CHAPTER I. About Community Care Behavioral Health Organization
I. About Community Care Behavioral Health Organization

Community Care is a federally tax-exempt Pennsylvania nonprofit and 501 (c)(3) behavioral health managed care organization (BH-MCO). We are subsidiary of UPMC and part of the UPMC Insurance Services Division.

Licensed as a Pennsylvania risk-assuming PPO by the Pennsylvania Insurance Department, Community Care manages behavioral health services for Medical Assistance beneficiaries who live in the counties served by Community Care. This includes members of the HealthChoices program in each of the regions, Southwest, Southeast, Capital-Lehigh, Northeast, and North Central (State and County options).

Community Care contracts with providers (individual or group practitioners, or facilities or organizations) to offer diverse behavioral health (mental health and chemical dependency) services to HealthChoices members.

For the success of our partnerships with members, providers, and the communities we serve, as well as for the achievement of our goals, Community Care relies on the strong commitment of all parties involved to conduct business lawfully and ethically. Community Care’s code of ethics is embodied in our mission statement, statement of values, and code of conduct.

These documents guide our interactions with all of our partners, stakeholders and each other. Consistent with our code of ethics, Community Care has developed quality management programs, policies, and procedures to ensure compliance with legal, regulatory, and professional requirements.

The following sections describe Community Care’s ethical framework and processes in detail:
A. Code of Ethics
B. Cultural Competency Vision
C. Overview of Quality Management
D. Compliance with Fraud and Abuse Reporting
E. Care Management Team

Call the Provider Line at 1-888-251-2224 with questions about Community Care’s ethical framework or other material in this manual.
I.A. Code of Ethics

Community Care’s code of ethics includes our Mission Statement as well as the following statement of values.

Statement of Values

Community Care holds the following values:

- Maintain member health and well-being as our highest priority.
- Be responsive to the needs of all members.
- Serve as a vital resource and partner for the region and communities in which we work.
- Value member satisfaction among our highest priorities and strive to ensure a compassionate, member-centered environment.
- Use professional ethics and integrity, which we believe are vital in making sound business decisions.
- Be accountable to the citizens of our regions in all of our work.
- Commit to a continuous quality improvement process that focuses on the highest level of customer satisfaction possible.
- Facilitate improvements in access to care and to provide optimal value for the dollars available.
- Link assessments and outcomes to the decision-making process by means of the latest clinical and information technology.
- Provide a culturally competent workplace that encourages employee growth and promotes employee satisfaction.
- Appreciate the diversity of our members, families, communities, providers, and staff.
- Build on the strengths of members, families, and communities by encouraging members and their families to participate at all levels of nationally recognized education and prevention programs.
- Respect and uphold the traditions of the communities of which we are a part.

I.B. Cultural Competency Vision

In 2000, Community Care developed the following Cultural Competency statement, with input from a group of network providers, community representatives, and oversight entities.

Our vision for an effective and accessible behavioral health system of care leads with high-quality services that improve the health and well-being of our community. Our goal is to offer a system, ultimately free of barriers to obtaining services, comprised of integrated, balanced, and responsive mental health and substance abuse care. It is based on the Pennsylvania *Call for Change: toward a Recovery-Oriented Mental Health Service System*, which defines “recovery” as:
“A self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.”

It includes consumer choice, self-determination, and acceptance, and is designed to reach individuals and families at risk of crisis or disability; stimulate, facilitate, and support recovery for persons with behavioral health disorders; enable recovery; and promote individual, family, and community health and well-being.

