Policy & Procedure			
Subject:	**Continuity for Behavioral Healthcare & Care Coordination with Primary Care and Behavioral Health Providers**		
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NCQA Reference(s):	Most current NCQA HP Standards and Guidelines		

POLICY

AmeriHealth Caritas Louisiana strives for full coordination of care between behavioral health providers and PCPs. In cases where there are chronic/complex medical needs and behavioral health needs, significant barriers to treatment or barriers to discharge from a hospitalization, AmeriHealth Caritas Louisiana will collaborate with medical providers and hospitals to access appropriate behavioral and physical health services.

PURPOSE

AmeriHealth Caritas Louisiana will work with primary care providers (PCP), specialists, and/or specialized behavioral health providers to ensure continuity of behavioral health care for health plan Enrollees. Basic behavioral health services performed in the primary care providers office, including appropriate referrals and coordination of care will be part of the ongoing collaboration between ACLA, behavioral health providers and the PCP. Specialized Behavioral Health services will be authorized for the Special Health Care Needs Population who requires more than basic behavioral health services.

ACLA Behavioral Care Manager Responsibilities:

1. Facilitate referrals between physical and behavioral health providers to ensure reciprocal

communication of Enrollee needs and follow up.

2. Facilitate integration of behavioral health professionals into the PCP office setting.

3. Conduct outreach calls to coordinate with PCP and office staff, Behavioral Health providers, community resources, and Enrollees.

4. Assist the physical health team in assessing Enrollees' needs for appropriate services, possible referrals, and care management services.

5. Assist behavioral health providers, Enrollees and other referral sources to determine appropriate levels of care and link Enrollees with Specialized Behavioral Health needs to behavioral health services. This includes Enrollees who are of the Chisholm class who meet criteria for behavioral health services or need a Comprehensive Diagnostic Evaluation, Enrollees who may be eligible for Permanent Supportive Housing (PSH) and pre-tenancy/tenancy supports, and Enrollees assessed as eligible for behavioral health services by the Preadmission Screening Resident Review (PASRR) Level II evaluation.

6. Identify, enroll and link Enrollees with Serious and Persistent Mental Illness (SPMI) including ER and other Psychotic Disorders, Major Affective Disorder, Bipolar Disorder, and Post Traumatic Stress Disorder who may also have at least one other co-existing medical condition. This also applies to children identified as Special Health Care Needs (SHCN) who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services members with co-occuring medical and behavioral conditions.

7. Coordinate with OJJ, DCFS, and DOE to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated.

8. During Member Transitions, Case Management/Utilization Management will ensure that the setting from which the Enrollee is transitioning is sharing information with the Enrollee's PCP and behavioral health providers regarding the treatment received and contact information.

9. When an Enrollee receives SBHS and has treatment plans developed through their behavioral health providers, ACLA Case Management/Utilization Management shall work with the Enrollee's behavioral health providers in order to incorporate the treatment plans into the Enrollee's overall POC and to support the Enrollee and the provider in their efforts to implement the treatment plan

10. Contact with Enrollees identified as needing special health care services shall be initiated

and a comprehensive assessment for those who are willing to engage with case management will be completed within 90 days of referral by the PCP or thirty (30) days if determined to need specialized health services following the PASRR Level II Evaluation.

11. ssist/arrange an initial assessment/LOCUS and an annual re-assessment/LOCUS for the SHCN population, including but not limited to Enrollees who may be eligible for Permanent Supportive Housing (PSH) and PSH Mental Health Rehabilitation services and/or additional behavioral health services and Enrollees who need ongoing specialized behavioral health services under the state plan (CPST/PSR, Assertive Community Treatment).

12. Complete PASRR Level II evaluations prior to NF admit for Enrollees who are identified with a mental illness via the PASRR Level 1 screen and submit recommendations of the least restrictive residential setting, level of care/ appropriate behavioral health services to OBH within four (4) calendar days of receipt of the referral from OBH.

13. Complete the care plan that includes the treatment recommendations outlined in the Level II evaluation and approved by OBH. Notify OBH when Enrollee undergoes a change in condition that may require a resident review, report any problems or issues with the PASRR process and when Enrollees are identified residing in a NF who has a Serious Mental Illness who has not received a Level II determination.

