

CHAPTER 6: BEHAVIORAL HEALTH SERVICES

Anthem HealthKeepers Medicare-Medicaid Plan (MMP)

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Pre-Authorization Hours 24 Hours – 7 Days a Week

Behavioral Health Services

Overview

Behavioral Health Services are an integral part of the **Health Care Management at HealthKeepers, Inc.** The mission of our behavioral health program is to improve the general outcome and quality of life for all members with behavioral health diagnoses or behavioral health risk factors while controlling costs for our state partners. This is accomplished through a four pronged approach that stresses:

- ☑ Prevention
- ☑ Early identification, especially in the non-behavioral health clinical arenas
- ☑ High-quality and appropriate treatment
- ☑ Recovery and resiliency

The Behavioral Health program works to address potential and actual behavioral issues of members in all arenas of the healthcare delivery system and at all states of distress. This includes collaborating with non-behavioral healthcare providers, primary care providers, specialists, community agencies, governmental institutions, the member's family and non-familial supports as appropriate and guided by the member's needs.

HealthKeepers, Inc. Behavioral Health Unit believes those individuals who receive both Medicare and Medicaid services should receive both seamless and integrated care which should result in the delivery of service that has fewer gaps and a higher quality of care. We believe through case management and care coordination services, members will receive the services they need in the most appropriate setting that addresses their complex behavioral health and medical needs in a timely manner. Anthem HealthKeepers' Behavioral Health Case Management programs are designed to identify these gaps, locate the most appropriate service setting, coordinate care, and improve Member health outcomes by not only integrating our interventions with our medical care programs but working closely with those providers who offer "non-standard" services to our members, such as the Community Service Boards.

HealthKeepers provides a clinical team staffed with Virginia-based behavioral health and medical case managers who work in close collaboration with community and Provider-based case managers, particularly those who work within the Community Service Boards or other organizations which

provide community based mental health rehabilitative services. The main functions of the Anthem HealthKeepers behavioral health case managers include, but are not limited to:

- ☑ Use health risk appraisal data gathered by HealthKeepers, Inc. from Members upon enrollment to identify Members who will benefit from engagement in individualized care coordination and case management.
- ☑ Use “trigger report data” based upon medical and behavioral health claims to identify Members at risk.
- ☑ Consult and collaborate with our medical case managers and disease management clinicians regarding Members who present with co-morbid conditions, disabilities, and / or chronic health conditions.
- ☑ Develop, with the Member, an individualized care plan to actively address identified needs.
- ☑ Provide Members with the assistance needed to access Provider-based case management for ongoing intensive case management, targeted case management (which remains carved out to the fee-for-service system), and other rehabilitative services and then continue involvement with the Member and the Provider to coordinate care among different agencies, medical providers, etc. to maximize the Member’s functioning in the community.
- ☑ Work directly with the Member, Provider, and other family and community support systems as appropriate, based upon the severity and chronicity of the Member’s condition.
- ☑ Work closely with the Community Service Boards in conducting utilization management activities for a range of outpatient rehabilitative services to assist the Member in managing their symptoms, improving functional status, and helping to prevent the need for more restrictive levels of care.
- ☑ Coordinate care and discharge planning with the Community Service Boards when Members are admitted to higher levels of care.

Behavioral Health Services

Integrated Behavioral Health Services Goals

The goals of the **Anthem HealthKeepers MMP Behavioral Health Program** are to:

- ☑ Ensure accessibility to available services for eligible members
- ☑ Expand adequacy of service availability
- ☑ Promote integration of the management and delivery of physical and behavioral health services to members
- ☑ Achieve quality initiatives including those related to HEDIS, NCQA, and the Virginia Department of Medical Assistance Services (DMAS) and Centers for Medicare and Medicaid Services (CMS) performance requirements

Work with Members, Providers and community supports to provide recovery tools and create an environment that supports members’ progress towards recovery goals

- ☑ Ensure utilization of the most appropriate, least restrictive, medical and behavioral healthcare in the right place at the right time

Behavioral Health Services Objectives

The objectives of the **Anthem HealthKeepers MMP Behavioral Health Program** are to:

- ☑ Promote continuity and coordination of care among physical and behavioral health care practitioners
- ☑ Enhance Member satisfaction by working with members-in-need to implement an individually-tailored and holistic support and care plan that allows the Member to succeed at achieving his/her recovery goals
- ☑ Provide Member education on treatment options and pathways toward recovery
- ☑ Provide high quality case management and care coordination services designed to identify Member needs and address them in a person-centered, holistic manner
- ☑ Work with care Providers to ensure the provision of medically necessary and appropriate care and services to our Members at the least restrictive level, including inpatient care, alternative care settings and outpatient care
- ☑ Enhance Provider satisfaction and success by working to develop collaborative and supportive Provider relationships built on mutually agreed upon goals, outcomes and incentives, promote collaboration between all health care partners to achieve quality and recovery goals through education, technological supports and the promotion of recovery ideals
- ☑ Utilize evidence-based guidelines and clinical criteria and promote the use of same in the Provider community
- ☑ Maintain compliance with local, state and federal requirements, as well as accreditation standards
- ☑ **HealthKeepers, Inc.**-contracted Providers deliver behavioral health (and substance use disorder services) in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by **DMAS and CMS**.

Behavioral Health Services

The Three Guiding Principles of the Anthem HealthKeepers MMP Behavioral Health Program

1. Recovery and Resiliency

Recovery is a Member-driven process in which Members find their paths to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite the continued presence of a disability.

Resiliency is the ability of an individual or family unit to cope and adapt to the challenges and change brought on by distress or disability while learning and developing the skills necessary to live a fulfilling and productive life despite the continued presence of a disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances. Accepting and managing one's life in a manner that displays optimism for personal successes manifested by traits of self-efficacy and high self-esteem is achieved by building resiliency.

Physical and behavioral health services will be rendered in a manner that allows the achievement of recovery for persons experiencing mental illness and substance use disorders and supports the development of resiliency of those who are impacted by mental illness, serious emotional disturbance and/or substance use disorder issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on mental health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery identified by **SAMHSA** include:

☑ **Self-direction:** Members lead, control, exercise choice over and determine their own path of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life.

☑ **Individualized and Person-centered care:** There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences and experiences including past trauma and cultural background in all of its diverse representations.

☑ **Empowerment:** Members have the authority to choose from a range of options and to participate in all decisions - including the allocation of resources - that will affect their lives and are educated and supported in so doing.

☑ **Holistic:** Recovery embraces all aspects of life, including housing, employment, education, mental and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person.

☑ **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the Member to move on to fully engage in the work of recovery.

☑ **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. ☑ **Peer support:** Mutual support - including the sharing of experiential knowledge and skills and social learning - plays an invaluable role in recovery. ☑ **Respect:** Community, systems and societal acceptance and appreciation of Members — including protecting their rights and eliminating discrimination and stigma — are crucial in achieving recovery. ☑ **Responsibility:** Members have a personal responsibility for their own self-care and journeys of recovery. ☑ **Hope:** Recovery provides the essential and motivating message of a better future — that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, Providers and others. Hope is the catalyst of the recovery process.

2. Systems of Care Services provided to persons with serious emotional disturbances and their families are best delivered based on the **System of Care Values and Principles** that are endorsed by **SAMHSA** and the **Center for Mental Health Services (CMHS)**. Services should be:

- ☐ Person-centered and family-focused with the needs of the person and family dictating the types and mix of services provided.
- ☐ Community-based with the focus of services as well as management and decision making responsibility resting at the community level.
- ☐ Culturally competent with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.
- ☐ Comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs.
- ☐ Personalized as evidenced by an individualized service plan formulated to meet unique needs and potential.
- ☐ Delivered in the least restrictive, most normative environment that is clinically appropriate.
- ☐ Integrated and coordinated with linkages between agencies and mechanisms for planning, developing and coordinating services.
- ☐ Inclusive of case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the Member and their family.
- ☐ Delivered without regard to race, religion, national origin, sex, physical disability or other characteristics.
- ☐ Oriented to recovery, providing services that are flexible and evolve over time.

3. Coordination of Behavioral Health and Physical Health Treatment Key elements of the model for coordinated and integrated physical and behavioral health services include:

- ☐ Ongoing communication and coordination between Primary Care Providers (PCPs) and specialty providers, including behavioral health (mental health and substance use) providers
- ☐ Screening by PCPs for mental health, substance use and co-occurring disorders
- ☐ Discussions by behavioral health provider of physical health conditions
- ☐ Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders and/or any known or suspected and untreated physical health disorders
- ☐ Development of patient-centered treatment plans Involving Members as well as caregivers and family members when appropriate
- ☐ Case management and disease management programs to support the coordination and integration of care between Providers

Fostering a culture of collaboration and cooperation helps sustain a seamless continuum of care between physical and behavioral health and positively impacts Member outcomes. To maintain continuity of care, patient safety and Member well-being, communication between behavioral health and physical care Providers is critical, especially for Members with co-morbidities receiving pharmacological therapy.