To help Community Care representatives (including providers) understand and participate in Community Care’s vision, we share these definitions:

- **Culture** is the patterns of behavior that include communications, actions, customs, beliefs, values, and institutions of a social group.
- **Cultural Identity** includes, but is not limited to race, ethnicity, language, age, region or country of origin, degree of acculturation, gender, socioeconomic class, religious beliefs, and gender.
- **Cultural Awareness** is the understanding that people are shaped by the social, linguistic, ethnic, and behavioral characteristics of the cultures to which they belong and that there are patterns of expressions, beliefs, values, and practices that can be shown to enable those providing behavioral health care to understand the diversity of people.
- **Cultural Sensitivity** is knowledge about the social, linguistic, ethnic, behavioral and interactional characteristics of a group or population, how those behaviors and characteristics may influence a group’s worldview and the demonstration of this knowledge through provider and organizational interactions and communications.
- **Cultural Competence** is the ability to systematically translate knowledge and understanding of the social, behavioral, and interactional differences of groups into attitudes and practices of care, such as acknowledgment, inclusion, and helpfulness that promote the behavioral health and well-being of individuals, families, and communities.

Cultural competence is an essential part of this vision. It benefits Community Care’s network of behavioral health providers by generating trust and maintaining credibility with members, agencies, and the community. Cultural competence demonstrates a commitment to eliminating barriers that prevent our agencies from meeting their potential and full responsibilities to their communities. That commitment is proven through effective policies and administration, effective frontline provision of services, and the evaluation of those services.

Providers will be informed (through mailings, website articles, forums, and other interactions) about Community Care’s commitment to a culturally competent system of services provision, instructed on standards and performance indicators, provided examples for demonstration of cultural awareness and sensitivity, given assistance and resources and evaluated on their progress toward cultural competence. Providers’ commitment is essential to our ongoing development of a responsive system of care.
I.C. Overview of Quality Management

The Community Care quality management program is based on a philosophy that emphasizes a systematic, organization-wide perspective that involves everyone. It is focused on achieving satisfaction for both internal and external customers and improving member outcomes within an organizational environment that seeks continuous improvement of systems and processes.

The foundation is good business ethics. Professional integrity and mutual respect are defining characteristics of the quality management program philosophy.

From its outset, Community Care recognized company-wide quality goals that have been integrated into all department activities. At its most fundamental level, quality management aims to sustain and improve the health status of members by measuring and improving performance of care and services within the healthcare delivery system processes and structure. Community Care is committed to improving the health status of the populations it serves and, by extension, the community. Our quality improvement program is designed with input from network practitioners and follows the guidelines of all regulatory and oversight agencies including the Department of Health and the National Committee for Quality Assurance (NCQA).

Areas of focus include:
- Delivering high-value, culturally competent care that incorporates the special needs and preferences of members.
- Continuously improving the clinical care and service provided to members.
- Enhancing the community’s health status through behavioral health wellness and preventive programs.
- Pursuing opportunities to improve the health status of members and target efforts to the needs of the population.
- Ensuring that care and services are available and are provided to members in a timely manner, appropriate to the member’s needs and preferences.
- Ensuring that care and services are coordinated between providers and across all delivery settings through the care management process.
- Establishing collegial relationships with providers to achieve superior clinical and customer service outcomes.
- Providing exceptional customer service.
- Continuously improving quality improvement processes by maintaining comprehensive, current, and effective quality management policies and procedures.
- Analyzing performance data and identifying opportunities to improve performance and outcomes.

High-quality culturally competent health care and responsive customer services are provided to all members. This philosophy is consistent with principles of continuous quality improvement as articulated by Deming, Juran, and others.
Community Care views quality as an integrated company responsibility (promoted by specific indicators facilitated by the Quality Management Department). Community Care's Board of Directors, management, departments, committees, oversight entities, providers, and community representatives all participate in quality improvement activities.

Community Care believes that input from appropriate committees, members, providers, and other stakeholders must be solicited on an ongoing basis in order for our quality efforts to be successful.

The philosophy stresses the importance of staff to achieve success. Teams of individuals are responsible for monitoring customer satisfaction and improving performance. Creativity and innovation within the scope of work are encouraged to ensure customer satisfaction and exceed client and member expectations. Staff is supported in efforts to continually improve performance. Community Care views staff as the solution to problems, not the cause. Community Care holds that the root causes of sub-optimal performance, problems, or variation in a process are usually related to the system or process itself and not to staff.

