

THE PROVIDER LINE

Vol 3-2009

Act 62, the Autism Insurance Act, in effect July 1, 2009

House Bill 1150 was signed into law on July 9, 2008 and became Act 62, the Autism Insurance Act. This act will impose changes for coverage of autism services through the Medical Assistance program and private health insurers. Act 62 goes into effect on July 1, 2009.

Act 62 requires:

- Many private insurers to be the first point of contact to cover the costs of diagnostic assessments for autism and of services for individuals with autism who are under the age of 21, up to \$36,000 per year;
- The Pennsylvania Department of Public Welfare to be the second point of contact to cover those costs for eligible individuals who have no private insurance coverage, or for individuals whose costs exceed \$36,000 that year; and
- The Pennsylvania Department of State to license professional behavior specialists and to establish minimum licensure qualifications for them. According to the Department of Public Welfare (DPW) website, this Act covers children or young adults under age 21 with a diagnosis of an autism spectrum disorder who are:
 1. Covered under an employer group health insurance policy (including HMOs and PPOs) that has more than 50 employees and the policy is not a “self-insured” or ERISA policy; (The Employee Retirement Income Security Act of 1974 (ERISA) is an American federal statute that establishes minimum standards for pension plans in private industry and provides for extensive rules on the federal income tax effects of transactions associated with employee benefit plans);
 2. On Medical Assistance; or
 3. Covered by Pennsylvania’s Children’s Health Insurance Program (CHIP) or Adult Basic.

Any of the pervasive development disorders defined in the current edition of the Diagnostic and Statistical Manual (DSM) are covered. These include autistic disorder, Asperger Syndrome, Rett Syndrome, Childhood Disintegration Disorder, and Pervasive Development Disorder — Not Otherwise Specified (NOS).

Services covered under this act are the diagnostic assessments and treatments of autism spectrum disorders, including:

- Prescription drugs and blood level tests;
- Services of a psychiatrist and/or psychologist (direct or consultation);
- Applied behavioral analysis; and
- Other rehabilitative care and therapies, such as speech and language pathologists, occupational and physical therapists.

If you have questions about Act 62, please contact your Provider Relations Representative or call the Community Care Provider Line at 1-888-251-CCBH.

We’ve added an institute in Pocono Manor, PA! See Page 8 for Recovery: KEEPING THE PROMISE institute information and registration form.

Pharmacy Corner

Many Members do not receive adequate monitoring

As part of a quality initiative, Community Care, in collaboration with UPMC, Unison, Gateway, AmeriHealth Mercy, and Keystone Mercy Health Plans, recently assessed whether Allegheny, Chester, York, Adams and Berks County HealthChoices members taking antipsychotics were being tested for lipid and glucose levels either 3 months before their antipsychotic fill and/or 12 months after the medication fill. The analysis showed that only 50% of the assessed HealthChoices members were having at least one lab done within the 18-month time period.

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Current guidelines from the Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes suggest baseline monitoring of fasting plasma glucose and lipid profile, along with weight and height (BMI), blood pressure, waist circumference and personal, as well as family, history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease (Diabetes Care 27:596-601, 2004). In addition to the baseline monitoring, the guidelines recommend that a fasting plasma glucose and lipid levels be assessed 3 months after initiation of an antipsychotic medication. Thereafter, plasma glucose values should be obtained annually, or more frequently in those who have a higher baseline risk for the development of diabetes. In those with a normal lipid profile, repeat testing should be performed at 5-year intervals or more frequently if clinically indicated.

Community Care sent a letter to physicians discussing the analysis and the current recommended guidelines for metabolic monitoring. Additionally, a letter was sent to

members with information on antipsychotics and emphasizing the importance of proper monitoring and follow-up. Several health plans are also providing information to prescribing physicians about this topic.

Stimulants and sudden death in children

A study recently published in the American Journal of Psychiatry found there may be an association between the use of stimulant medications for attention deficit hyperactivity disorder and sudden unexplained deaths in healthy children. In the study, researchers used mortality data from 1985-1996 and compared cases of sudden death in 564 healthy children with 564 children who died as passengers in automobile accidents. After ruling out factors such as a history of known cardiac problems and known causes of death, the researchers found 10 sudden, unexplained deaths in children taking stimulant medications. They compared those 10 deaths to age-matched controls who died in car crashes and found the odds of sudden death were 7.4 times higher for children taking stimulant medications.

