PROMISe Re-enrollment

Community Care has reported over the past year the requirement for all Medical Assistance enrolled providers to review their re-enrollment/revalidation status and to take appropriate actions. The deadline for submission of applications with an expiration date of March 24, 2016 is quickly approaching.

The Pennsylvania Department of Human Services (DHS) issued two bulletins: the Office of Medical Assistance Programs (OMAP) issued Bulletin 99-14-06, “Re-Enrollment/Revalidation of Medical Assistance (MA) Providers,” and the Office of Mental Health and Substance Abuse Services (OMHSAS) issued Bulletin OMHSAS-14-03, “Affordable Care Act (ACA) Re-enrollment Guidance for Behavioral Health Providers,” outlining the requirements for re-enrollment (revalidation) for continued participation in the MA program for currently enrolled providers.

The Department requires that all providers, regardless of provider type, re-enroll every five years by submitting a fully completed provider enrollment application, specific to the program for which they are enrolled, along with any required additional documentation/information based on provider type, for every active and current service location. The regulation requires the Department to complete the initial revalidation of currently enrolled providers by March 24, 2016 and at least every five years thereafter. Providers may view enrollment requirements and applications here.

Providers of HealthChoices Supplemental Services, enrolled through the behavioral health managed care organization (BH-MCO), will continue to work with the BH-MCO related to securing enrollment. The BH-MCO will provide the current HealthChoices Supplemental Services Provider Enrollment Application/required documentation and coordinate the submission of the application/documentation to OMHSAS for processing.

continued >
PROMISe Re-enrollment

In order to determine the next enrollment deadline, providers can log into the PROMISe provider portal, where the re-enrollment/revalidation date will be displayed in the masthead of the portal for each service location. The date identified is the expiration date for that specific service location based on the most recent application on file with DHS. As a reminder, each enrollment deadline is service location specific.

Service locations for which the provider has not completed the re-enrollment process by the assigned deadline will expire and no longer remain active. If the enrollment is closed, the provider will not be paid for services provided after the date of the closure. Providers will still be expected to submit a full application along with any required additional documentation to reactivate the closed enrollment. However, the effective date of the new enrollment will not be made retroactive to cover any lapsed enrollment periods.

Please note that DHS has recommended that applications be submitted at least 90 days prior to the expiration in order to allow time for processing. Therefore, for enrollments that expire on March 24, 2016, PROMISe Revalidation Applications must be submitted no later than December 24, 2015.

At Community Care, we are working closely with our providers to do everything possible to try to prevent service interruptions for our members and payment interruptions for our providers. Currently, Community Care Provider Relations staff have been reaching out to providers of Supplemental Services (which includes individual master’s level licensed clinicians) to assist with the completion of the PROMISe Revalidation Application. If you have not yet received a Supplement Services application from your Community Care Provider Relations representative, please contact us immediately to review your status and begin the application process, if necessary. If you do not know who your Provider Relations representative is, you may find the information here.
Naloxone for Opioid Overdose

Drug overdose deaths have reached epidemic levels, with overdose being the leading cause of injury-related deaths in the United States, according to the CDC. In 2014, Pennsylvania ranked ninth in the country (18.9 per 100,000 people) in drug overdose deaths and first in drug overdose deaths among young adult men (19–25). Prescription opioids and heroin are consistently the most prominently involved substances in drug overdoses.

The use of naloxone (Narcan®, Evzio®) by emergency responders, family members, and peers is a proven strategy for successfully addressing opioid overdoses. Naloxone is an opioid antagonist indicated for partial or complete reversal of opioid depression induced by natural or synthetic opioids. It is FDA approved to treat suspected or known acute opioid overdose.

SAMHSA has encouraged evaluation of prescription for naloxone for all individuals on long term opioid treatment, “With proper education, patients on long-term opioid therapy and others at risk for overdose may benefit from having a naloxone kit to use in the event of overdose”. For more information, see the SAMHSA Overdose Prevention Toolkit.

The FDA recently approved a nasal spray version of naloxone (Narcan® by Adapt Pharma, Inc.) under its fast-track approval process. No assembly is required for this FDA approved nasal naloxone, making it easier to administer than other forms of naloxone. Naloxone is also approved in injectable forms. Until the approval of the nasal spray, an adapter attached to the end of a needleless syringe was used to administer naloxone nasally.