Community Care will share information with network providers about our:

- Quality improvement program, including goals, processes, and outcomes as related to care and service.
- Efforts to measure the availability of practitioners, facilities, and treatment programs and actions taken to improve availability.
- Efforts to measure the accessibility of care and service for members and actions taken to improve accessibility.
- Overall findings of member satisfaction activities (such as the annual Member Satisfaction Survey), including what we do to improve member satisfaction.
- Clinical practice guidelines and processes that measure guideline adherence.
- Expectations for exchange of information with primary care physicians (PCPs) and within the behavioral health continuum to facilitate continuity and coordination of care.
- Medical necessity criteria, including how to view or obtain a copy.
- Availability of and process for contacting the appropriate Community Care peer reviewer to discuss utilization management decisions.
- Description of the availability of an independent external appeals process for utilization management decisions made by Community Care.
- Policy prohibiting financial incentives for utilization management decision-makers.
- Member rights and responsibilities statement.
- Confidentiality policies including our routine uses and disclosures of enrollees’ protected health information (PHI), enrollees’ rights to approve the release of PHI not covered by the routine consent, and access to the enrollees’ medical records.
- Preventive behavioral health programs including how successful these programs have been.
- Treatment record policies regarding confidentiality of treatment records, documentation standards, systems for organization of treatment records, standards for availability of treatment records at the practice site, and performance goals.
If you would like more information regarding our quality improvement program, contact us at 1-888-251-2224. We will provide you with a description of the program and an update on our progress toward meeting our goals.

If you have any suggestions for improving our quality improvement program or if you have any questions about this information, please contact us:

Community Care Behavioral Health Organization
339 Sixth Avenue
Suite 1300
Pittsburgh, PA 15222

I.C.1. Quality Improvement Methodology

Community Care uses many processes in our quality management activities. A clear understanding of processes and knowledge of the reason for performance levels are essential to the quality management program. In order to understand performance, the interdependent processes must be clear. Processes are related both hierarchically and in a matrix with many interrelationships. Until performance is measured using a rigorous methodology, the actual state is unknown. Once a baseline is established, performance can be understood in quantifiable terms. It is either out of control, in control but not within limits, or in control and within limits. Continuous improvement aims at having performance consistently at optimal achievable levels.

Measurement with disciplined rigorous methodology is a principle strategy of the quality management program. This structured, disciplined operating orientation focuses on long-term continuous improvement, recognizing that there are no quick fixes. Decisions are based on fact and actual performance data, not opinions and anecdotal evidence. Quantitative methods are the foundation of the information used in making decisions. Measurement and performance data are fundamental to the quality management program.

The improvement system is continuous and consistent throughout the organization. The continuous improvement system employs methodology for problem-solving, action planning, and performance improvement. The most commonly used problem-solving methodology is the “plan, do, check, act” method (the Shewhard-Deming cycle).
I.C.2 Measurement

Explicit, well-defined critical performance measures are the essential component of Community Care’s quality management program. Critical performance indicators represent what is most important to Community Care in defining quality. They are developed using sound methodological principles. The performance data that result from measurement are reliable so that decisions can be made with confidence.

Measurements are specifically defined in Community Care’s quality assurance Work Plans. Each topic includes the measurements, goals, and timing of each activity. On an annual basis, Community Care publishes the results of Work Plan monitoring activities and studies in our communications. Interventions and results are also described.

I.C.3 Record Review

Certain measurements in Community Care’s annual Quality Management Work Plan rely upon data collection through confidential record review. Selected network providers are contacted in advance of a record review. Areas of focus include topics such as accessibility to covered services, appointment availability, coordination of care, quality of care, and record keeping. Community Care expects providers to agree to furnish pertinent sections of an enrollee’s medical records, consistent with appropriate rules of confidentiality for patient records as described in the Network Provider Agreement and as specifically required by HealthChoices.

