Mental Health Outpatient

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:

1. Additional information regarding co-occurring enhanced programs
2. Documentation – added expectation that all relevant diagnoses be reflected on claims submissions
3. Added section regarding risk assessment expectations
4. Care Coordination – additional information regarding assessment and coordination for physical health diagnoses
5. Outcomes – added information about eMbraceCare

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is Magellan's expectation that providers apply these Performance Standards when developing internal quality monitoring activities. Magellan will use this document as a guide when conducting quality reviews. Entities providing services as part of the PA HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type and speciality. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, and Chapters 1153 and 5200 as well as licensing program requirements and any contractual agreements made with Magellan in order to be eligible for payment for services.

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

Level of Care Description

Outpatient programming includes a range of services offering long and short-term treatments for varying diagnoses and severity of illness to provide coping skills and available support systems to members. These services are provided in a manner consistent with the principles articulated by the Community Support Program (CSP), the Child and Adolescent Service System Program (CASSP), the Department of Health standards, recovery principles, mental illness/substance abuse (MISA) principles and relevant medical necessity guidelines (MNG).

Scope of Services

Prior to the initiation of services, an individual must have a valid principal DSM-5 diagnosis and a comprehensive biopsychosocial assessment must be completed. Treatment should be guided using recovery-based approaches and supports. The individual's potential for growth and recovery should be emphasized. These services are provided by clinics or with individual practitioners that meet Magellan

credentialing requirements. The ages treated by the provider can vary according to their Service Description. Services should be offered at times that are conducive to the individuals served. Outpatient providers are equipped to refer to crisis services and should have emergency management protocols for after hours.

Service Description

Mental Health Outpatient Services include the implementation of the most promising approaches for an individual who is diagnosed with a behavioral health illness. The individual's potential for growth and recovery should be emphasized. Intervention strategies should attempt to improve the individual's quality of life as well as alleviate symptoms. The goals of the individual should drive the treatment plan.

It is best clinical practice for these services to be provided by a Mental Health Professional (MHP). Accordingly, clinic-based practices should be delivered by a licensed, certified, or master's prepared individual as per facility policy and the Pennsylvania Code. Mental Health Professionals should be supervised in their practice by a psychiatrist, senior clinician, or other appropriately trained clinicians. Per the regulations, services within a licensed outpatient clinic may also be provided by a mental health worker under the supervision of a MHP. Clinics are expected to have a policy and procedure outlining appropriate clinical supervision frequency as well as content and substance of the supervision. The clinic is expected to maintain ongoing training and supervision records for clinicians who are employed as outlined in the facility policy.

Independent practitioners must be masters prepared, licensed, Medicaid-enrolled and credentialed with Magellan. Independent practitioners must have a referral mechanism in place for psychiatric consultations that meet approved access standards.

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

Service Exclusions

While there are times when this might be needed, it is considered duplicative for an individual to participate in Outpatient Services in conjunction with:

- Psychiatric Inpatient Services
- Substance Use Withdrawal Management
- Substance Use Residential 3.5 or 3.7 (excluding 3.1)

- Substance Use Partial Hospital Program
- Substance Use Intensive Outpatient Program
- Substance Use Outpatient
- Substance Use Case Management
- Residential Treatment Facility Services
- Residential Treatment Facility for Adults
- Family Based Services
- Intensive Behavioral Health Services (IBHS) if receiving Mobile Therapy
- Multi-Systemic Therapy
- Functional Family Therapy
- Assertive Community Treatment
- Psych Rehab - Site Based and Mobile
- Mental Health Partial Hospital Program
- Dual Diagnosis Treatment Team

If you feel additional services are needed, please coordinate with your Magellan Care Manager.

Referral Process

Magellan does not require prior authorization from providers for most outpatient mental health services. Referrals may come from a variety of different sources, and a member can call member services or utilize Magellan's website to identify a provider. Upon receipt of a referral, the provider should coordinate an initial appointment/assessment in accordance with Magellan's Provider Handbook Supplement and the member's availability. The provider would make the recommendation for the appropriate service for the member based on the assessment findings.