14. Connect Enrollees to behavioral health services if the Preadmission Screening Resident Review (PASRR) Level II evaluation notes the need for specialized behavioral health services while the Enrollee is in a NF or if LDH determines Enrollee is not eligible for NF or Enrollee chooses an alternate community-based option and is eligible for behavioral health services. Notify OBH when problems or issues occur with PASRR process or when a Enrollee residing in a NF who has SMI has not received a Level II determination.

15. Collaborate with NF(s) in Louisiana to coordinate the discharge and transition of Enrollees into the community for continuance of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers. Assure an initial and annual re-assessment/LOCUS is completed prior to discharge from NF to determine eligibility to Specialized Behavioral Health services such as but not limited to CPST/PSR, CI, ACT or other outpatient services.

16. Collaborate with LDH PSH referral to permanent for Enrollees who may be eligible or have been determined by PSH to be eligible for PSH by reviewing medical necessity for pre-tenancy and tenancy behavioral health services.

17. Identify and outreach potential PSH candidates, arrange an assessment/LOCUS as needed and refer to PSH. Assist with the PSH application and arrange behavioral health services and/or PSH Mental Health Rehabilitation services as needed. Assist or collaborate with supports services and Enrollees with barriers or issues that may jeopardize PSH and/or tenancy services.

18. Collaborate with state agencies or external entities when needed and with the authorized consent of the Enrollee or the Enrollee's caretaker/representative. These may include but are not limited to the Office of Citizens with Developmental Disabilities, the Department for Children and Family Services, the Department of Education, the Office of Juvenile Justice, the Department of Health (LDH), the Office of Behavioral Health, the Office of Aging and Adult Services and LDH Permanent Supportive Housing.

19. Assist with linking children/youth who need a Comprehensive Initial Diagnostic Evaluation and direct Enrollees with an Autism Spectrum Disorder diagnosis to providers who are Licensed Behavior Analysts for further evaluation and treatment (i.e. Applied Behavioral Health Analysis).

20. Attend monthly or ad hoc care management rounds/meetings with physical and/or behavioral health providers.

21. Collaborate with ACLA BH medical director to assess ongoing needs of Enrollees and PCP to enhance integration of services.

22. Develop training, in collaboration with BH Medical Director, for the PCP offices related to integration of BH/PH services and assessments, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACES), substance use, and ADHD screenings/treatment.

23. Conduct site visits as appropriate to implement programs and provide support to other special programs.

24. Assist Provider Network with orientation, training and education of Providers and Behavioral Health management of Enrollees with coexisting medical and behavioral health disorders requiring co-management.

Assist Provider Network with developing and arranging for training of ACLA providers and other individuals involved in care management activities on identification and screening of behavioral health conditions and referral procedures.

PCP/Behavioral Health providers Responsibilities:

1. The PCP shall provide basic behavioral health (BH) services and refer the Enrollee(s) to the appropriate health care specialist as deemed necessary for specialized BH services. The PCP shall ensure that all medically necessary services are made available in a timely manner.

2. The PCP will conduct screens for common behavioral health issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACES), ADHD and

substance use to determine whether the Enrollee needs behavioral health services.

3. The PCP will utilize enhanced detection and treatment of behavioral health disorders in primary care settings.

4. The PCP will implement utilization of approved communication and consultation with behavioral health providers of co-enrolled Enrollees with co- existing medical and behavioral health disorders requiring co- management.

5. The PCP will develop plans of care to address risks and medical needs and work with AmeriHealth Caritas Louisiana to develop plans of care for Enrollees receiving case management services.

6. Providers furnishing services to the member maintain and share the member's health record in accordance with professional standards;

7. Poviders will provide active assistance to member's receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the ACLA.

Utilizaton Management

1. Document authorized referrals in its utilization management system;

2. ACLA UM shall provide continuation of such services for up to ninety (90) Calendar Days or until th member is reasonably transferred without interruption of care, whichever is less; and;

3. UM and/or CM will coordinate with the court system and State child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the written request of LDH when there is a need to inform the cour of available services and limitations, and participating in crossagenc staffing.

