COE can occur for a variety of reasons. There is no specification of the length of time a client can receive COE services; however, if a member has completed their care management plan and/or has no new goals or significant HRSN/SDOH needs that they wish to work on the clients can be transitioned out of enhanced care management services to allow capacity for other high-risk clients. At the point of COE transition, the individual should be able to navigate community-based resources independently.

Enhanced care management discharge/transition should occur if one or more of the following criteria are met:

- The member had no contact with the program for > 60 days, and there is a record of three or more attempts to contact by the COE that includes friends or family members as well as other providers who have worked with the individual in the past (e.g., residential treatment providers, community mental health centers (CMHCs), or PCPs). The date of this discharge ascertainment is as close to the 61-day window with contact attempts as possible. COE indicates the discharge date and a qualifier that this is a Discharge Without Contact (DWC).
- The member is incarcerated and cannot be contacted for at least two months, in which case the estimated release date from jail or prison is provided or estimated, based on the sentence. COE indicates the discharge date and a qualifier that this is a "Client Incarcerated". The COE will indicate in the discharge plan in the EHR the name and location where the individual is incarcerated, if available. If the member can be reached, even if Medicaid cannot be billed, and will likely be released within the next two to three months, COEs should keep the member as active and indicate incarcerated status.
- The member has completed planned COE care management services; the COE indicates the transition date and that is a successful "transition from COE services" and codes it as "Client Completed Planned COE Services".
- The member requires more intensive care coordination, is moving, or chooses to receive services from another provider; the COE indicates the discharge date and codes it in REDCap as "Client Transferred to other COE". If the member transfers to a provider that is not a COE, the care management can be provided by their current COE.
- The member has died. The COE indicates the discharge date (which is the date the death is known) and code the discharge reason as "Client Deceased".

- The member has contact with the COE but declines to continue receiving COE services, code the discharge reason "Client Voluntary Discharge". COE staff should offer the individual rapid re-enrollment should they wish to reengage with COE services.

The member should be informed of crisis services or how to re-engage with COE services if the member believes there might be a need in the future. The COE Case Manager should ensure that necessary referrals are made. COE will list in the discharge plan in the client's chart the names and locations of PCP, OTP, CMHC, peer services/recovery support and/or other treatment provider(s) who will provide ongoing care and medication. Clients who have completed their planned COE services, or who no longer wish to be enrolled in care management/peer support services, may remain in medication management ***and/or*** primary care with the COE. This information should be placed in the client's chart.

Outcomes

Expected outcomes can be demonstrated through a list of quantitative measures, such as targets for:

- Number of individuals who receive COE care management services per month
- Average duration of COE care management service receipt
- Rate of referrals to each service identified in Description of Service above
- Average improvement of scores on the Brief Assessment of Recovery Capital survey

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

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 provider agreement with Magellan regarding cooperation with appeal and grievance procedures. The identified provider will receive an acknowledgement letter summarizing the complaint items and requesting documentation to be submitted for the review. The response and documentation should be faxed to 888-656-2380 on or before the deadline listed in the letter. Additional information and follow up activities might be requested.

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

Grievance Process

Magellan and the Pennsylvania HealthChoices Program Standards and Requirements defines a grievance as a request by a member, the member's representative or health care provider (with written consent of the member), to have Magellan or a utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

Magellan reviews requests from providers for behavioral health services to ensure that approved services are medically necessary and appropriate.

If a level-of-care request is not authorized at the level, frequency or duration as requested, Magellan members are entitled to grieve a medical necessity denial. At the time of a denial, Magellan informs members of this right and how to proceed. Each medical necessity grievance is handled in a timely manner consistent with the clinical urgency of the situation and in compliance with the HealthChoices Program Standards and Requirements Appendix H.

If a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the behavioral health provider will meet with the member, and the member's family if appropriate, to discuss treatment changes and options. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the recovery plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

Quality Management

A COE provider must demonstrate its ability to:

- Comply with the requirements of 62 P.S. § 1406(a) and 55 Pa. Code § 1101.63(a) by agreeing not to charge any Medicaid enrollee for covered services.
  - Please refer to the regulation at: https://pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter1101/s1101.63.html&d=reduce

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 our County Partners and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices' members.

Magellan's Quality Improvement Program's policies and procedures are structured to support compliance with the accreditation requirements of several organizations, including the National Committee for Quality Assurance (NCQA) and URAC. Assessment of compliance with these requirements is integrated into our quality improvement activities.

Per Magellan's contractual agreement, providers must cooperate and participate with all quality improvement procedures and activities. Providers shall permit access to any and all portions of the medical record that resulted from member's admission or the services provided. Magellan's utilization review program and/or quality improvement program may include on site review of covered services and shall permit Magellan staff on site access.

In support of our Quality Improvement Program, providers are essential quality partners. It is important that providers are familiar with our guidelines and standards and apply them in clinical work with members in order to provide, safe, effective, patient-centered, timely, and equitable care in a culturally sensitive manner. Please refer to the Magellan National Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information and guidelines.

In addition to adhering to state and federal regulations, providers are responsible to:

- Follow policies and procedures outlined in Magellan's National Provider Handbook and HealthChoices 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 recovery 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 commits to a strong cultural competency program and believes that all people entering the behavioral health care system must receive equitable and effective that respects individual member preferences, needs and values, and is sensitive to residual stigma and discrimination. Magellan encourages providers to maintain practices deeply rooted in cultural competence and prioritize health equity and inclusion. These practices include focusing on continual training and education to support staff. Cultural Competence and Diversity, Equity, and Inclusion (DEI) resources are available on www.Magellanofpa.com to help develop provider cultural competency programs.

There are instances where Members may benefit from oral interpretation, translation services, and materials/communication approaches in non-English languages or alternative formats. Providers are encouraged to maintain staff training to support Members with language assistance needs and ensure that their team is prepared to respond to provide the best possible treatment outcomes. For practitioners, Magellan makes in-person, video or telephonic interpretation services available, as needed. Magellan offers language assistance service educational resources for network providers. These are located on Magellan's website.

Please note: Reporting requirements for Magellan remain consistent and in line with the PA DHS Bulletin, OMHSAS-15-01. A copy of all reportable incidents must be submitted to Magellan's Quality Management Department within 24 hours of an incident or upon notification of an incident. The types of incidents that are reported to Magellan include: Death, Attempted Suicide, Significant Medication Error, Need for Emergency Services, Abuse/Childline Report, Neglect, Injury/Illness, Missing Person, Seclusion, Restraint, Other.

Magellan requires an electronic submission process. This can be accessed here: https://www.magellanofpa.com/for-providers/provider-resources/forms/adverse-incident-reporting-form/