Admission Process

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

Co-Occurring Enhanced Programs

During the admissions process if a member is assessed for co-occurring needs and requires a referral for ASAM 1.0 or 2.1 LOC for co-occurring enhanced services they must meet the diagnostic criteria for a mental health disorder as well as a substance use disorder. This information is defined in the current

Diagnostic and Statistical Manual of Mental Disorders (*DSM*) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission.

Treatment or Service Plan

Treatment planning should involve the individual, as well as expectations of family members if they are involved in treatment. Treatment plans are recovery-oriented and strength-based and should be developed within the first two sessions. Per Chapters 1153 and 5200 of the PA Code, the initial treatment plan should be developed, reviewed, approved, dated, and signed prior to the provision of any treatment services beyond the 30th day following intake. Treatment plans should include measurable and observable goals, interventions to be used, and clearly defined discharged criteria. Individuals should sign their treatment plan, as well as receive a copy of it. The treatment plan must also be signed by the mental health professional or the mental health worker under the supervision of the mental health professional, and either the psychiatrist or advance practice professional depending on whether the individual is receiving medication management services. Part of treatment planning can include connection to community supports. All staff involved in the individual's treatment should have knowledge of treatment plan and goals. Treatment planning should note progress, strengths, barriers, and discussion of alternate levels of care if improvement is not observed in a clinically appropriate timeframe or the individual's mental status deteriorates to the point that cannot be safely managed in an outpatient setting. All co-occurring enhanced programs must include both mental health and substance use issues identified in the assessment process when developing a treatment plan with members.

Treatment Plans must be reviewed and updated at a minimum of every 180 days. Providers also need to ensure that they are maintaining compliance with their own services descriptions in relation to treatment planning.

Expectations of Service Delivery

Outpatient Services are recovery oriented and should be centered around a strengths-based treatment approach that include the expectations of the individual and their support system. Risk assessments should be completed during each session with appropriate documentation of the outcome. Both Social Determinants of Health (SDOH) factors and physical health factors for the individual should be explored, documented, and supported as needed. It is recommended that clinicians be trained in evidence-based practices and/or hold relevant certifications related to the population serviced.

Documentation

The documentation of the individual's mental health record allows mental health professionals to evaluate and plan for treatment, monitor health care over time, it facilitates communication and continuity of care among healthcare professionals involved in the individual's care, it ensures accurate

and timely claims review and payment, it promotes appropriate utilization review and quality of care evaluations, and it can be used for research and education. The following elements are important to follow and align with the minimum PA Medical Assistance (MA) documentation requirements:

- The record must be legible throughout and it is recommended that they be typed.
- The record must identify the individual on each page.
- Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be counter-signed by responsible licensed provider.
- Alterations of the record must be signed and dated.
- The record must contain a preliminary working diagnosis, as well as final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
- The record must contain all relevant diagnoses inclusive of mental health, substance use, and physical health, and be reflected on claims submissions.
- Treatments, as well as treatment plan, must be entered in the record.
- 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 record must indicate the progress at each session, change in diagnosis, change in treatment and response to treatment.
- The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.
- The disposition of the case must be entered in the record.
- The record must contain documentation of the medical necessity of a rendered, ordered or prescribed service.
- The documentation of treatment or progress notes for all services, at a minimum, must include:
    - The specific services rendered;
    - The date the service was provided;
    - The name(s) of the individual(s) who rendered the services;
    - The place where the services were rendered;
    - The relationship of the services to the treatment plan – specifically, any goals, objectives and interventions.
    - Progress at each session, any change in diagnosis, changes in treatment and response to treatment;
    - The actual clock hours that services were rendered.