4. PerformRx and CM will collaborate as needed to ensure continuation of the behavioral health therapeutic classes (including long-acting injectable antipsychotics) and other medication assisted treatment (including buprenorphine/naloxone an naloxone products) prescribed to the member in a mental health treatment facility for at least sixty (60) Calendar Days after the facility discharges the Enrollee, unless the ACLA Medical Director psychiatrist, in consultation and agreement with the facility' prescribing physician, determines that the medications are: not medically necessary; or Potentially harmful to the Enrollee.Behavioral health providers shall screen for basic medical issues.

ACLA Responsibilities:

1. Coordinate and assist with transitions between levels of care. Services shall be of sufficient intensity to ensure Care Managers are able to identify and coordinate services and supports to prevent institutionalization and assist the Enrollee with maintaining community placement.

2. Offer or arrange self-management training and health education to Enrollees and caregivers regarding conditions.

3. Ensure continuity of care for identified Special Health Care Needs Populations including managing transitions between pediatric and adult Health Care providers.

4. Collaborate with nursing facilities and ICF/IIDs to coordinate aftercare planning prior to discharge and transition of Enrollees for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers.

5. Case Management/Utilization Management collaboration from hospitals, residential facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of Enrollees for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers and after-care appointments; and

6. Collaborate with the Department of Corrections and local criminal justice systems in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services for Enrollees, including referral to community providers, prior to reentry into the community including, but not limited to, Enrollees in the Louisiana Medicaid Program pre-release program.

7. Ensure care coordination that actively linking Enrollee to providers and coordination with, medical services, residential, social, community and other support services where needed.

8. For Enrollees who have DD eligibility, verification of the Statement of Approval and collaboration with Local Governing Entities (LGEs) and Support Coordination Agencies.

9. Coordinate care for out-of-network services, including specialty care services as neededC

10. Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers:

    a) Identify barriers to adequate healthcare and assisting with timely resolution.

b) Ensure continuity and coordination of care for Enrollees who have been determined by a medical provider to need specialized behavioral health services or who may require inpatient/outpatient behavioral health services.

c) Coordinate with the PCP and SMO to ensure integrated care for Enrollees with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for Enrollees with co-existing medical-behavioral health disorders.

d) Assist Enrollees without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder.

e) Provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures. Distributing Release of Information forms as per 42 CFR §431.306, and provide training to ACLA providers on its use.

f) Include documentation in the Enrollee's medical record that attempts are made to engage the Enrollee's cooperation and permission to coordinate the Enrollee's over-all care plan with the Enrollee's behavioral health provider.

g) Provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.

h) Ensure continuity and coordination of care for Enrollees who have been screened positive or determined as having need of specialized medical and/or behavioral health services or who may require inpatient/outpatient medical health services.

i) For staff Enrollees working directly with Enrollees, ensure crisis intervention training.

j) Conduct Care Management rounds at least monthly with the ACLA Physician or as needed.

k) ACLA, SMO, and LDH representative will participate in regular collaborative meetings at least yearly or as needed.

l) Document authorized referrals in ACLA's clinical management system.

ACLA's Provider Network Mangement, Program & Innovation Analyst Population Health Medical Service and BH Medical Director will facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs considering the recommended principles that guide care integration as follows:

a. Mental illness and addiction are health care issues and shall be integrated into a comprehensive physical and behavioral health care system that includes primary care settings;
b. Many people suffer from both mental illness and addiction. As care is provided, both illnesses shall be understood, identified, and treated as primary conditions;
c. The system of care shall be accessible and comprehensive, and shall fully integrate an array of prevention and treatment services for all age groups. It shall be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement;
d. and It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with Federal and State laws, regulations, rules, policies, and other applicable standards of medical record confidentiality and the protection of patient privacy.

AmeriHealth Caritas Louisiana associate may need to use and/or disclose a Enrollee's Protected Health Information (PHI) for the purposes of Treatment, Payment, or Health Care Operations (TPO). Federal HIPAA privacy regulations do not require Health Plans to obtain a Enrollee/Consumer's written consent or Authorization prior to Using, Disclosing, or Requesting Protected Health Information (PHI) for purposes of TPO therefore; AmeriHealth Caritas Louisiana is not required to seek a Enrollee/Consumer's authorization to release their PHI for any one of the aforementioned purposes (see policy #168.227, General Policy – Use and Disclosure of Protected Health Information Without Enrollee Consent/Authorization). Case Management Standards of Practice used in the performance of Case Management services is a Health Care Operation.

