CHAPTER III. About Being a Community Care HealthChoices Provider
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Community Care’s goals in developing and supporting a network of HealthChoices providers are to:

- Have a comprehensive range of providers to deliver all behavioral health services covered under HealthChoices regardless of participation in Federal Health Care Programs under Sections 1128 or 1128A of the Social Security Act.
- Offer an adequate number of practitioners and facilities appropriately dispersed throughout Community Care’s service area to allow for easy and convenient access by members.
- Offer a sufficient number of specialist and ancillary providers to permit ample choice for referrals regardless of cost.

Community Care’s goals are also to include providers who:

- Serve high-risk populations.
- Have demonstrated a commitment to public sector consumers.
- Are committed to implementing treatment services that are consistent with the principles of the Community Support Program (CSP), Bureau of Drug and Alcohol Programs (BDAP), and the Child and Adolescent Service System Programs (CASSP).
- Have worked to involve consumers and families actively in the design and implementation of treatment programs.
- Have understood the relevance of psychosocial assessments in the design and implementation of treatment.
- Represent both general and specific treatment skills.
- Will broaden access to assessment and treatment services, provided in a respectful and competent manner.

All providers of behavioral health services that are identified to participate in any of Community Care’s networks are required to participate in a network management screening process prior to being offered an application. Community Care then reviews this information with its county partners prior to make a network inclusion decision. Community Care prospectively identifies member needs based on knowledge of prior services used, psychosocial factors, member and family suggestions and provider experience. The geographic distribution and demographic characteristics of members are analyzed as well as the provider’s ability to meet the assessed and expected member needs.

In the event that a provider is denied network inclusion, the provider is notified in writing by the Network Relations Department of the decision. A clear rationale for the decision and an explanation of the right to appeal is included.
Community Care contracts with the following types of providers of behavioral health services:

- **Practitioners** in individual or group practice (physicians, psychiatrists, addictionologists), doctoral or masters-level licensed clinical psychologists, doctoral or masters-level clinical psychiatric nurse specialists, doctoral or masters-level licensed social workers and other masters or doctoral-level licensed behavioral health clinicians).
- **Facilities** (facilities and organizations).
- **Providers** (denotes information that applies to both practitioners and facilities).

The Community Care credentialing program is committed to:

- Careful selection, credentialing, and recredentialing of practitioners to ensure that members receive quality care and services from qualified professionals.
- Thorough assessment of facilities to ensure that members receive quality care and services in a full continuum of settings.
- Maintaining the confidentiality of provider related information in the provider files as well as the Credentialing Committee:
  - All Credentialing Department staff and reviewers sign employee confidentiality statements.
  - All Credentialing Committee members sign confidentiality statements.
  - Each Credentialing Committee meeting is opened with a statement regarding the confidentiality of printed material and discussions related to providers.
  - Provider specific materials prepared for the Credentialing Committee are proprietary and remain at Community Care following the Credentialing Committee meeting.
  - Provider files are maintained in locked file cabinets at Community Care.
- Make available to providers, upon written request, the ability to view any materials, except recommendations, National Practitioner Data Bank (NPDB) responses, and other peer-review protected documents, submitted in relation to their applications.

The following sections provide information about providing quality care to Community Care’s members, including how to become a contracted provider, how to maintain standards for confidentiality, record keeping, provision of quality care, and other issues affecting providers:

- Practitioner Credentialing, Contracting, Recredentialing
- Facility/Organization Assessment, Contracting, Reassessment
- Confidentiality and Disclosure Policy
- Record Keeping Standards
- Clinical Practice Guidelines
- New Technologies
- Significant Member Incident Reporting (Patient Safety)
- Provider Cultural Competency
- Provider Benchmarking
• Provider Satisfaction
• Provider Education
• Provider Advisory Committee

Providers are encouraged to call the Provider Line at 1-888-251-2224 (available 24 hours a day/seven days a week) for assistance.

Practitioner Rights

The organization’s policies and procedures include the right of practitioners to:

• Review information submitted to support their credentialing application.
• Correct erroneous information.
• Receive the status of their credentialing or recredentialing application, upon request.
• Receive notification of these rights.

III.A. Practitioner Credentialing, Contracting, Recredentialing

For a practitioner, credentialing is the first step in Community Care’s quality management process to ensure that members receive high-quality, responsive, and culturally-competent care.

Practitioners who wish to provide services to members must complete the credentialing process before they are eligible to contract to provide services to members. The practitioner credentialing process includes evaluations of the practitioner (such as licensing) and the site where services are to be provided.

III.A.1 Practitioner Credentialing Process

A practitioner is credentialled on the date in which the Credentialing Committee reviews and approves the candidate's completed application.

The Credentialing Committee ensures that practitioners initially meet and continue to meet Community Care’s criteria and standards for participation in the network. The Credentialing Committee reviews practitioner credentials and information for initial credentialing and thereafter at least every three years.

The practitioner credentialing process involves the following major steps:

• Each credential (degrees, certifications, licenses) must be verified with primary sources (academic institution, certifying body, licensing board or agency, etc.).
• Each practitioner evaluating or treating children and adolescents under the age of 18 must submit a Pennsylvania State Police Criminal Background Check (Act 34), Pennsylvania Child Abuse History Clearance (Act 33), and FBI Background Check that are no older than 1 year from the date of submission.
• Each practitioner serving older (age 60 and older) or care dependent adults must submit a Pennsylvania State Police Criminal Background Check that is no older than 1 year from the date of submission.
• The completed application (all credentials verified with primary sources) must be reviewed and approved within 180 days of the date the application was signed. If not, the application must be refreshed with Community Care by returning a copy of the original application with a new attestation to the practitioner to review for any changes or additions. This application must be returned to Community Care with a newly signed and dated attestation.

Verifying credentials with primary sources is performed by the Credentialing Department. This includes a review of information on sanctions or limitations with Medicare, Medicaid or state licensing agencies (NPDB, Cumulative Sanctions Report, Federal State of Medical Boards (FSMB), etc.).

All criteria must be met and verified to consider the application complete for credentialing.

III.A.2 Change in Practitioner Information

Any change to information submitted by a practitioner during the credentialing and contracting process, or at any time thereafter, including information such as street and/or suite address and telephone and/or facsimile numbers, must be communicated to Community Care's Network Relations Department.

To prevent problems such as interruptions of referrals, failure to receive authorizations for services, or denial of payment for services provided to members, practitioners are asked to call their designated Provider Relations Representative through the Community Care Provider Line (1-888-251-2224) with any change to practitioner information at least 30 days in advance of any such change. The Provider Relations Representative will request written documentation of the change through the completion of an Attachment A form in order to process this change in Community Care's database.