I.C.4 Quality Management Program Structure

The quality management program description describes the structure and processes of the quality management program. The Work Plan lists the activities that comprise the quality management program. The Quality and Care Management Committee (QCMC) oversees implementation of the program and Work Plan.

The quality management program is designed to continuously improve performance and provide members with high-quality, cost-effective healthcare services, access and availability to culturally competent healthcare providers and services, continuity and coordination of care across all health care delivery settings, and effective behavioral health prevention programs and health education services.

I.C.5 Availability Standards

Community Care monitors availability by category of service, through its GeoAccess reporting capabilities, to ensure access to a Provider:

- Within 30 minutes for urban areas.
- Within 60 minutes for rural areas.

These measures are included in the Quality Management Work Plan.
I.C.6 Accessibility Standards

Community Care monitors access to routine, urgent, and emergent appointments:

A routine request for an appointment met within seven days.
An urgent request for an appointment met within 24 hours.
A non-life-threatening request met within one hour.
A life-threatening emergency met immediately.

These measures are included in the Quality Management Work Plan. Refer to Section IV.D for more information about accessibility.

I.D. Compliance with Fraud and Abuse Reporting

To fulfill our mission and to act in accordance with our values, code of conduct, and policies, Community Care monitors and investigates suspected fraud and abuse, defined as follows:

- **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. Examples of fraud could include a provider submitting a bill for a service that did not occur, billing for a time period greater than the time actually spent with the client, billing for provision of a service that did not meet the service definitions, billing or charging Medical Assistance recipients for covered services, billing more than once for the same service, or dispensing generic drugs and billing for brand name drugs.

- **Abuse** by a provider is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. "Abuse" also includes Community Care member practices that result in unnecessary costs.

Community Care monitors for possible fraud and abuse within our provider network by conducting audits, investigating fraud, waste, and abuse (FWA) referrals, and analyzing billing and payment data. When suspected fraud or abuse is identified, Community Care reports these occurrences to appropriate licensing, reporting, and investigative agencies and takes appropriate action to prevent future fraud or abuse.
I.D.1 Procedures for Suspected Fraud or Abuse

Any Community Care staff member suspecting fraud must report the suspicion, either to his or her supervisor or directly to Community Care's Fraud and Abuse Department. The report can be made via the Fraud and Abuse Hotline at 1-866-445-5190, e-mailed to CCBH_Fraud_Abuse@upmc.edu, or by submitting an internal referral to the Director or Manager of the FWA Department. If the supervisor is notified first, he or she must report the suspicion to the Director of Fraud and Abuse within one business day of receiving the staff member's report.

Consequences of confirmed fraud include repayment of monies paid for the fraudulent claims and the requirement to submit a corrective action plan that outlines how the audit exceptions will be prevented in the future. Notification of the identified fraud incident will be sent to the Department of Human Services, Bureau of Program Integrity (DHS/BPI), the appropriate county administrators, and the county oversight entities. Suspension or exclusion from the Community Care network of providers may also occur as a result of the fraudulent activity.

I.D.2 Avoiding Fraud and Abuse

Community Care encourages providers to read this Provider Manual and/or call the Provider Line (1-888-251-2224) with any questions about standards of care, documentation and record keeping, claims/billing procedures, or any other activity that could be associated with a fraud or abuse concern. In addition, Community Care offers provider training on these and other topics.

I.D.3 Reporting Suspected Fraud and Abuse to the Department of Human Services

The Department of Human Services has established a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients. The hotline number is 1-866-379-8477 and operates between the hours of 8:30 a.m. and 3:30 p.m., Monday through Friday. Voice mail is available at all other times. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Suspected fraud and abuse may also be reported via the DHS website at:

http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/

Information reported via the website can also be done anonymously. The website contains additional information on reporting fraud and abuse.
I.E. Care Management Team

“Advocates” is a word often used by others to describe Community Care’s care management team because of their attention to quality, clinical effectiveness, member choice, and the recovery philosophy. This clinically focused team was created early in Community Care’s history—as the means to effectively assist members in making informed decisions about the services and supports that are available to them and to assist providers in quality service delivery through consultation and collaboration. Care management focuses on:

• Adult mental health services.
• Services for children and adolescents.
• Drug and alcohol services.
• Dual diagnoses services.
• Service Precertification.
• Members identified as high risk.