Because of the study's limitations, the FDA can not conclude that the data in the study affect the overall risk-benefit profile of stimulant medications used to treat ADHD in children. The FDA recommends physicians follow the current prescribing information for stimulants, which advises an echocardiogram or an electrocardiogram if patient/family history or physical examination suggest an underlying risk for or the presence of heart disease. The American Heart Association began recommending an electrocardiogram be performed prior to starting any child on stimulant medication, in addition to medical history and physical exam, in April 2008.

The FDA is conducting another study evaluating the potential of cardiovascular problems associated with stimulant medication use in children. The results from this study should be available later this year.

Formulary information on Community Care website

As a reminder, behavioral health medication summary tables have been posted on Community Care’s website. The medication tables were created to help providers determine coverage of behavioral health medications from the different physical Health Plans and the DPW Fee-For-Service formulary. The Physical Health Plans Drug Formularies for Behavioral Health Medications tables include coverage information on antidepressants, antipsychotics, stimulants, and typical mood stabilizers. The summary tables can be found at www.ccbh.com –Provider Resources – HealthChoices Resources – Informational Articles.

For more information from a specific plan, providers can also refer to the Pharmacy Contact Information for Physical Health Plans article which contains the physical health plan formulary website links.

Formulary updates

The physical health plans that manage our members’ pharmacy benefits have informed us of behavioral health formulary changes that have occurred or will occur for Medical Assistance members. A table listing these updates is on page 4.

Health Plans that have formulary changes will contact members and providers who are using any of the drugs affected by the formulary update. If you have questions concerning these updates, please contact the respective Health Plan’s Pharmacy Services number as provided.

New products update

Fanapt (iloperidone), a new atypical antipsychotic, received FDA approval May 6, 2009 for the acute treatment of schizophrenia in adults. Fanapt is a mixed dopamine D2/serotonin 5HT2A receptor antagonist. The recommended starting dose is 1 mg twice a day. Fanapt must be titrated slowly to a target dose of 6-12 mg twice a day to avoid orthostatic hypotension. This titration may cause the control of symptoms to be delayed during the first 1-2 weeks of treatment. The dose of Fanapt should be decreased by one-half when administered concomitantly with a strong CYP2D6 or CYP3A4 inhibitor.

Fanapt can cause QTc prolongation, therefore, its use should be avoided in combination with other drugs that increase the QTc interval and is not recommended in patients with hepatic impairment. The most commonly observed side effects were dizziness, dry mouth, fatigue, nasal congestion, orthostatic hypotension, somnolence, tachycardia, and weight gain. Fanapt will be available later this year in 1 mg, 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, and 12 mg tablets.

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PHARMACY UPDATE 2009

Physical Health Plan - Pharmacy Services	Updates	Effect Date
<p>AmeriChoice 1-800-922-1557 www.americhoice.com</p>	<p>Addition of Cymbalta (duloxetine) with prior authorization required.</p>	<p>April 1, 2009</p>
<p>AmeriHealth Mercy Health Plan 1-866-610-2774 www.amerihealthmercyhp.com</p>	<p>Addition of venlafaxine extended release (Effexor XR) tablets.</p>	<p>February 2009</p>
<p>Keystone Mercy Health Plan 1-800-588-6767 www.keystonemercy.com</p>	<p>Addition of all generic topiramate products (Topamax).</p>	<p>June 2009</p>
<p>Health Partners 1-888-991-9023 www.healthpart.com</p>	<p>Prescription drug formulary is available for free through the Epocrates RX drug database to all network physicians.</p>	<p>April 2009</p>
<p>Gateway Health Plan 1-800-528-6738 www.gatewayhealthplan.com</p>	<p>Addition of galantamine (Razadyne) with prior authorization required and quantity limits of 60 tablets per 30 days. Addition of zaleplon (Sonata) with quantity limits of 30 tablets per 30 days.</p>	<p>May 1, 2009</p>
<p>Unison Health Plan 1-877-651-2217 www.unisonhealthplan.com</p>	<p>Addition of prior authorization required for Second Generation Antipsychotics for members less than 5 years of age. Current utilizers less than 5 years of age will be grandfathered. Addition of quantity limits of 30 tablets per 30 days on Seroquel XR 50 mg (quetiapine) and Seroquel XR 200 mg. Addition of Seroquel XR 150 mg with quantity limits of 30 tablets per 30 days.</p>	<p>March 4, 2009 July 1, 2009 July 1, 2009</p>
<p>UPMC for You 1-800-396-4139 www.upmchealthplan.com</p>	<p>Addition of prior authorization required for atypical antipsychotics for members less than 12 years of age. Members will not be grandfathered.</p>	<p>August 1, 2009</p>

New products update

(continued from page 3)

Nuvigil (armodafinil), the longer-lived enantiomer of Provigil (modafinil), received FDA approval 06/19/07 and became available 06/04/09. Nuvigil is indicated to improve wakefulness in adult patients with excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), narcolepsy, and shift work sleep disorder (SWSD).