PLEASE NOTE: If a practitioner change involves adding or changing a contract service or a site where services are provided to Community Care members, the addition or change must be reviewed by the appropriate committee, and if approved, must meet recredentialing standards and a site visit may be required—before payment for services can be processed.
III.A.3 Practitioner Contracting

A practitioner may begin the contracting process after the practitioner completes credentialing by Community Care. Community Care seeks to contract with specific practitioners to provide specific behavioral health services at specific sites (See the Guidelines for Obtaining Approval for In-plan Services at the beginning of this Provider Manual).

Criteria considered for contracting include:

• The service needs of prospective members.
• The geographic and demographic distributions of members.
• The geographic distribution and cultural competencies of practitioners.
• Each practitioner’s scope of services, capacity to serve members, and responsiveness to quality issues.

For any practitioner terminated from the network, up to a 60 day transition of care period may be initiated for Members under that Practitioner’s care (See Section IV.E.3).

III.A.4 Practitioner Recredentialing

Practitioners must be recredentialled not more than three years from the date of credentialing/last recredentialing. The Credentialing Department will notify practitioners in advance when it is time to start the recredentialing process, which is similar to the credentialing process with the additional consideration of quality information supplied by the Community Care Quality Management Department. An application for recredentialing is considered complete when it includes the following:

• Primary source verification of the practitioner’s credentials (such as any new degrees or certifications since last credentialing/recredentialing, verification of current licensures, and malpractice and claims history).
• Provider Benchmarking (See Section III.1) including analyses of member complaints, Significant Member Incidents, and quality and/or compliance audits.

All practitioners must be recredentialled before their expiration date. Failure to be recredentialled before the expiration date will result in termination of the practitioner’s contract with Community Care and will prevent payment for any services provided after the expiration date.

A practitioner whose credentials with Community Care have expired cannot be authorized or paid for services provided after the expiration date. Because verifying credentials with primary sources requires a minimum of seven weeks and may take up to six months, Community Care’s Credentialing Department sends applications for recredentialing before each practitioner’s deadline. Practitioners are urged to start the recredentialing process as soon as the application is received. The Credentialing
Department will remind practitioners periodically of application components that remain incomplete.

III.B. Facility/Organization Assessment, Contracting, Reassessment

Assessment of a Facility (hospital, residential treatment facility, community mental health center, clinic, partial hospitalization program, or any other organization providing behavioral healthcare services in a community setting) is the first step in Community Care's quality management process to ensure that members receive high-quality, responsive and culturally competent care. A facility must complete this process in order to be eligible to contract to provide services to Community Care members. Assessment includes evaluations of the facility (such as licensing) and the site where services are to be provided. Community Care ensures that facilities initially meet and continue to meet Community Care's criteria and standards for participation in the network. Community Care assesses facilities upon initial application and thereafter at least every three years.

III.B.1 Facility/Organization Assessment

A facility is considered to have completed its assessment on the date the Credentialing Supervisor and Chief Medical Officer or designee reviews the candidate's completed application, verifies that all criteria have been met and signs the Facility Assessment Form.

The Facility assessment process involves four major steps:

- Credentialing staff confirms the facility's licensure and facility's accreditation, if any, and status or standing of the facility with state regulatory bodies.
- Each location where the facility will offer services to Community Care members must "pass" a site visit unless the facility is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Committee on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation of Services for Children and Families (COA), OR supplies a complete licensing report from the appropriate licensing entity to Community Care. If, after assessment, a facility adds a location where Community Care services are to be provided and the new location has not been reviewed, a site visit may need to be conducted at this new location unless the site has been reviewed by the accrediting agency or a complete licensing report has been submitted. In lieu of a Community Care site visit, Community Care will accept a copy of the licensing site visit report indicating that the facility is in full compliance with all of the licensing regulations/standards.
- During the site visit, documentation must "pass" the review of treatment record keeping practices, which may include review of a blinded or mock up treatment record. The site visit includes a review of treatment record keeping practices.
• All facilities providing services to children and adolescents under the age of 18 must have a policy in place requiring the Pennsylvania Child Abuse History Clearance, Pennsylvania State Police Criminal Record Check and FBI Background Check for employees working with this population.
• All facilities providing service to Older (age 60 and older) and care dependent adults must have a policy in place requiring a Pennsylvania State Police Criminal Background Check for those individuals who may have direct contact with this population.
• The completed application (with all primary source verification completed, site visit(s) and treatment record keeping practices completed satisfactorily) must be reviewed and approved within 180 days of the date the application was signed. If not, the application must be refreshed with a newly signed authorization. To ensure that data accurately reflects current facility information, Community Care maintains the 180 day standard to complete this process. In the event that this process shall exceed 180 days, the facility will be sent a copy of the original application and be required to sign a new attestation to confirm that the data is accurate or indicate any changes in the original information on the application.

Primary source verification is performed by the Community Care Credentialing Department. Community Care Provider Relations staff conduct the site visit. Before the site visit is scheduled, the facility will be given a copy of the Non-Accredited Facility On-site Review Form that lists the criteria for assessing/reassessing a site, such as presence of fire extinguishers and handicapped-accessible restrooms. In addition, policies and procedures must be in place for a plan assessment of the provider’s ability to provide urgent and routine care, to enroll additional patients in accordance with standards adopted by Community Care and a policy or policy statement regarding cultural awareness and diversity competence.

Included in the site visit is the review of treatment record keeping practices using the Medical Record Review Form, which is performed to assess the adequacy of documentation/record keeping procedures.

All facility criteria must be verified to consider the application for assessment complete.

**III.B.2 Change in Facility information**

Any change to information submitted by the facility during the assessment and contracting process or any time thereafter, including information such as mailing address and telephone and facsimile numbers, must be communicated to Community Care's Network Management Department. To prevent problems such as interruptions of referrals, failure to receive authorizations for services, or denial of payment for services provided to members, facilities are asked to call their designated Provider Relations Representative at least 30 days in advance through the Community Care Provider Line (1-888-251-2224) with any change to facility information.
Community Care will request written documentation of the change through the completion of an Attachment A form so that all Community Care Departments can be notified of the change.

**PLEASE NOTE:** If the facility change involves adding or changing a service or a site where services are provided to Community Care members, the addition or change must be reviewed. If approved, a site visit may be required before payment for services can be processed.

**III.B.3 Facility Contracting**

A facility may begin the contracting process after the facility completes assessment by Community Care. Community Care seeks to contract with facilities to provide specific behavioral health services in specific geographic locations (See the Guidelines for Obtaining Approval for In-plan Services at the beginning of this Provider Manual).

Criteria considered for contracting include:

- The service needs of prospective members.
- The geographic and demographic distributions of members.
- The geographic distribution and cultural competencies of facilities.
- Each facility's scope of services, capacity to serve members and responsiveness to quality issues.

For any facility terminated from the network, up to a 60 day transition of care period—for routine ambulatory services only—may be initiated for members under that facility provider's care (See Section IV.E.3).

**III.B.4 Facility Reassessment**

Facilities must be reassessed not more than three years from the date of assessment/last reassessment.