Behavioral Health Provider Services We believe the success of Providers is necessary to achieve our goals. We are committed to supporting and working with qualified Providers to ensure that we jointly meet quality and recovery goals. Our commitment includes:

- ☐ Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery
- ☐ Supporting Providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person
- ☐ Simplifying precertification rules, referrals, claims and payment processes to help Providers reduce administrative time and focus on the needs of Members.

Behavioral Health Services Health Plan Clinical Staff All clinical staff are licensed and have at least four years of prior clinical experience. Our Medical Director is board-certified in psychiatry. Our highly trained and experienced team of clinical care managers, case managers and support staff provide high quality care management and care coordination services to our Members and strive to work collaboratively with all Providers.

Behavioral Health Services General Requirements

1. Coordination of Physical and Behavioral Health Services As a network Provider, you are required to notify a Member's PCP when a Member first enters behavioral health care and anytime there is a significant change in care, treatment, medications or need for medical services, provided that you have secured the necessary release of information from the Member or the Member's legal guardian. You should provide initial and summary reports to the PCP on at least a quarterly basis.

The minimum elements to be included in such correspondence are: ☐ Patient demographics ☐ Date of initial or most recent behavioral health evaluation ☐ Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the Member (e.g., complaint of physical ailments) ☐ Diagnosis and/or presenting behavioral health problem(s) ☐ Prescribed medication(s) ☐ Behavioral health clinician's name and contact information

2. Member Records Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews: Information related to the provision of appropriate services to a Member must be included in his or her record with documentation in a prominent place whether there is an executed declaration for mental health treatment. For Members in the population, a **comprehensive assessment** that provides a description of the Member's physical and mental health status at the time of admission to services.

This comprehensive assessment covers: ☐ **Psychiatric and psychosocial assessment** that includes: ☐ Description of the presenting problem ☐ Psychiatric history and history of the Member's response to crisis situations ☐ Psychiatric symptoms ☐ Multi-axial diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM) ☐ Mental status exam ☐ **A medical assessment that includes:** ☐ Screening for medical problems ☐ Medical history ☐ Present medications ☐ Medication history ☐ **A substance use assessment that includes:** ☐ Frequently used over-the-counter medications ☐ Current and historical usage of alcohol and other drugs reflecting impact of substance use in the domains of the community functioning assessment ☐ History of prior alcohol and drug treatment episodes and their effectiveness ☐ History of alcohol and drug use ☐ **A community functioning assessment or an assessment of the Member's functioning in the following domains:** ☐ Living arrangements, daily activities (vocational/educational) ☐ Social support ☐ Financial ☐ Leisure/recreational ☐ Physical health ☐ Emotional/behavioral health ☐ An assessment of the Member's strengths, current life status, personal goals and needs

3. Treatment Planning A patient-centered **support and care plan**, which is based on the psychiatric, medical, substance use and community functioning assessments listed above, must be completed for any Member who receives behavioral health services. ☐ There must be documentation in every case that the Member and, as appropriate, his or her family members, caregivers or legal guardian participated in the development and subsequent reviews of the treatment plan. ☐ The support and care plan must be completed within the first 14 days of admission to behavioral health services and updated every 180 days, or more frequently as necessary based on the Member's progress toward goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.

- ☒ There must be a signed release of information to provide information to the Member's PCP or evidence that the Member refused to provide a signature.
- ☒ There must be documentation that referral to appropriate medical or social support professionals have been made.
- ☒ If the Provider uncovers a gap in care, it is their responsibility to help the Member get that gap in care fulfilled. Their documentation should reflect their action in this regard.
- ☒ For Providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the Member.
- ☒ The treatment/support/care plan must contain the following elements:
 - ☒ Identified problem(s) for which the Member is seeking treatment
 - ☒ Member goals related to each problem(s) identified, written in Member-friendly language
 - ☒ Measurable objectives to address the goals identified
 - ☒ Target dates for completion of objectives
 - ☒ Responsible parties for each objective
 - ☒ Specific measurable action steps to accomplish each objective
 - ☒ Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts who can assist the Member in resolving crisis; and the Member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
 - ☒ Actions agreed to be taken when progress toward goals is less than originally planned by the Member and Provider
 - ☒ Signatures of the Member as well as family members, caregivers or legal guardian as appropriate.
- ☒ Progress notes are written to document status related to goals and objectives indicated on the treatment plans.
- ☒ Correspondence concerning the Member's treatment and signed and dated notations of telephone calls concerning the Member's treatment
- ☒ Progress notes should indicate active follow up actions for referrals given to the Member and actions to fill gaps in care
- ☒ A brief discharge summary must be completed within 15 calendar days following discharge from services or death
- ☒ Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the Member is receiving behavioral health services
- ☒ Treatment Plan and Progress Notes should be signed by the supervising physician