The recommended dose for OSAHS or narcolepsy is 150 mg or 250 mg given once a day in the morning. The recommended dose for patients with SWSD is 150 mg once daily approximately 1 hour prior to the start of a work shift.

The most common adverse events in clinical studies were headache, nausea, dizziness, and insomnia. Nuvigil also carries a bolded warning for serious or life-threatening rash, including Stevens-Johnson Syndrome. Its use is contraindicated in patients with a history of left ventricular hypertrophy and in patients who have experienced mitral valve prolapse syndrome when previously receiving CNS stimulants.

Nuvigil should be used with caution in patients with a history of psychosis, depression, mania, myocardial infarction, or unstable angina. Controlled trials showed small average increases in mean systolic and diastolic blood pressure for patients taking Nuvigil compared to placebo which may require new or increased use of antihypertensives.

Nuvigil is available in 50 mg, 150 mg, and 250 mg tablets and is a Schedule IV controlled substance.

Addressing Provider Benchmarking Issues (PBIs) to improve service

A Comprehensive Provider Evaluation, one of Community Care's many quality management tools, is used to monitor the quality of services delivered by network providers. Evaluations ensure that members are treated in a safe and healthy environment that is conducive to recovery. The qualitative and quantitative data generated by the evaluations is used to improve practice standards.

Reviewing Provider Benchmarking Issues (PBIs) is part of the evaluation. PBIs impact service and access to care. In order to improve the quality of care, if a trend is identified, Community Care may request that the provider submit an action plan that addresses the issue.

Examples of PBIs include:

- No appointment scheduled after discharge.
- Precertification performed in an untimely fashion.
- Continued stay review conducted outside the designated time frame.
- Aftercare provider unable to give appointment within seven days of discharge.
- Poor treatment plan submitted.
- Psychiatric evaluation below standards.
- Outpatient provider/practitioner at capacity.

A full list of PBIs, along with detailed explanations and Community Care's expectations related to each incident, is available at www.ccbh.com.

Ensuring quality patient care

Community Care's Credentialing Department requires primary source verification — direct contact of the sources of credentials, such as schools, residency programs, licensing agencies, and specialty boards — to guarantee that statements of education, training, experience and other qualifications are legitimate, unchallenged, and appropriate.

Primary source verification is necessary not only to meet the requirements of main accreditors such as the National Committee for Quality Assurance (NCQA), but is also critical in avoiding legal problems and ensuring quality patient care. Primary source verification ensures that only trained, qualified individuals are admitted to the network.

What is the role of the applicant?

An applicant's primary responsibility is to complete his or her application truthfully, completely, and on time. An applicant should also help to obtain any supporting documents that are necessary to process his or her application.

In the first quarter 2009, the department has credentialed/re-credentialed 291 practitioners and 42 facilities.

For further information about Community Care's credentialing process, contact Jan Arrigo at 412-454-2122 or arrigojm@ccbh.com.

Improving the health of Members and the community

Member quality of life is of the utmost importance to Community Care. To ensure that members and the community are receiving the best care and are satisfied with services, Community Care solicits feedback via forums and advisory meetings. These comments, concerns, and suggestions are then reviewed internally and interventions are implemented to improve upon the care provided.

Recent interventions include the opening of a Walk-in Crisis Program and a Crisis Residential Program in Allegheny County, the addition of a new Community Treatment Team to the network, the hiring of additional Certified Peer Specialists, and lastly the implementation of a Telephone Crisis Program and Mobile Crisis Program in Allegheny County.

Community Care continues to meet member needs and provide high quality care to the community.

Health information for persons who are deaf, deaf-blind, or hard of hearing

A new website, <http://www.healthbridges.info/>, has been developed for people who are deaf, deaf-blind, or hard of hearing, as well as for health providers and insurers.

Sponsored by Staunton Farm Foundation, Office of Mental Health and Substance Abuse Services (OMHSAS), Center for Hearing and Deaf Services, Inc., and others, this website was created by people who are deaf, deaf-blind, or hard of hearing. The site provides reliable health and advocacy-related information in a format that is accessible to all.