The Credentialing Department will notify facilities in advance when it is time to start the reassessment process, which is similar to the assessment process with the additional consideration of quality information supplied by the Community Care Quality Management Department. An application for facility reassessment is considered complete when it includes the following:

- Credentialing staff confirms any new licensures, facility accreditation and certifications, etc., since last assessment/reassessment, verification of current licensures, etc.
- Monitors of Facility performance (Provider Benchmarking, See Section III.1), including analyses of Member Complaints, Significant Member Incidents and Quality and/or Compliance audits.
All facilities must be reassessed before their expiration date. Failure to be reassessed before the expiration date will result in termination of the facility's contract with Community Care and will prevent payment for any services provided after the expiration date. A facility whose assessment with Community Care has expired cannot be authorized or paid for services provided after the expiration date.

Because verifying credentials with primary sources requires a minimum of seven weeks and may take up to six months, Community Care's Credentialing Department sends applications for reassessment before each facility's deadline. Facilities are urged to start the reassessment process as soon as the application is received. The Credentialing Department will remind facilities periodically of application components that remain incomplete.

III.B.5 Termination of Provider from the Network

Community Care may terminate a provider from the network without cause or with cause.

III.B.5a Termination without Cause

The Provider Agreement may be terminated without cause by either party at any time upon 90 days prior written notice to the other party. Such notice shall clearly state the effective date of such termination. All terms and provisions of this agreement shall remain in effect until the effective date of termination except as otherwise provided.

III.B.5b Termination with Cause

Action to terminate a provider with cause may be initiated when Community Care becomes aware of any of the following:

- Serious issue regarding the provider’s quality of care.
- Revocation or suspension of a provider’s license or other legal credential authorizing the provider to practice in any state or jurisdiction.
- Revocation or suspension of Drug Enforcement Agency (DEA) registration or Controlled Dangerous Substance (CDS) certificate.
- Professional review action by any state or jurisdiction issuing a professional license or any federal agency, professional organization, or other identified regulatory organization.
- Contractual violation, including, but not limited to:
  - Breach of confidentiality.
  - Failure to comply with terms of a corrective action plan.
  - Material misrepresentation of information on the provider application for credentialing/recredentialing or assessment/reassessment.
  - Conviction of a felony.
• Cancellation or failure to renew or maintain professional liability insurance in the amounts acceptable to Community Care.

The Provider is notified in writing via certified mail of the action to initiate termination with cause, including the reason for this action. Included in this correspondence is an explanation of the process to request an appeal of the decision to terminate with cause (See following Section III.B.6).

III.B.6 Notification and Process to Appeal Adverse Determinations Regarding Network Participation

Providers are notified in writing of any determination affecting their continued participation in the provider network, including credentialing/recredentialing or assessment/reassessment, suspension of new referrals, or termination from the network. This written notification will include the reason for the decision and an explanation of the appeal process, if any.

The appeal process is as follows:

• Within 30 days from the date of the notification, the provider must send a letter, fax, or email to the Community Care Chief Medical Officer (CMO) to request to appeal the decision.
• The CMO will schedule an Appeal Committee meeting to be held within 30 days of receiving the provider’s request.
• The provider will be informed of the date, time, and place of the meeting as well as the provider’s right to be present at the hearing, to be represented by an attorney, to present relevant information, and to request a different date and time for the hearing should the provider be unable to attend as scheduled.
• The provider will receive written notification of the Appeal Committee's decision within two business days of the date of the decision.

The decision of the Appeal Committee is final.

III.C. Confidentiality and Disclosure Policies

Community Care has developed policies concerning confidentiality to guide Community Care staff and providers in collecting, using, and disclosing information that is necessary and appropriate to provide high quality services efficiently, whether the information was created by Community Care or acquired in connection with our business activities. The confidentiality policies are intended to meet all requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) and apply to, but are not limited to, all member information, provider information (including credentialing/assessment, contracting, and benchmarking) and quality management program documents and meeting minutes.
Confidentiality policies and procedures describe in detail how Community Care protects members’ Rights and Responsibilities related to privacy in all settings (See Section II.A), to know what information is routinely gathered about them and how it is used, to review this information (including their medical records) and to authorize disclosure of their member identifiable information in special circumstances.

The following sections highlight Community Care’s confidentiality policies and procedures that may apply to providers (who are “contractors” of Community Care and may also be “representatives” of Community Care).

The topics regarding member identifiable information that are covered in the following sections include:

- What constitutes member, provider and Community Care confidential information (Section III.C.1a).
- How to handle confidential information (Section III.C.1b).
- How to maintain confidentiality when transferring information by mail, fax, and email (Section III.C.1c).
- Destroying confidential information (Section III.C.1d).
- Collecting and using member identifiable information (Section III.C.2).
- Informing members about confidentiality (Section III.C.3).
- Who is able to give informed authorization for release of member identifiable information (Section III.C.4).
- Member access to utilization records (Section III.C.5).
- Disclosure of member identifiable information, including disclosure without authorization of the member/member representative, validity of authorization and verbal authorization for release of information (Section III.C.6-7).
- Community Care’s requirements for provider storage and transmission (by email or fax) of member identifiable information (Section III.C.8).

Community Care’s policy on confidentiality describes for Community Care employees, representatives (including providers), and members, our policies and procedures on obtaining authorizations for use of member medical information, allowing members access to their medical records held by providers and protecting access to member “protected health information” as defined by HIPAA.

III.C.1 General Confidentiality Provisions

Community Care agents and contractors (including providers) potentially having access to confidential information are required to sign Community Care’s Statement of Confidentiality agreeing to be bound by Community Care’s strict confidentiality policies and procedures, or must conform to equivalent provisions as determined by Community Care staff or legal counsel. Breach of the Statement of Confidentiality or equivalent is grounds for immediate termination with cause (See Section III.B.5).
III.C.1a What Constitutes Confidential Information

The following are highlights of what constitutes confidential information:

- Member identifiable data and information, including explicitly identifiable data such as member name, social security number, or other identifier that can be directly linked to a specific individual and implicitly identifiable data such as member address, telephone number, date of birth, or other information that, alone or in combination with other available information, can lead to identification of a specific individual, are confidential.

- Data and information specific to practitioner providers, including but not limited to, that used for network development, credentialing, performance evaluation, quality assurance, quality improvement, and peer review are Confidential. A practitioner provider’s name, professional degree, status as a member of Community Care’s practitioner provider network, business address, business telephone number and specialty/specialties or self-identified areas of special interest are not considered confidential when disclosed for legitimate business purposes. Data and information related to a practitioner provider’s racial, cultural, or ethnic background, age, religious affiliation, gender and ability to communicate in languages other than English, are Confidential unless the practitioner provider explicitly authorizes the release of this information. For example, completing optional sections of the provider credentialing/recredentialing or assessment/reassessment application regarding a provider’s ability to communicate in languages other than English may be used to help fulfill members' requests when making referrals.