AmeriHealth Caritas Louisiana Associates may not Use, Request, or Disclose to others, any PHI that is more than the Minimum Necessary to accomplish the purpose of the Use, Request, or Disclosure (with certain exceptions as outlined in policy #168.217, Minimum Necessary Rule). AmeriHealth Caritas Louisiana Associates are required to comply with specific policies and procedures established to limit uses of, requests for, or disclosures of PHI to the minimum amount necessary. AmeriHealth Caritas Louisiana will maintain adequate administrative, technical and physical safeguards to protect the privacy of PHI from unauthorized Use or Disclosure, whether intentional or unintentional, and from theft and unauthorized alteration. Safeguards will also be utilized to effectively reduce the likelihood of Use or Disclosure of PHI that is unintended and incidental to a Use or Disclosure in accordance with AmeriHealth Caritas Louisiana policies and procedures (see policy #168.213, General Guidelines to Safeguard Protected Health Information).

AmeriHealth Caritas Louisiana will reasonably safeguard PHI to limit incidental Uses or Disclosures. An incidental Use or Disclosure is a secondary Use or Disclosure that cannot reasonably be prevented, is limited in nature, and occurs as a by-product of an otherwise

permitted Use or Disclosure (see policy #168.222, Safeguards to Protect the Privacy of Protected Health Information.

As per 42 CFR Part 2, a signed Enrollee's consent form is required for the sharing of past and current substance use information.

DEFINITIONS

Primary Care Provider (PCP):
An individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of an Enrollee's health care. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.

Care Coordination – Deliberate organization of patient care activities by a person or entity, including the Contractor that is formally designated as primarily responsible for coordinating services furnished by providers involved in the Enrollee's care, to facilitate the appropriate delivery of health care services. Care coordination activities may include but aren't limited to the coordination of specialty referrals, assistance with Ancillary Services, and referrals to and coordination with community services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of the Enrollee's care.

PROCEDURE

Referral and Coordination Criteria

Care Managers refer and coordinate care with behavioral health providers and agencies that promote continuity. Referrals for behavioral health services are based on clinical assessment and identified behavioral needs of the Enrollee. Any Enrollee with both complex behavioral and physical health needs requiring ongoing coordination is referred to complex care management (CCM) *Policy 156.202* Population Health Management (PHM) *Referral Trigger.* Care Managers also assist and link Enrollees without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder.

Referral sources may include the following:

a. External referrals including but not limited to self-referral by Enrollee and/or referral from the Primary Care Provider (PCP), Specialist or other provider.
b. Internal department referrals including but not limited to Utilization Management (UM), Appeal Department, Enrollee Services and Quality Management (QM).

c. Internal process referrals arising from PLAN processes such as New Enrollee Assessment, Care Gap outreach, 24/7 call follow-up and/or EPSDT outreach.
d. External program referrals through contracted vendors.
e. Monthly predictive modeling reports using software algorithms provided by claims and pharmacy data.
f. Regulatory agency referrals from state Medicaid agencies or others.
g. Referrals related to Enrollees identified with need for non-covered, excluded services.
h. Referrals from State Agencies including but not limited to Office of Citizens with Developmental Disabilities, the Department for Children and Family Services, the Department of Education, the Office of Juvenile Justice, the Louisiana Department of Health (LDH), the Office of Behavioral Health, the Office of Aging and Adult Services and LDH Permanent Supportive Housing.
i. Community Care Management Team

Collaborating with the Primary Care Provider/Specialist, AmeriHealth Care managers refer Enrollees who have both complex physical and behavioral health needs.

AmeriHealth Caritas Louisiana has Utilization Management (UM) and Population Health Management (PHM) rounds during which complex cases with difficult discharge planning and follow up treatment plans are discussed.