In addition to the above notations, providers must follow the applicable MA regulations for the services for which they are licensed and enrolled.

Risk Assessment

Outpatient providers should have a standard suicide risk assessment that is utilized with the members routinely throughout the course of treatment. If a member indicates as high risk for suicide, a crisis plan should be created to support the member's needs. Both risk assessments and crisis plans should

be updated periodically to best meet the member's needs. Members who experienced an acute inpatient admission should have risk assessments completed at their return to Outpatient services.

Co-occurring Enhanced Service Delivery

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

Care Coordination

When possible and with the individual's permission, there should be coordination between programs as the individual prepares to discharge to ensure continuity of care. If an individual presents to a higher level of care during treatment in outpatient services and consent is given, there should be coordination between providers so that relevant clinical information can be provided to support the higher level of care and to ensure a smooth transition back to outpatient.

If upon initial assessment physical health factors are identified, it is best practice to assess for the stability of the identified physical health factors and the member's perceptions as to their ability to self-manage their physical health needs. The impact that behavioral and physical health factors have on each other should be discussed along with how these factors may influence treatment. If barriers are identified in managing one's physical health needs, the barriers and possible resolution to identified barriers should be reviewed with member and may be considered for inclusion in goal planning discussions. Physical health diagnoses, medications and treating providers should be documented within a member's treatment record. Providers should encourage members to receive annual physicals. Any lab results obtained that may impact treatment, such as psychiatry, should be included in care discussions.

Coordination and consultation by the behavioral health provider with a physical health professional may be indicated to support a member's whole health and enhance overall treatment outcomes. A behavioral health provider's engagement with a Primary Care Practitioner and/or a member's physical health managed care organization is recommended to ensure continuity of care across treating providers. 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.

Outpatient providers should evaluate, and document Social Determinants of Health (SDOH) information related to housing, access to food, employment status, education, and transportation issues that impact each member's care. Once SDOH have been evaluated, appropriate referrals to community services should be made once member consent is received. Risk assessment should be completed in every outpatient therapy session to determine if a higher level of care is required or if other resources are appropriate.

Discharge Planning and Transition

There should be a clear discharge plan that was discussed with the individual throughout treatment and was reviewed prior to discharge to ensure understanding. Discharge plans should be inclusive of resources and/or plans to support a member's physical health and Social Determinants of Health factors, as applicable. Individuals should be connected to clinically appropriate aftercare services that meet their needs, and they should be given a copy of this plan with dates of follow up appointments as needed. Individuals should be offered crisis support services, and a safety plan should be created. Individuals should also be made aware how to reconnect with services if a future need should arise. With an individual's permission, it would be beneficial to connect with the aftercare provider around treatment goals, progress, and current needs to ensure continuity of care, as well as include family/supports. There should be evidence of discharge planning from the beginning of services, and its continued discussion should be documented in progress notes and treatment plans. Discharge planning should take into consideration progress and ability to be treated in a less restrictive setting, as well as lack of progress requiring a higher level of care.

Transfer/Discharge Criteria

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

- The member has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care. Continuing the chronic disease management of the member's condition at a less intensive level of care is indicated;
- The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. The member is determined to have achieved the maximum possible benefit from engagement in services at the current level of

care. Treatment at another level of care (more or less intensive) in the same type of service, or discharge from treatment, is therefore indicated;

- The member has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve his or her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated;

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

Outcomes

Mental Health 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 outcomes tools appropriate to the members served

Magellan's branded, clinically driven care model, eMbraceCare, uses a person-centered approach that is designed to support an individual's achievement of improved personal health outcomes and wellness, by encouraging positive living, along with the provision of services that meet individual needs in a whole health manner. Positive living, the ultimate goal of eMbraceCare, is a lifelong process for individuals experiencing behavioral and substance use disorders that includes incorporating all of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Eight Dimensions of Wellness into their lives. These Eight Dimensions of Wellness include the following:

1. Emotional - Coping effectively with life and creating satisfying relationships.
2. Environmental - Achieving good health by occupying pleasant, stimulating environments that support well-being.
3. Financial - Satisfaction with current and future financial situations.
4. Intellectual - Recognizing creative abilities and finding ways to expand knowledge and skills.
5. Occupational - Achieving personal satisfaction and enrichment from one's work.
6. Physical - Recognizing the need for physical activity, healthy foods, and sleep.
7. Social - Developing a sense of connection, belonging, and a well-developed

support system.