- Information specific to a practitioner practice group or facility, including but not limited to, that used for network development, organizational assessment and contracting, performance evaluation, quality assurance, and quality improvement, is Confidential. However, a practitioner practice group or facility name, status as a participant in Community Care’s network, business address, business telephone number, and services offered are not considered confidential when disclosed for legitimate business purposes.

- Community Care’s business data and information, including but not limited to salaries, policies and procedures, finances, business plans, information about providers participating in the network when not being released for legitimate business purposes, proposals to potential or current customers, information disclosed to Community Care in confidence by any third party, and performance evaluation, quality assurance, and quality improvement data and information where providers are individually identifiable are Confidential.

III.C.1b Keeping Information Confidential

- For all Community Care representatives:
  - Divulging computer passwords and security system pass codes is prohibited.
  - Divulging access codes and keys with any individual who does not have the right to such access codes or keys is prohibited.
• All computers that have the ability to access confidential data or information must be protected with a confidential log-in password; turned off or logged off at the end of the workday; and protected with a confidential screen-saver password in the event that the computer is turned on and logged on while the computer user is away from his or her work area.

• Community Care’s agents, contractors (including providers), employees, staff, and volunteers may not access or view confidential data or information unless required by their duties or responsibilities for, or on behalf of, Community Care.

• Community Care’s agents, contractors (including providers), employees, staff, and volunteers may not discuss confidential data and information in an area where individuals, including other Community Care agents, contractors, employees, staff, and volunteers who do not have the right to know about the information, may overhear the information.

• All confidential data and information must be maintained in a manner that prevents access by individuals who do not have a right to access the data and information. All physical media, including but not limited to, paper, magnetic and optical, used to store confidential data and information must be stored under a double-lock system. All physical media containing confidential information that are still in use by Community Care agents, contractors (including providers), employees, staff and volunteers at the end of the day must be locked in that individual’s desk or in another secured storage area. All desks or secured storage areas must be in areas with keyed entry, maintaining a minimum of a dual-key system. All physical media containing confidential information that are no longer needed by Community Care agents, contractors, employees, staff and volunteers must be returned to locked master storage at the end of the day. All electronic media containing confidential information must be password-protected.

### III.C.1c Transferring Confidential Information

The transfer of confidential information for legitimate business purposes between Community Care’s agents, contractors (including providers), employees, staff, and volunteers in their official capacities as representatives of Community Care is considered an internal transfer, even though they may be in different physical locations. The transfer of confidential information other than to Community Care’s agents, contractors, employees, staff, and volunteers in their official capacities as representatives of Community Care is considered an external transfer and must be made in accordance with Community Care’s Authorization to Disclose Information (See Section III.C.6).

• The internal transfer of all confidential data and information must be conducted in a manner that limits potential access by individuals who do not have a right to access the data and information. When not hand-carried and personally delivered to the recipient, physical media containing confidential data and information must be placed in a sealed envelope marked “Confidential.”
• Confidential data and information sent by facsimile must bear a prominent confidentiality notice similar to the following: “This facsimile transmission contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this message in error, please notify the sender by facsimile or telephone and destroy this document.”

• Confidential data and information sent by email must be flagged as confidential and bear a confidentiality notice similar to the following within the message: “This email contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this email in error, please notify the sender by return email, securely delete this file and any electronic or magnetic copies and destroy any paper copies.”

**III.C.1d Destroying Confidential Information**

Confidential data and information no longer required for legitimate business purposes must be destroyed in a secure manner. Paper records must be thoroughly shredded. Magnetic files must be deleted in a manner that does not permit the files to be undeleted, for example, by reformatting a floppy disk using the “secure” format option. Either optical storage media must have the files securely deleted or, if this is not possible, the storage media must be destroyed.

**III.C.1e Committee Oversight of Confidentiality**

Community Care’s privacy officer and the Compliance Department are responsible for approving and periodically reviewing all policies and procedures related to confidentiality and for identifying, developing and implementing mechanisms to oversee the implementation and application of Community Care’s confidentiality policies and procedures.

Highlights of this department’s responsibilities include the following:

• At least annually, the department and privacy officer will evaluate ways to (1) reduce the collection of member identifiable data and information and (2) aggregate or de-identify such data and information as close to the collection point as possible, as identified by surveying Community Care representatives, holding brainstorming sessions with Community Care representatives and evaluating complaints.

• The privacy officer is responsible for reviewing and approving information given to members, including information about Community Care’s confidentiality policies and procedures.

• Community Care has identified circumstances necessitating special protection of member identifiable data and information and these are described in the policy and procedure “Handling of Member Identifiable Information.” Requests for special protection of member identifiable information are referred to the privacy officer, who
will consider the request, determine whether it should be honored and notify the requestor of the decision. If the request is honored, the privacy officer will determine the mechanism to adhere to the request and update the procedure “Internal Handling of Member Identifiable Information” to reflect the addition. If the privacy officer determines not to honor the request, the requestor will be notified of his or her right to appeal the decision through Community Care’s appeals process.

- All member and provider concerns regarding confidentiality shall be logged as complaints and processed through Community Care’s complaint and appeals process.
- The privacy officer along with the Chief Medical Officer, reviews requests for access to member identifiable data and information from all sources, internal and external. In determining the timeframe in which to conduct the review, the Chief Medical Officer will consider the potential benefit to members of allowing requested access to data and information. When deciding whether or not to honor the request for access to such data and information, the Chief Medical Officer will weigh the potential benefit and risks to members.
- The Chief Medical Officer is responsible for reviewing all requests for access to confidential data and information for research purposes.

### III.C.2 Collecting and Using Member Identifiable Information

Community Care collects and uses member identifiable data and information routinely in the performance of its work. Purposes for which data and information are routinely collected include:

- Verification of member eligibility for services.
- Management of behavioral health benefits, including prospective, concurrent, and retrospective reviews and decisions regarding coverage for requested treatment.
- Coordination of care.
- Billing.
- Adjudication of claims.
- Performance measurement and improvement (“quality assurance”).
- Compliance audits.
- Prevention and disease management activities.
- Provider credentialing.
- Investigating and resolving inquiries and complaints.
- Processing appeals.
- Complying with regulatory requirements and accreditation standards.

Community Care is responsible for notifying members of Community Care’s routine collection and use of member identifiable data and information for the purposes just described. The use of member identifiable information for purposes other than those listed requires written authorization from the member or representative, unless use of the information is permitted or required by applicable law or a valid court order.
III.C.3 Informing Members about Confidentiality

Community Care prepares information for members that describes Community Care’s confidentiality policies and procedures. This information covers key points of the information contained in Community Care’s Confidentiality Policy, such as:

- Collecting and Using member identifiable Information.
- Handling of member identifiable Information.
- Ability to give informed authorization.
- Member access to utilization records.
- Disclosure of information.
- An accounting of disclosure of member protected health information (PHI) to members.
- Amending PHI by the member.

Information about confidentiality is disseminated to members in:

- Member “Rights and Responsibilities.”
- Member instructions on how to obtain care, appeal a coverage decision, and access customer services support.
- The member complaint process.