Dr. Rachel Levine, Pennsylvania Physician General, has issued a standing order that makes naloxone available to any Pennsylvanian who wishes to have access to it. The standing order can be downloaded from the Pennsylvania Department of Health website. The Pennsylvania Department of Drug and Alcohol Programs website contains a list of pharmacies that routinely stock naloxone, SAMHSA's Overdose Prevention Toolkit, as well as other resources and instructional materials.
Community Care would like to remind you about our website. We include information about many topics of interest on our website. You can view and/or download information about the following topics on the website.

- Information about Community Care's Quality Improvement Program including goals, processes, and outcomes as related to care and service.

- Information about Community Care's behavioral health care screening programs, including how to use the services and how Community Care works with a practitioner's patients in the program. The website has screening tools for members to use for:
  - Alcohol use with depression.
  - Anxiety with ADHD.

- The process to refer members to case management.

- The process for facility staff, including discharge planners, to refer members to case management.

- Information about how to obtain or view copies of Community Care's adopted clinical practice guidelines, including those for:
  - Major depressive disorder.
  - Substance use disorder.
  - ADHD.

- Information about Community Care's medical necessity criteria, including how to obtain or view a copy.

- Information about the availability of staff to answer questions about UM issues.

- The toll-free number to contact staff about UM issues.

- The availability of TDD/TTY services for members.
Information Online

- Information about how members may obtain language assistance to discuss UM issues.
- Community Care’s policy prohibiting financial incentives for utilization management decision-makers.
- A description of the process to review information submitted to support a practitioner’s credentialing application, correct erroneous information and, upon request, to be informed of the status of the credentialing or recredentialing application.
- Community Care’s member rights and responsibilities statement.

If you have any questions about accessing our website or if you would like more information about any of the above items, please call the Provider Line at 1.888.251.2224. The most recent information about Community Care and our services is always available on our website.
Discharge Management Plans and Medication Reconciliation

Community Care and our county partners are working with OMHSAS and IPRO to reduce behavioral health readmissions as part of the Successful Transition Performance Improvement Project (ST PIP); an area of focus for this project is discharge management plans. Discharge management plans (DMPs) are important to ensure members leave the hospital with the resources to be successful in the community and can reduce readmission. Community Care along with our county partners participated in a chart abstraction project with four hospitals in our network to review their DMPs. Other BH-MCOs also completed chart abstraction projects around the state. Indicators that were reviewed included members with medication reconciliation and/or scheduled and kept follow-up within 7 and 14 days. DMPs should be present in a member’s record, shared with the member, and include medication reconciliation and detailed information about timely, appropriate follow-up care.

The chart abstraction project identified medication reconciliation as an opportunity for improvement. Medication reconciliation is the process of identifying the most accurate list of a member’s current medicines—including name, dosage, frequency, and route—and comparing it to the current list in use, recognizing discrepancies and documenting changes. Reconciliation decreases the number of medication errors, including omissions, duplications, dosing errors, and drug interactions.

Medication reconciliation should be documented and include:

- An evaluation of medications taken prior to admission, including instructions regarding continuation or discontinuation at discharge.
- A list of all medications prescribed at discharge (drug name, dosage, schedule, and reason).
- A notation if the member is not prescribed any new medications at discharge.
Discharge Management Plans and Medication Reconciliation

This process compares the member’s medications on admission, transfer (including between locations, providers, or different levels of care within the same location), or discharge to and from an inpatient facility. This process should involve the member, family, caregivers, PCP, other treatment providers, and the pharmacist. To complete the medication reconciliation process, you should:

1. Develop a list of current medications.
2. Develop a list of medications to be prescribed.
3. Compare the medications on the two lists.
4. Make clinical decisions based on the comparison.
5. Communicate the new list to appropriate caregivers and to the member.
6. Ensure discharge instructions contain a list of all medications, with clear indication of changes from the member’s pre-admission medications.

All medications should be reconciled, including prescription, over-the-counter, homeopathic, vitamins, herbals, and nutritional supplements. Creating a medication reconciliation form may assist you in collecting this information. You can find examples of medication reconciliation forms here.

Remember, medication reconciliation should:

- Be member-centered, taking into account the member’s level of health literacy.
- Promote communication among the member, caregivers, and health care providers.
- Emphasize the need for members to take an active role in managing their medicines.

Community Care will expand the discharge management planning measure to five additional hospitals in 2016 and encourages all network providers to complete appropriate discharge management planning and medication reconciliation with members.
Antipsychotic Prior Authorization Policy for GHP Members

Community Care would like to inform you of an important change being implemented by Geisinger Health Plan (GHP). Starting February 1, 2016, GHP will require a prior authorization for all antipsychotics prescribed for children under the age of 18.