Care management uses diverse resources and team member expertise to ensure that assistance is available to members and providers whenever needed.

Care management operates 24 hours a day/seven days a week, with clinical supervisors on call at all hours. All care management staff have direct access to Community Care’s Professional Advisor staff, 24 hours a day. Care management works closely with other departments in Community Care, such as network management, information systems, quality management, and credentialing. In addition, Community Care’s prevention, outreach, communications, and training teams support members and providers in other ways.

The purpose of the care management team is to:

• Ensure that services are medically necessary and are being delivered at the appropriate intensity for a prescribed length of time with member participation as a part of the treatment team.
• Ensure coordinated care for all services and supports that the member is receiving and follow up care as a member is transitioning from one level of care to another.
• Monitor the quality of care in several ways, including review of treatment documents, attendance at team meetings, member and provider feedback, and analysis of utilization information.
• Provide a responsive complaint and grievance process that ensures members can voice their opinions about the care, services, and information they receive.
• Be available to answer questions from members and providers.
It is common for Community Care’s care managers to attend treatment team meetings, to work with groups of providers and other stakeholders in specialty areas to improve the quality of care, and to design trainings in areas where education is requested and/or needed. Care Managers work with members, families, providers, and others; often in community settings.

I.E.1 Adult Mental Health, Substance Use, and Dual Diagnoses Services

An important function of care management is to ensure coordinated care and follow up. This is especially important when members are unfamiliar with treatment and community support options. Care managers are committed to ensuring that each individual member has the tools needed to move forward in the recovery process.

Care managers are looking for:

- Appropriate clinical information including discussion of treatment options with the member and/or family.
- The consideration of non-traditional services such as Psychiatric Rehabilitation, Diversion and Acute Stabilization, Enhanced Clinical Case Management, Acute Case Management and Community Treatment Teams (CTT) as well as Recovery and Peer Supports.
- Proactive discussion, planning, and documentation of strategies for members to utilize when dealing with crisis situations.
- Effective provider collaborative efforts focused on diverting members from the most restrictive levels of care and increasing community tenure.
- Identification of a need for workgroup meetings with providers, members, and other stakeholders to establish consistent “best practices” for specific levels of care.

Care managers act as consultants to the treatment team when requested. They also closely monitor:

- Overall access to services within designated time and distance standards and gaps with needed services.
- The geographic make-up of the provider network ensuring a diverse network of options for members.
- The appropriate application of Medical Necessity Criteria (MNC) and proper documentation of supporting information for the purpose of utilization management.
- Coordination of care activity between behavioral health and physical health providers.
- Inquiries, complaints, and strategies to assist members with multiple and/or complex needs.
- The extent to which members with a co-occurring disorder receive referrals for services and supports that fully address their needs.
In order to serve special population groups and members with high utilization of the most restrictive levels of care, a “tier” methodology is utilized to identify members who may require special intervention by a care manager. All members have a specific care manager assigned to them.

Team members work collaboratively to serve members that have been dually diagnosed. Mental Illness/Substance Abuse (MISA) screenings have become part of a formal program for members who are receiving both mental health and drug and alcohol services. Care managers ask questions during regular utilization reviews to determine whether providers are screening for dual disorders and offering appropriate referrals to members when a co-occurring disorder is identified. The program is monitored on an ongoing basis through quality record reviews.

I.E.2 Services for Children and Adolescents

Community Care’s child and adolescent team is a specialized group of care managers with a strong background and expertise in the areas of child and adolescent services as well as family systems. These care managers collaborate with providers and children and their families in reviewing options for treatment, coordinating services, and ensuring timely access to needed services.