Information about confidentiality is sent to members annually via member newsletters and in the Member Handbook. Community Care’s Notice of Privacy is also posted on our website at http://www.ccbh.com/privacy.

III.C.4 Ability to Give Informed Authorization for Release of Member Identifiable Information

Community Care obtains special authorization from members or representatives to release member identifiable information, as described in the procedure for Disclosure of Information (See Section III.C.6). Community Care has made the following determinations regarding the giving of valid authorization for the release of member identifiable health information:

- A member who has reached the age of majority as identified by Community Care’s eligibility data is capable of giving informed authorization for release of information on his or her own behalf unless Community Care has received notification that the member has been adjudicated incompetent.
- The natural or adoptive parent of a minor member, as identified by Community Care’s eligibility data, is capable of giving informed authorization for release of information on behalf of the minor member unless Community Care has been informed that the parent has been adjudicated incompetent, the parent is not the legal guardian of the minor member, or the minor member has been legally emancipated.
• An emancipated minor member is capable of giving informed authorization on his or her own behalf. If not already on file with Community Care, Community Care will request proof of the minor member’s status from the minor member before honoring the authorization for release of member information.

Community Care expends all reasonable effort to develop and maintain an accurate and efficient system for identifying who is eligible to give valid authorization for release of member identifying information. Having established such a system, Community Care reasonably relies on the absence of information indicating that a member or parent of a minor member has been adjudicated incompetent or that a parent is not a minor member’s legal representative, for accepting an authorization for release of information as valid. Verifying that a member or parent of a minor member is competent would place an undue burden on Community Care and in most instances would require a breach of confidentiality.

When Community Care is informed that a member is unable to give special authorization for the release of information, Community Care will accept authorization from and/or release records to, a representative legally authorized to approve (authorize) the release of, or to receive, a member’s personal health information. Community Care requires written proof of the individual’s status as a legally authorized representative of the member and that the status as a legally authorized representative covers the area for which the authorization for information is being sought.

Individuals capable of giving valid authorization for the release of member identifiable health information are also entitled to have access to that information, except that parents or guardians of children age 14 years or over may not have access to the child’s health information without the authorization of the child.

**III.C.5 Member Access to Utilization Records**

In accordance with HIPAA Section 164.524, members may request to access their utilization file. The member may request to view his/her information by contacting Community Care. Community Care will coordinate the processing of the request. The privacy officer will respond to the request within 10 days. The process for requesting information is outlined in Community Care’s Confidentiality Policy.

**III.C.6 Disclosure of Member identifiable Information**

Community Care requests authorization from the member or member’s legally authorized representative before disclosing member identifiable data or information (except as described in the procedures for “Collecting and Using Member identifiable Information” (See Section III.C.2) and “Disclosure Without Authorization of Member to Member Representative” (See Section III.C.6a)). The member or the member’s legally
authorized representative has the right to deny the request to release member
identifiable information without consequence for the member or the member’s coverage.
If member identifiable data and information are to be disclosed for purposes other than
described in the procedures for “Collecting and Using Member identifiable Information”
(See Section III.C.2) and “Disclosure Without Authorization of Member or Member
Representative” (See Section III.C.6a), the authorization of the member or member’s
legally authorized representative is required.

Times when authorization of the member or member’s legally authorized representative
is required include:

- Before disclosing member identifiable data and information for research purposes.
- Before disclosing the member’s behavioral health signs, symptoms, diagnoses, or
treatment to a primary care physician (PCP) or other clinician not providing
behavioral health care to the member.
- When disclosing the member identifiable data and information that could foreseeably
result in the member being contacted by another organization for marketing
purposes.

Whenever member identifiable information is disclosed, only that information necessary
to accomplish the purpose of the disclosure is released.

III.C.6a Disclosure without Authorization of Member or Member Representative

Member identifiable information can be disclosed without authorization of the member
or the member’s legally authorized representative in the following circumstances:

- When such disclosure to health care personnel, a health care facility, the member’s
identified significant other or the police is required to prevent loss of life or injury to
the member.
- When authorized by an appropriate and valid court order.
- When authorized by Community Care’s legal counsel to meet the requirements of
any applicable state or federal law.
- To report child abuse or neglect.
- To meet public health reporting requirements.
- To the Pennsylvania Department of Health, Pennsylvania Department of Human
Services and the Pennsylvania Insurance Department for the monitoring of health
care systems, government programs, and compliance with civil rights laws.
- To federal officials for intelligence, counterintelligence, or other national security
activities authorized by law.
- When required by Protective Services for the President and others.
- To military command authorities in order to provide medical information about a
member serving in the armed forces.
- When it concerns Workers Compensation.
- To coroners and medical examiners.
• Information about inmates of a correctional institution or under the custody of a law enforcement official may be released to that institution or official.

III.C.6b Validity of Authorization to Release Member Information

Community Care considers an authorization to release member identifiable information to be valid only if all of the following are met:

• The member or member’s legally authorized representative is informed of the specific information to be released and the purpose(s) of the release in language which he/she can understand.
• The member or member’s legally authorized representative is informed that the provision of care or treatment will not be affected by the decision of the member or member’s legally authorized representative.
• The authorization is obtained in a manner that complies with applicable laws and regulations.

III.C.6c Written and Verbal Authorization for Release of Information

The authorization to release information should be in writing. However under some circumstances it may be necessary to obtain authorization verbally. The use of a verbal authorization should be approved in advance by Community Care’s legal counsel or, if circumstances indicate the need for a rapid decision about the acceptability of a verbal authorization, by a member of Community Care’s senior management. The written authorization must include provision of the following information:

• The name of the person or entity providing the information.
• The specific information to be released.
• The purpose for the release.
• The individual or entity authorized to receive the information.
• The expiration date of the authorization.
• The signature of the member or member’s legally authorized representative.
• The address of the member or member’s legally authorized representative.
• The signature of the witness.
• The date of the authorization.

Two representatives of Community Care (such as employees, staff, or practitioner providers) must witness the entire process of obtaining verbal authorization to release information.

III.C.7 Handling of Practitioner-specific Information

Community Care considers practitioner specific data and information, including but not limited to, that information used for network development, credentialing/assessment, performance evaluation, quality assurance, quality improvement, compliance audits and peer review, to be confidential to the extent permitted by law.
A practitioner’s name, professional degree, status as a member of Community Care’s practitioner network, business address, business telephone number and specialty (ies) or self-identified areas of special interest are not considered confidential when disclosed for legitimate business purposes.

Data and information related to a practitioner’s racial, cultural, or ethnic background; age; religious affiliation; gender; and ability to communicate in languages other than English is confidential unless the practitioner explicitly authorizes the release of this information. For example, if the practitioner volunteers the information on the credentialing/assessment form that the practitioner has the ability to communicate in languages other than English, this information may be used by Community Care to meet specific member needs or requests when making referrals.