8. Spiritual - Expanding a sense of purpose and meaning in life.

Performance Outcome Management System (POMS) is a tool the Department of Human Services (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).
- Whenever there is a change in any POMS element.

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 (Section 2.2.1). The identified provider will receive an acknowledgement letter summarizing the complaint items and requesting documentation to be submitted for the review. The response and documentation should be faxed to 888-656-2380 on or before the deadline listed in the letter. Additional information and follow up activities might be requested.

The information that is collected through Magellan's investigation is presented to a first level complaint review committee, which makes the first level complaint decision. HealthChoices standards and regulations, contractual standards, and generally accepted standards of care apply those standards to the issue at hand. Magellan is required to make a decision and send a letter to the member explaining the findings and the reasons for the decision within 30 calendar days of receipt of the Complaint.

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

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

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

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

Persons receiving services should be provided with information explaining the agency's complaint/grievance policies and procedures. Programs often provide this information upon admission to the service; however, it should also be readily accessible throughout the duration of services.

Physicians and staff should have adequate training on helping individuals as needed to report, address, and resolve a complaint or grievance.

Grievance Process

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

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

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

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

Please see the Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information including provider-initiated grievances and filing a provider complaint.

Quality Management

Quality care for members and their families is important. Magellan is committed to continuous quality improvement and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and services. Magellan has collaborated with Counties and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices' members.

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

NCQA's accreditation standards for managed behavioral health care organizations (MBHOs) emphasize quality standards and activities in a number of areas. NCQA reviews the quality of care and service we deliver, as well as the direct care provided, particularly in the areas of access and availability to care, utilization management, and continuity of care across behavioral health programs. Magellan has developed a number of performance measurement and quality oversight activities to support these NCQA standards and HealthChoices' requirements.

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

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

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

- Follow policies and procedures outlined in Magellan's Provider Handbook and Provider Handbook Supplement.
- Meet treatment record standards as outlined in the Treatment Record Review Tool found under Audit Tools in the Appendix of Magellan's Provider Handbook.
- Provide treatment records as requested for quality-of-care issues and adhere to clinical practice guidelines and HEDIS®-related measures.
- Participate as requested in treatment plan reviews, site visits and other quality improvement activities.
- Use evidence-based practices.
- Adhere to principles of member safety.
- Attend or log on to provider training and orientation sessions.
- Participate in the completion of a remediation plan if quality of care concern arises.
- Encourage use of member and clinician outcome tools including use of the PHQ-9 and other standardized tools at intake and established treatment intervals, and to review real-time reports together.
- Incorporate the use of secure technology into their practice to make accessing services more convenient for members, e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, electronic referrals to other practitioners or programs, and online access to personal health record information.
- Assist in the investigation and timely response of member complaints.

- Assist in the investigation and timely response of adverse incidents.

Magellan supports a wide range of evidence-based and best practices. Magellan requests that contracted providers and practitioners keep inventory and fidelity of evidence-based or best practices that they offer and incorporate into treatment.

Magellan commits to a strong cultural competency program and believes that all people entering the behavioral health care system must receive equitable and effective treatment in a manner that is respectful of individual member preferences, needs and values and sensitive to residual stigma and discrimination. Magellan encourages providers to maintain practices that are deeply rooted in cultural competence as well, focusing on continual training and education to support staff. Cultural Competency and the LGBTQIA+ Tools are available here 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.