Links to resources across the state are provided. New topics are discussed each month; visit often! And, please remind Community Care members of this resource.

School-Wide Positive Behavior Support: an evidence-based practice

Community Care has implemented school-based behavioral health (SBBH) teams in northeast Pennsylvania and is evaluating expansion to other parts of the state. These teams are part of School-Wide Positive Behavior Support (SWPBS), a systems approach to establishing the social, cultural, and behavioral supports needed for all children in school to achieve both social and academic success.

The SWPBS approach emphasizes utilizing data and team-based decision making to define, teach, and support appropriate student behaviors and create a positive school climate. There is a continuum of support provided to students in a three-tiered model. All students are taught school-wide expectations (primary) in an effort to provide the greatest impact with the least amount of intervention. Secondary (small groups of identified students) and tertiary (individual student) interventions are provided for those who need additional support after primary interventions are not successful.

One of the tenets of SWPBS is that approximately 80% of students will respond favorably to the established school-wide expectations. Those who do not respond are identified by school staff and administration as needing more support. In order to determine the type of support a student may need, a functional behavior assessment (FBA) is often conducted. An FBA is a way to gather information by learning what predicts and maintains problem behavior. An FBA — used in conjunction with other “tools” in the clinician’s “tool box” — can change as behaviors and environments change. Most importantly is to view

all of the child’s behaviors within the context of any underlying emotional factors and/or any other child or family issues.

School-Based Behavioral Health (SBBH) Teams are thought of as an intensive, or Tier 3 intervention. A student is often referred to a SBBH Team after many other interventions are tried. These students, and their families, often have complex mental health needs and the students are struggling with academics, as well as behavior.



Contact Kate Nicholson, MS, Children’s Services Clinical Manager at 412-454-2145 or nicholsonkm@ccbh.com for more information about the SBBH model.

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Understanding the function of behavior

What is meant by “function of behavior?” Function is our “theory” about the underlying cause for the behavior. It helps us to answer questions such as “What triggers the behavior?” or “What does the child gain or lose by engaging in the behavior?” These are referred to as the antecedent, behavior, and consequence (A, B, C) pathway.

If we can understand these important components about the child’s behavior, we might be able to alter something in the environment or something within the child in order to see a more appropriate behavior response from the child.

Recovery

Keeping the Promise.

Community Care is sponsoring regional institutes to highlight the work that's been done to date to promote behavioral health recovery and to identify next steps in the behavioral health delivery system transformation process. Featured speakers include local leaders, members of the Community Care Recovery Team, and other content experts. Topics include the CommonGround™ toolkits developed by Community Care and renowned recovery expert, Pat Deegan, PhD, to promote recovery, and "Hearing Voices: A Simulation to Increase Empathy and Understanding."

The institutes, provided by Community Care at no cost to you, are intended for all behavioral health stakeholders including consumers and their families, providers, administrative and clinical staff from regulatory offices and mental health programs, Intensive Case Managers and Resource Coordinators, psychiatrists and psychologists, counselors, nurses, social workers, and medical program residents and other students. CEUs are available.

Given the number of people who want to participate in our recovery institute, we've added another session on August 11, 2009 in Pocono Manor, PA.

PLEASE NOTE: If you're registered for the August 12, 2009 institute in Scranton, PA, but find this new date and location more convenient, let us know and we'll do our best to accommodate you.

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Community Care Recovery Institute Registration Form

Mail or fax your completed registration form to:

Community Care
One Chatham Center, Suite 700
Pittsburgh, PA 15219
Attn: Karen Neal
Fax: 412-454-2177;
Phone: 412-454-8646

Registration forms should be received at least two weeks before the date of the institute. Please indicate which institute you plan to attend:

- 07/28/09 North Central Region
Nittany Lion Inn, State College
- 07/29/09 North Central Region
Lake View Lodge, DuBois
- 08/12/09 Northeast Region
Radisson Hotel, Scranton
- 08/11/09 Carbon, Monroe, and Pike Counties**
The Inn at Pocono Manor,
Pocono Manor

**JUST
ADDED!**

Name _____

Title _____

Agency _____

Street Address _____

City _____

State _____ Zip _____ County _____

Daytime Phone () _____

E-mail _____

Special Needs* _____

For continuing education credits, indicate:

- NBCC Counselor Nurse
- Psychologist Social Worker

* Notify us of your special needs at least two weeks in advance.