Regarding files of practitioner information maintained at Community Care:
• Physical files are maintained in a locked room or locked file cabinet when not being used by credentialing staff or the Credentialing Committee.
• Practitioner files stored in electronic, magnetic, or optical format are protected with a secure password.
• Access to practitioner files is limited to credentialing staff, Credentialing Committee, network management staff, and the compliance staff.
• Upon request, practitioners may review information in their file, except for any information from the National Practitioner Data Bank (NPDB). Review of NPDB information is prohibited by federal statute.
• Practitioners are informed of the right to review information in their file through the cover letter in the application packages for credentialing/recredentialing or assessment/reassessment.
• Practitioners may obtain a copy of their file by making the request in writing. Credentialing staff will send a copy of the practitioner’s file, marked “Confidential,” to the practitioner within 10 business days of receipt of the written request for the file. NPDB information and peer review (peer reviewer) information is not included in the file sent to the practitioner.

Practitioners are notified by Credentialing staff of any information obtained during credentialing/recredentialing or assessment/reassessment activities that varies substantially from the information provided by the Practitioner.

Practitioners have the right to correct erroneous information by submitting corrections in writing or sending additional documents to the Credentialing Department. Credentialing staff document the verbal information or corrections provided by the practitioner, including the date and signature of the individual obtaining the information.

**III.C.8 Provider Confidentiality**

Community Care providers are responsible for maintaining confidentiality in the collection, use, and disclosure of member identifiable information. Requirements are as follows:
• Member identifiable data and information (such as medical records, appointment books, correspondence, laboratory results, billing records and treatment plans), whether paper-based or on removable electronic data storage media, must be maintained under lock and key, either in locked cabinets or in a locked area. The data storage area must be separate from public areas such as waiting rooms, areas where services are delivered and any other areas accessible to unauthorized persons. When unlocked, paper records and removable computer storage media must be maintained in a secure location where they are not accessible and their content is not visible to unauthorized individuals.

• When computers are used to store member identifiable information, they must be password-protected (unless all persons at the site are authorized access and the computers are in secure locations not accessible to unauthorized individuals). Computer monitors must be positioned such that they are not visible to unauthorized individuals.

• If electronic mail (email) is used to transmit member identifiable data or information, the email must be flagged as confidential and a confidentiality notice must be prominently displayed at the beginning of the email that conveys a message substantively similar to the following: “This email contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this email in error, please notify the sender by return email, securely delete this file and any electronic or magnetic copies and destroy any paper copies.”

• Telefacsimile (fax) machines must be located where faxes may not be intercepted or viewed by individuals not authorized to access member identifiable information. When member identifiable information is transmitted by fax, a confidentiality notice similar to the following must be prominently displayed on the cover sheet: “This facsimile transmission contains confidential and privileged information for use only by the intended recipient. Do not read, copy, or disseminate this material unless you are the intended recipient. If you believe you have received this message in error, please notify the sender by facsimile or telephone and destroy this document.”

Please call the Provider Line (1-888-251-2224) for any authorization for release of information forms that might be needed in the care of members.

III.D. Record Keeping Standards

Community Care has established treatment record documentation guidelines, performance goals, and standards for availability of treatment records to facilitate accurate record keeping, communication between practitioners and coordination and continuity of care within the behavioral health continuum and the medical delivery system. Community Care expects providers to implement these treatment record documentation guidelines.
Each member’s medical record must meet the following standards:

- The member address, employer or school, home and work telephone numbers, emergency contacts, marital/legal status, authorization forms, and guardianship information is documented, as relevant.
- The member’s name or identification number is present on each page.
- The responsible clinician’s name and professional degree are documented.
- All entries are dated.
- The record is legible.
- Relevant medical conditions are listed, prominently identified, and updated.
- Presenting problems and relevant psychological and social conditions affecting the member’s medical and psychiatric status are documented.
- Special status situations such as imminent risk of harm, suicidal ideation, or elopement potential are prominently noted, documented, and updated in compliance with written protocols.
- Past medical and psychiatric history is documented, including previous treatment dates, provider information, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.
- Allergies and adverse reactions are clearly documented.
- Medication(s) that have been prescribed, dosages of each medication and the dates of initial prescription and of any changes in medication regimen.
- DSM-5 primary diagnosis is documented.
- Complete developmental history is documented for children and adolescents.
- The following are documented:
  - Symptoms
  - Mental status
  - Member strengths and limitations
  - Compliance with treatment plan
  - Compliance with medication regimen, if appropriate
  - If the member has drug and alcohol issues (past and/or present), the results of the provider’s inquiry as to the welfare of children and significant others living in the home
  - Progress towards treatment goals
  - Coordination of care information, as applicable
  - Date of next session
  - Discharge plan

Community Care expects providers to maintain an organized treatment record keeping system. The following elements are required components of an organized record keeping system.

- A unique treatment record for each member.
- Treatment record notes maintained in chronological or reverse chronological order.
- An organized system for maintaining documents for each member; for example, all diagnostic reports maintained together in a section of the folder.
• An organized filing system that provides easy access to unique member files.
• Consent to release information and informed consent documentation as appropriate.
• Treatment record documentation occurs as soon as possible after the encounter with special status situations, such as imminent harm, suicidal ideation, or elopement potential prominently noted.

Community Care expects all practitioners and facilities to provide treatment to members in a safe environment. All providers should assess a member for suicidal ideation and homicidal ideation throughout a member’s treatment. If a member is being treated in an outpatient setting and expresses suicidal or homicidal ideation, the provider should take the appropriate actions to ensure that the member and others are safe, such as facilitating an inpatient hospitalization admission.

Upon admission for an inpatient psychiatric hospitalization, the initial evaluation completed by the facility psychiatrist should clearly document that the member was assessed for both suicidal and homicidal ideation. Additionally, members should be assessed for suicidal and homicidal ideation on an ongoing basis to ensure the member’s safety, as well as the safety of others. Providers should also proceed with a Duty to Warn if indicated.

When a member is discharged from an inpatient hospitalization stay, a crisis plan should be developed by the facility and reviewed with the member upon discharge. The crisis plan should also include the phone number of the appropriate county services for mental health emergencies.

All medical records and reports completed by the provider for Community Care members are to be available, as appropriate, to practitioners and staff other than the treating practitioner; Community Care; the Centers for Medicare and Medicaid Services (CMS; formerly the Health Care Financing Administration (HCFA); National Committee for Quality Assurance (NCQA); or Pennsylvania Department of Health, licensing body, or regulatory agency; or other agencies as required by applicable law and regulations, for at least seven years after the initial date the provider delivered health care services to the member under contractual agreement with Community Care, regardless of termination of the contractual agreement.

The review of treatment record keeping practices, using a Medical Record Review Form is one component of the provider’s credentialing site visit. Facilities not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Committee on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation of Services for Children and Families (COA) must meet the record keeping standards established by Community Care. Record keeping must also meet all licensing regulations. The provider is sent the Medical Record Review Form instrument prior to the scheduled site visit.