These care managers:

- Provide parents with specific information.
- Monitor the prescription of services and actual service delivery for each child.
- Attend interagency team meetings.
- Monitor Behavioral Health Rehabilitative Services for Children and Adolescents (BHRSCA) through active participation with the treatment team.
- Monitor Residential Treatment Facility (RTF) services with an emphasis on transition planning.
- Ensure coordination of care between behavioral health providers and with the Primary Care Physician.
- Ensure proper involvement of children/family services agencies or juvenile justice agencies when needed.
- Facilitate coordination with schools.
- Facilitate physical health and behavioral health Integrated care.
- Consider non-traditional services such as therapeutic services in Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy (MST) and Functional Family Therapy (FFT).
- Act as consultant to the treatment team when requested.

Community Care also provides written informational material for parents, including prevention program materials and information about Community Care’s Family Advisory Committee events.
I.E.3 Pre-certification Team

Community Care maintains a dedicated team of care managers to conduct precertification reviews for acute levels of care. These care managers ensure that individuals’ needs and strengths have been assessed, that the specific level of care requested meets MNC and that the requested level of care provides the least restrictive environment for the member to continue the recovery process. In addition, the care managers on the precertification team may assist the member and provider in identifying options and facilitating diversion planning. These care managers will also facilitate coordination of care efforts based on the member’s treatment history, current authorized services and active crisis plan.

I.E.4 High Risk Intervention

This specific team of care managers works with members and their providers to resolve complex or high risk factors which impact the member’s ability to progress towards recovery. Face to face or telephone contact is focused on both the member and provider. Because medical conditions often co-exist with a behavioral health diagnosis, coordinating care with physical health practitioners is also a priority.

This team’s activities are driven by the needs and strengths of the individual member with frequent consultation with the Community Care professional advisors.

Care managers focus on performance standards. They ensure that quality standards (performance standards) are met. Community Care created these standards in conjunction with providers, members, and other stakeholders with the goal of providing consistent, high-quality care to all members. We accomplish this goal by offering written and specific quality standards by level of service and by using effective quality monitoring.

To date, Community Care has created performance standards for:

- Acute Partial Hospitalization
- Behavioral Specialist Consultation
- BHRS for Autism Spectrum Disorders
- Community Treatment Teams (CTT)
- Diversion and Acute Stabilization/Respite
- Drug and Alcohol – Medically Monitored Short-Term Rehabilitation Programs
- Drug and Alcohol Partial Hospitalization
- Family-Based Mental Health Services
- Family-Focused Solution Based
- Individualized Residential Treatment/CRR
- Inpatient Services
- Mobile Therapy
- Outpatient Services
- Psychiatric Rehabilitation
• Psychiatric Rehabilitation Clubhouse
• Psychologists and Psychiatrists Completing Best Practice Evaluations
• Residential Treatment Facilities (RTF)
• School-Based Outpatient
• School-Based Partial Hospitalization Program
• Summer Therapeutic Activities Program
• Targeted Case Management: Intensive Case Management (ICM), Resource Coordination (RC)
• Telepsychiatry

Care Managers may refer to the "performance standards" as they are collaborating with a provider. Care managers ensure that:

• Clinical information given to the care manager meets the standards and guidelines for MNC review.
• All information is complete and up to date.
• Information is clear and specific.
• Performance standards for that specific level of care are met.

Because care managers collaborate closely with providers during the utilization management process, they can often provide additional oversight, consulting, and monitoring to those providers who may be having difficulty meeting network benchmarking standards.

For information about approval standards refer to Guidelines for Obtaining Approval for In-plan Services at the beginning of this guide. Authorization is based on administrative and Medical Necessity Criteria. For information about Medical Necessity Criteria, refer to Section IV.B or visit our website at: http://www.ccbh.com/providers/phealthchoices/medicalnecessity

For more information about Performance Standards, visit our website at: http://www.ccbh.com/providers/phealthchoices/performancestandards