GHP is implementing this prior authorization in order to promote safe and appropriate medication use. There has been a significant increase in the prescribing of antipsychotics in children during the past several years, particularly for off-label uses such as ADHD. The long-term safety of these medications in children is unknown and studies indicate that metabolic monitoring in children on antipsychotic medications is often incomplete.

Prescriptions for these medications will be required to be written by or in consultation with a pediatric neurologist, child and adolescent psychiatrist, or child development pediatrician for children 14 and under. For those members over the age of 14, scripts can be written by a general psychiatrist in addition to the other specialties listed. Documented monitoring of weight, BMI, blood pressure, glucose, lipids, and assessment of extrapyramidal symptoms will also be required.

Community Care encourages you to pursue a prior authorization in a timely fashion for any member who will require an antipsychotic after February 1, 2016. Prior authorization forms are available on GHP’s website.

If you should have any questions about this change for GHP Family members, please call the GHP Family Pharmacy Department at 1.855.552.6028. Representatives are available Monday through Friday from 8:00 a.m. to 5:00 p.m.
Quality Improvement Program

Community Care believes that high-quality behavioral health care is a priority. Our quality improvement program is designed with input from network practitioners and follows the guidelines of the National Committee for Quality Assurance (NCQA). Areas of focus include:

• Delivering high value, culturally competent care that incorporates the special needs and preferences of members.

• Continuously improving the clinical care and service provided to members.

• Enhancing the community’s health status through wellness and preventive behavioral health programs for members.

• Pursuing opportunities to improve the health status of members and targeting efforts to the needs of the population.

• Ensuring that care and services are available and provided to members in a timely manner that is appropriate to the needs and preferences of members.

• Ensuring that care and services are coordinated between providers and across all delivery settings through the care management process.

• Establishing collegial relationships with providers to achieve superior clinical and customer service outcomes.

• Providing exceptional customer service.

• Continuously improving quality improvement processes by maintaining comprehensive, current, and effective quality management policies and procedures.

• Analyzing performance data and identifying opportunities to improve performance and outcomes.

If you would like more information regarding our quality improvement program, contact us at 1.888.251.2224. We will provide you with a description of the program and an update on our progress toward meeting our goals. If you have any suggestions for improving our quality improvement program, please contact us at:

Community Care Behavioral Health Organization, Quality Management
339 Sixth Avenue, Suite 1300, Pittsburgh, PA 15222
Provider Performance Issues (PPIs)

The Provider Performance Issue process uses qualitative and quantitative measures to provide feedback to providers and to ensure providers practice within an environment conducive to recovery and that adheres to performance standards.

PPIs are completed by care management or customer service staff. The Quality Department reviews each issue and monitors trends by provider and level of care. A quality improvement plan may be requested from a provider if a trend is identified. The PPI process is not intended to be punitive.

For questions related to the PPI process or our performance standards, please call your assigned care manager or the Community Care Provider Line at 1.888.251.2224.

Community Care identified the following items as conducive to recovery and adhering to performance standards:

- Timely completion of precertification.
- Development of a coordination of care plan while member is still in the hospital.
- Timely completion of discharge review.
- Provider is prepared for clinical review and has all necessary information.
- Provider reviewed continued stay review in designated time frame.
- Provider followed care plan developed by facility and care manager.
- Cultural competency: provider meets member's cultural preferences.
- Discharging provider scheduled aftercare appointment within 7 days of discharge.
- Aftercare providers schedule an appointment within 7 days of discharge.
- Complete discharge summary submitted.
- Provider kept member in facility without authorization.
- Provider at capacity.
- Timely reporting of incidents by provider.
Provider Performance Issues (PPIs)

Regarding child and adolescent levels of care, Community Care identified the following items as conducive to recovery and adhering to performance standards:

- BHRS/RTF: Psychological evaluation meets standards.
- BHRS/RTF: CM invited to ISPT meeting in timely manner.
- Appropriate BHRS/RTF treatment plan submitted.
- Timely submission of completed BHRS/RTF packets.
- Timely submission of FBMHS treatment plans and crisis plans.

Community Care can identify other issues as deemed clinically important.

Providers are expected to:

- Adhere to Provider Manual specifics and performance standards.
- Follow administrative processes.
- Communicate and coordinate with the treatment team.
- Ensure quality of care to members.