Opioid Center of Excellence

Magellan Behavioral Health of Pennsylvania (Magellan) Performance Standards

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

Current Version Information

Substantive changes in most recent update:

- Scope of Services - Additional information added to clarify expectations.
- Service Description - Expectation that services are provided in 15-minute units and must include active case management added.
- Service Exclusions – updated.
- Care Coordination – Expectation regarding physical health factors added.

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 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.

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/

Description

Opioid Centers of Excellence (COE) are specialized programs within the Magellan Network. COEs are tasked with engaging members with an 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. This service is intended to support individuals in the community that are struggling with opiate use and in need of connection to substance use disorder treatment, medical treatment, and other services to promote recovery. Individuals that are 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. A COE does not provide treatment; however, they must be able to offer at least one form of Medication Assisted Treatment (MAT) within their program.

Scope of Services

Contracted COE providers in the Magellan HealthChoices' network are required to be actively enrolled with the Pennsylvania Medical Assistance Program for their contracted provider type and specialty (for COEs the provider specialty is 232), at the approved OMHSAS service location.

Programs will follow their DDAP license(s) for allowable maximum number of members served.

Per Appendix G and Magellan's expectations, the following services, when provided as clinically appropriate and included or reflected in the individual member's care plan, constitute community-based care management services as defined in the State Plan. This includes:

- Face to face encounters with the member.
- COE care management services may be provided via telemedicine in accordance with OMHSAS-22-02 Revised Guidelines for the Delivery of Behavioral Health Services Through Telehealth.
- Telephonic engagement with the member that meet the standards established.
- Transportation with the member that meets the standards established.

Screening and Assessment

- The level of care assessment, including American Society of Addiction Medicine (ASAM), should be part of the COE record whether the assessment was performed by the COE or by another assessment provider.
- If a level of care assessment results in a recommendation of MAT, the COE must provide education related to MAT.
- Assessments to identify a member's needs related to Social Determinants of Health (SDoH), administered in home and community-based settings whenever practicable.
- Screenings for clinical needs that require referrals or treatment.
- The Brief Assessment of Recovery Capital (BARC-10) to each COE client must be administered within 30 days of the initial encounter with the COE Provider.

Care Planning

The COE's plan of care should clearly outline how the COEs are supporting members in connecting to treatment, community, and health services. Per Appendix G, development of integrated, individualized care plans should include at 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 PCP, mental health service provider, drug & alcohol treatment provider, pain management provider, obstetrician, or gynecologist, and 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.
- Measurable objectives or goals.

Referrals

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.

Service Description

A COE provides services which include professionally directed Case Management (CM) services and Certified Recovery Specialist (CRS) services. 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. This service is conducted by a DDAP-licensed drug and alcohol facility and service hours **must be available 24/7.** Service delivery is centered on the member's needs, both clinical and nonclinical.

A COE must demonstrate its ability to employ a community-based care management team, **which must include a Certified Recovery Specialist credentialed by the Pennsylvania Certification Board,** and may include peer navigators, nurses, social workers, and other provider types.

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 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. A COE must administer the Brief Assessment of Recovery Capital (BARC) survey to each individual admitted to the COE. The BARC must be administered within 30 days of the initial encounter with the COE provider and re-administered at six-month intervals.

Full-time Equivalent CM and CRS caseloads may not exceed 30 active members.

Services are provided in 15-minute units and the billable service for the month must include active case management, it may not be a check in with the member.

Service Exclusions

While active in a COE, members may not receive community-based CRS services, nor may they receive Case Management services outside of the COE. 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.

Referral 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 Process

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; or if unable to provide the assessment, the COE 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 Primary Contractor or its BH-MCO, in coordination with the OUD-COE, shall utilize the inclusion and exclusion criteria established in the OUD-COE Fidelity Checklist. The Department will make the OUD-COE Fidelity Checklist available to the Primary Contractor or its BH-MCO.

Recovery or Service Plan

The COE must, in collaboration with the member, develop an integrated, individualized care plan that includes, at a minimum:

- The member's treatment and non-treatment needs
- The member's preferred method of care management, such as face-to-face meeting, telehealth, phone calls, or through a secure messaging application
- The identities of the member's community-based care management team, as well as the member's support system

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.

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 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.

Care Coordination

Care Coordination is the prime objective of a COE Case Manager. Providers are expected to encourage the member to permit communication with Primary Care Physicians (PCPs) and other behavioral health providers. It is expected that a release of information (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.

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 member and may be 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.

The COE Case Manager must ensure linkage with the member's PCP, other behavioral health providers including community treatment team, prescribing physician, and other community support services. Housing stability must be considered when treating the

member at any level of care, and appropriate referral to support systems outside of the behavioral health system may need to occur if housing is inappropriate or at risk.

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

When a member is connected with community services and resources and seems to be stable in terms of connections to community supports the COE is expected to discharge the member from service at the COE.

A member must have a clearly stated discharge plan. Discharge from a COE may be member initiated or COE initiated. A member may be discharged if all areas of their service plan have been adequately addressed, the member has been connected to support services that assist in recovery maintenance, the member wishes to terminate service. If the member continues to need community support and medication management, the provider is expected to solidify plans for those activities. The member should be informed of crisis services or how to reengage 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.

If a member unexpectedly stops engaging in services, the COE must make attempts to re-engage the member in services. These outreaches must be documented in the member's record. After 60 days of no contact, the COE must notify a member, in writing, of a decision to involuntarily terminate the member's enrollment at the COE. The notice shall include the reason for termination. The member may be re-enrolled at any time.

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:

- Use a formalized and documented quality improvement process:
  - For information about quality improvement processes or continuous process improvement, please see https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod4.html#:~:text=In%20health%20care%2C%20quality%20improvement,analyzed%2C%20improved%2C%20and%20controlled

- 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 http://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 (https://www.magellanofpa.com/for-providers/provider-resources/forms/adverse-incident-reporting-form/).

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.