The provider may prepare for the medical record review by designating an actual treatment record for review, preparing a blinded treatment record, or preparing a mock treatment record for review. The purpose of the credentialing medical record review is to ensure that the provider has resources in place to collect the information needed through all stages of evaluation and treatment. A score of 80% is required to pass the medical
record review. Providers are notified in writing if the score is below passing. When the score is below passing, the provider must submit a written corrective action plan. A follow-up medical record review will be scheduled within six months to monitor implementation of the provider’s corrective action plan.

In addition, quality staff assess completeness of treatment records by using one or more of the following methods:

- Reviewing a sample of treatment records on-site at the practitioner’s office.
- Obtaining a sample of treatment records from practitioners via mail or fax to Community Care.
- Reviewing treatment records sent to Community Care for other reasons.

Community Care’s performance goal for completeness of treatment record documentation is 80%. Aggregate results of the assessment of treatment record documentation are communicated periodically to providers.

III.E. Clinical Practice Guidelines

Community Care utilizes clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances. These evidence-based guidelines are reviewed annually, updated as appropriate, and approved by Community Care’s Quality and Care Management Committee (QCMC) and Board Quality Improvement Committee (BQIC). Annually, Community Care measures performance against each of the clinical practice guidelines via claims data or record reviews. Providers are notified of changes to these guidelines via provider newsletters or web-based communications. Currently, the following guidelines are being utilized:

- American Academy of Pediatrics ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents, as well as its supplemental information Implementing the Key Action Statements, November 2011.

To obtain a copy of the APA guidelines, contact the American Psychiatric Association, 1400 K Street NW, Washington, DC 20005 or visit the website: http://psychiatryonline.org/guidelines.aspx
To obtain a copy of the NIDA guideline, contact the National Institute of Drug Abuse, National Institutes of Health, 6001 Executive Boulevard, Room 5213, Bethesda, MD 20892. The guideline may also be obtained via the NIDA website at: http://www.nida.nih.gov/PODAT/PODATIndex.html.

For information about our practice guideline measurements, contact Community Care at 1-888-251-2224.

III.F. New Technologies

Community Care provides for a systematic assessment of new technologies and new applications of existing technologies for behavioral health care, including clinical interventions, procedures, devices, and certain types of pharmacological treatments. Community Care’s New Technology Subcommittee, chaired by the Chief Medical Officer, meets on a routine basis to consider new technologies proposed for inclusion in a benefits package. In those instances in which Community Care does not make the final decision on the inclusion or exclusion of a technology in the benefits package, Community Care assesses the new technology and makes a recommendation to the appropriate decision-making body.

III.G. Unusual Incidents/Significant Member Incident Reporting (Patient Safety)

A Significant Member Incident (SMI) or sentinel event is an unexpected and undesirable outcome that has an adverse impact on the outcome of care. The detail of each SMI is promptly reviewed to determine needed follow-up and to coordinate communication between Community Care, the provider, and county agencies, as appropriate, to avoid unnecessary duplication of reports.

Community Care receives information about SMIs in various ways. Examples of ways information about SMIs are received include staff, practitioner, provider, member, governmental reports, and publications.

SMIs include but are not limited to:

- Completed suicides.
- Severe suicide attempts/self-inflicted injury.
- Apparent serious physical accidents/suspicious deaths.
- Adverse effects of medications requiring medical intervention.
- Member injury due to restraint/seclusion.
- Apparent homicide or serious physical assault by client.
- Life threatening injury or illness while on provider site requiring hospitalization.
- Sexual/physical abuse complaint by member against provider.
- Sexual abuse/physical assault complaint incurred by member at provider site.
- Failure to follow mandated Childline reporting requirements.
- Elopement.
• Any fire requiring emergency services of the fire department.
• Arrest of a member active in treatment.

Providers must report these events within 24 hours of the incident occurring or within 24 hours of the provider learning of the incident. Providers may report SMI by calling the Provider Line (1-888-251-2224), calling their designated care manager at Community Care, or faxing the incident report to the Quality Management Department at 1-888-249-5646. The provider is to inform Community Care when they become aware of any loss of life during treatment or within 30 days of treatment. Providers are also expected to comply with all applicable state and federal laws and professional and legal requirements regarding reporting of SMI. Providers should report all cases of suspected child or elder abuse that involve a Community Care member to the appropriate agency as defined by law, as well as to Community Care.

Community Care has developed a plan for identifying SMI that ensures prompt review of the detail related to each incident and determining needed follow-up. This process coordinates communication between the provider, Community Care, the county, and the oversight agency. As a result, duplication of reports is minimal and further contact with the provider specific.

The individual receiving information about a SMI initiates the Significant Member Incident Form and enters the information into a database. The data elements include at a minimum the:

• Date information about when the SMI is received.
• Date SMI occurred.
• Member name and identification number.
• Provider name and contact number.
• Nature of the incident.

All SMI are forwarded to the quality clinician, SMI coordinator within one business day of the date the information became known to Community Care. The quality clinician, SMI coordinator:

• Reviews the issue thoroughly and determines the urgency of the SMI.
• Determines the appropriate individual to investigate the SMI.
• Notifies the Chief Medical Officer (CMO) or designee about the SMI (each occurrence of unexpected and undesirable outcome that has an adverse impact on the outcome of care must be thoroughly reviewed by the CMO or designee).
• Documents all information and actions on the Significant Member Incident Form.
• Contacts the provider or others as needed.
• Obtains additional information, as needed to conduct a thorough investigation of the SMI, including any aspects of clinical care and safety involved.
• Obtains the medical records from the provider, if necessary.
• Conducts an office site visit if needed for issues such as office safety.
• Tracks the SMI to resolution.
• Prepares a written report of the findings of each SMI review including any recommendations.
• Forwards a copy of the completed SMI investigation results to the county/oversight agency when indicated.

Identifying and monitoring SMI is part of quality improvement activities, which Community Care performs as part of our comprehensive provider evaluation process (CPEP). Community Care directs any media inquiries regarding SMIs to the Senior Director of Quality Management and informs all other members of senior management at Community Care of the incident.

Providers are expected to report all cases of child abuse to the appropriate reporting agency as defined by law. They are also expected to report this to Community Care when it involves one of our members. We track this through our SMI reporting mechanisms. The provider may report this either verbally or in writing. The Pennsylvania Childline phone number is 1-800-932-0313.

Orientation and ongoing provider education concerning this policy occurs through the provider manual, provider education and training processes, and on a one-to-one basis, as necessary with providers. SMIs that are considered serious are contained in the provider benchmarking review for recredentialing purposes. This process is a part of the comprehensive provider evaluation process (CPEP) and includes monitoring provider standards of practice as well as their timely response in addressing incidents identified.

III.H. Provider Cultural Competency

As stated in Section I.B, Community Care has a vision for an effective and accessible system of behavioral health care that requires providers to be culturally competent. To enhance cultural competency of network providers, Community Care:

• Assesses providers’ cultural competency.
• Presents a training session for providers in principles of cultural competence.
• Has developed outcomes measures related to the care provided in a culturally diverse system.