Care Coordination with Primary Care Providers

Collaboration with the primary care provider (PCP)

1. AmeriHealth Caritas Louisiana strongly supports the need for coordination of care between the behavioral health provider and the Primary care provider (PCP) of the Enrollee.
2. It is the expectation of AmeriHealth Caritas Louisiana that providers will explain the importance of care coordination to the Enrollee so that their consent and cooperation can be obtained for these communications.
3. Without a signed release, providers and AmeriHealth Caritas Louisiana cannot share substance abuse treatment information.
4. AmeriHealth Caritas Louisiana strongly encourages providers to obtain treatment information.
5. Behavioral Health Providers will be encouraged to share information directly with the Enrollee's PCP with the appropriate consent.
6. Individualized treatment plans shall be developed by the Enrollee's primary care provider and/or other lead provider as appropriate with the Enrollee's participation and in consultation with any specialists caring for the Enrollee.

7. AmeriHealth Caritas Louisiana requires behavioral health providers to attempt to obtain a signed consent form from Enrollees so that information about important aspects of care can be forwarded to the PCP.

8. Should the Enrollee refuse consent, documentation regarding the refusal should be placed in the Enrollee's chart. The Care Manager will document attempts made to engage the Enrollee's cooperation and permission to coordinate the Enrollee's over-all care plan with the Enrollee's behavioral health provider.

9. All behavioral health providers are required to document and share the following information for the Enrollee with AmeriHealth Caritas Louisiana and PCP:
    - A written summary of each Enrollee's treatment
    - Primary and secondary diagnoses
    - Findings from assessments
    - Medication prescribed
    - Any other relevant information

10. Coordinate with OCDD, LGEs, and support coordinators concerning the care of the Enrollees who have co-occurring Behavioral Health and Developmental Disabilities. A Statement of Approval from OCDD shall not preclude services from ACLA.

11. PCPs are expected, with informed Enrollee consent, to provide behavioral health providers with any relevant health status information. This helps to ensure that the Enrollee's medication management remains safe, therapeutic interventions are effective, and overall healthcare is efficient and unduplicated.

12. AmeriHealth Caritas Louisiana's Medical Director or physician advisors are available as a resource to PCPs for general discussions regarding psychiatric care or for specific case consideration to help in better managing the patient's treatment. AmeriHealth shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.

13. When working jointly with the behavioral health provider and PCP on case management to meet an Enrollee's needs, the following information will be shared for coordination purposes:

    a. Assigned Care Manager at AmeriHealth Caritas Louisiana with contact information
    b. Provide member's with information on how to contact the person designated to coordinate the services the member accesses
    c. Enrollee information to the extent necessary to coordinate care, typically including but not limited to:
        i. Enrollee diagnoses
        ii. Enrollee treatment history
        iii. Current treatment providers
        iv. Identified compliance and adherence issues
        v. Participation in any Disease Management, High-Risk Case Management, or other in- plan or ancillary services

14. Upon written request, share with LDH or other health care entities serving an Enrollee with special health care needs the results and identification and assessment of that Enrollee's needs to prevent duplication of assessment activities.

Emergency Coordination

If an Enrollee is in need of emergency behavioral health services, AmeriHealth Caritas Louisiana shall instruct the Enrollee to seek help from the nearest emergency medical provider. AmeriHealth Caritas Louisiana shall initiate follow-up with the Enrollee within forty-eight (48) hours for follow-up to establish that appropriate services were accessed. Refer to *Policy PHM 229 Threats to Enrollee Safety.*

REFERENCES (Cited Policies and Procedures and Source Documents)

- Policy PHM 229 Threats to Enrollee Safety
- Policy 156.701 Coordination with other Healthcare and non-Healthcare Services
- Policy 156.202 Population Health Management (PHM) Referral Trigger

ATTACHMENTS

- N/A

REVIEW/REVISION DATES

- 01/07/2018—Annual Review
- 04/08/2020 – Annual Review
- 02.11.2021 – Annual review
- 10/30/2022 – Updates to align with 1/1/2023 contract

[-End of Policy-]

Policy and Procedure Approval

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□ New X Revision □ Review, No revision

□ Replacement (Replaced policy & procedure No._____)

Approval Signatures:

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