Assessment of cultural competency includes evaluation of the diversity of providers in the network and their documentation of all member informational materials (including audiovisual materials, training documents, service pamphlets and radio or television public service announcements).

Cultural competency is demonstrated by:

• Documentation that multi-linguistic populations have access to appropriate translators and, when a predetermined percentage of Community Care’s membership speaks a language other than English, to appropriate multi-linguistic written member materials.
• Documentation that member materials address the needs of special-service populations.
• Documentation that materials are culturally sensitive and appropriate to the member audience.

Providers’ cultural competency is evaluated using instruments and methods that are consistent with cultural patterns and norms of the members being served. The instruments vary according to the specific cultural groups being surveyed. However, all instruments evaluate whether the provider understands the culture of the community being served and uses strategies to avoid breakdowns and pitfalls due to cultural insensitivity in the provision of care. The Quality Management Department reviews all complaints received related to cultural competency of providers, conducts trend analyses, and determines appropriate follow-up when needed. Providers’ commitment is essential to our ongoing development of a responsive system of care.

III.I. Comprehensive Provider Evaluation Process (CPEP)

Community Care believes that a successful partnership with providers includes collaboration between Community Care and our provider network to improve the clinical and quality care delivered to HealthChoices members. Community Care employs several methods to evaluate providers to ascertain and improve the quality of care provided to members through the provider network. This process can only be accomplished through the involvement, participation, and collaboration of providers. It also ensures that Community Care begins this quality assessment from the time of application for network inclusion. Quantitative and qualitative performance data are necessary for a useful system of comprehensive provider evaluation.

Goals of the CPEP include:

• Ensuring that every provider (both individual practitioners and facilities) is providing care to members, which meet best practice clinical and quality standards.
• Ensuring providers’ care meets access standards
• Ensuring that every provider is culturally competent to provide services to members
• Striving to continually improve the practice standards of the provider network in both urban and rural areas.
• Utilizing both qualitative and quantitative measures to provide feedback to providers, county (ies), oversight entities, OMHSAS, and other stakeholders to ensure appropriate care.
• Identifying areas for improvement with subsequent opportunities for corrective action.
• Identifying individual provider clinical practices in comparison to other providers.
• Ensuring a safe and healthy environment for members with appropriate attention to family/significant other involvement.
• Ensuring that providers practice within an environment conducive to recovery and resiliency principles.
• Obtaining feedback from members, families, and other stakeholders through a variety of forums.
• Providing select information to members, families, and other stakeholders.
In addition, the CPEP creates opportunities for providers to:

- Internally monitor themselves.
- Review claim reports about service activity.
- Review claim reports compared to aggregate claims reports of like providers.
- Identify trends.
- Improve the safety of their clinical environment.
- Participate in the resolution of member complaints.
- Promote appropriate family involvement.
- Ensure financial stability within their organizations.
- Promote their internal processes within a quality improvement framework.
- Establish policies that support performance standards and quality of care issues.
- Promote best practices.
- Review current practices with other providers.
- Implement evidence based practices.

The overall comprehensive provider evaluation process consists of several methods of evaluation to meet the stated goals.

These methods include:

- Credentialing/Facility Assessment and ongoing Recredentialing/Facility Reassessment.
- Compliance with Community Care Performance Standards.
- Compliance with IPRO data collection and improvement processes.
- Compliance with Evidence Based Practices.
- Evidence from medical record reviews.
- Trending of Significant Member Incidents (SMIs).
- Demonstrated compliance with mental illness/substance abuse (MISA) screenings, coordination of care standards, and domestic violence screenings.
- Evidence of compliance with submission of requested reports including BHRS reporting.
- Timely return of quality improvement plans.
- Cooperation with Consumer/Family Satisfaction Teams and interventions related to member concerns.
- Claims-based Provider Benchmarking Reports.
- Complaint trends.
- Grievance trends.
- Licensure status change (Provisional).
- Identification of provider performance incidents, e.g., lack of adequate discharge planning, late submission of BHRS packets.
- Overall compliance with provider network contract.
- Results of Fraud, Waste and Abuse Department visits.
The CPEP is the responsibility of the Provider Relations/Network Development, Care Management, Customer Service, Quality Management, Provider Reimbursement, and Compliance Departments of Community Care and is managed through quality. Data from each method may occur at various times throughout the year, and provider dialogue and intervention may occur when trends are identified. Specific provider information is retained through the Quality Management Department. Community Care provides feedback, through various quality activities to providers on an ongoing basis. In addition, Community Care analyzes aggregate network performance, making information available to providers through articles, committees, public forums, and individual provider meetings or site visits.

Certain information identified as a result of the comprehensive provider evaluation process related to individual providers may fall under protected, peer reviewed, and privileged information and will not be shared publicly. This information, however, will be shared with specific Community Care county contractors and OMHSAS.

III.J. Provider Satisfaction

Provider satisfaction is important to Community Care and we have multiple ways in which providers can express both their satisfaction and dissatisfaction with our operations.

We contract with an outside survey company to conduct an Annual Provider Satisfaction Survey. The survey tool is designed to assess provider satisfaction in a variety of areas including (but not limited to): utilization management, quality management, provider relations, complaint & grievance procedures, care management, customer service, and claims.

Providers are encouraged to take the time to complete the survey. We welcome your comments and feedback on the services you have received from our staff and are interested in how we can improve provider services. The results are reviewed both internally and with the Quality and Care Management Committee. The Committee identifies areas for improvement and interventions are developed to increase satisfaction in those targeted areas.

If you are dissatisfied with any aspect of Community Care's operations, we urge you to express your concern by calling the Community Care Provider Line (1-888-251-2224). If an issue cannot be resolved informally, you may lodge a formal complaint. You may express your provider complaint orally or in writing. If the complaint cannot be resolved immediately, Community Care will send a resolution letter within 30 days.

Community Care also utilizes the formal Provider Advisory Committee to receive feedback from Providers. The Committee meets quarterly and Providers are encouraged to participate. If you are interested in becoming involved in this committee please call the Provider Line at 1-888-251-2224 to get more details.
III.K. Provider Education

Community Care offers provider training on a variety of topics, with a focus on developing skills in managing care, meeting and exceeding performance standards, and ensuring cultural competence in delivery of behavioral healthcare services throughout the network. The person who will receive mailings about these sessions is the designated contact person identified in your network application. Please check with your Community Care provider relations representative for the name of this person or if you need to change the contact person (key contact).

III.L. Provider Advisory Committee

All Community Care providers are eligible, welcome, and urged to participate in the Community Care Provider Advisory Committee in their local area. These committees are designed to allow providers to give feedback to Community Care on a regular basis.

There are other Community Care committees that include providers. If you would like to participate, please call the Community Care Provider Line (1-888-251-2224).