4. Psychotropic Medications Prescribing Providers must inform all Members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications and other forms of treatment. If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the Member or if appropriate a referral to a nutritionist or obesity medical professional. If diabetes is a problem, the medical record needs to reflect a discussion with the Member about their condition and their treating Provider should be identified in the documentation, and coordination efforts with that Provider should be indicated as well. The medical record is expected to reflect such conversations as having occurred. The medical record is expected to indicate the prescription data has been shared with the Member's PCP.

Members on psychotropic medications may be at increased risk for various disorders. As such it is expected that Providers are knowledgeable about side-effects and risks of medications and regularly inquire about and seek for any side-effects from medications. This especially includes:

- ☐ Follow-up to inquire about suicidality or self-harm in patients placed on antidepressant medications as per Food and Drug Administration and American Psychiatric Association guidelines
- ☐ Regular and frequent weight checks and measurement of abdominal girth especially for those on antipsychotics or mood stabilizers
- ☐ Glucose tolerance test or hemoglobin A-1C tests especially for those Members on antipsychotics or mood stabilizers
- ☐ Triglyceride and cholesterol checks especially for those Members on antipsychotics and mood stabilizers
- ☐ ECG checks for Members placed on medications with risk for significant QT-prolongation.
- ☐ Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association among others. Summary guidelines are referenced in our Clinical Practice Guidelines located on our website at mediproviders.anthem.com/va. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions must be documented in the Member's medical record.

5. Utilization Management

Utilization Management (UM) Decisions are governed by the following statements:

- ☐ UM-decision making is based only on appropriateness of care and service and existence of coverage.
- ☐ Practitioners or other individuals are not specifically rewarded for issuing denial of coverage care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denial of benefits.
- ☐ Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

5a. Timeliness of Decisions on Requests for Authorization Behavioral Health

1. Emergency inpatient admission requests: Within 3 hours of receipt of request
2. Urgent Pre-Service Requests: Within 72 hours of request
3. Urgent Concurrent Requests: Within 24 hours of request
4. Routine, Non-urgent Requests: Within 14 calendar days
5. Retrospective Review Requests: Within 30 days of request

Medical Management Support Model of Care

HealthKeepers, Inc. has developed an evidenced based model of care that offers coordinated care delivered by a network of Providers with expertise to meet the needs of the specialized population. The effectiveness of the model of care is measured annually as part of our Quality Management Program. We have designed a care system to meet the intentions of the Virginia Commonwealth Coordinated Care program, a coordinated, integrated person-centered system of care that assures high quality and an excellent Member experience. The model of care is a comprehensive care management and care coordination program that incorporates our experience and the goals of the Virginia Commonwealth Coordinated Care program.

The goals of Virginia Commonwealth Coordinated Care program are to:

- ☑ Improve the quality of care for Members
- ☑ Maximize the ability of Members to remain safely in their homes and communities with appropriate services and supports, in lieu of institutional care
- ☑ Coordinate Medicare and Medicaid benefits across health care settings and improve continuity of care across acute care, long-term care, behavioral health, and home and community-based services settings by using a person-centered approach
- ☑ Promote a system that is both sustainable and person- and family-centered, and enables Members to attain or maintain personal health goals by providing timely access to appropriate, coordinated health care services and community resources, including home- and community-based services and mental health and substance use disorder services
- ☑ Increase the availability and access to LTSS including HCBS
- ☑ Improve transitions of care across health care settings, Providers and HCBS.
- ☑ Maximize the ability of dual eligible Members to remain in their homes and community-based settings with appropriate services and supports in lieu of institutional care
- ☑ Preserve and enhance the ability for Members to self-direct their care and receive high quality care
- ☑ Optimize the use of Medicare, Medicaid and other State/County resources

Each Member has an interdisciplinary care team (ICT) assigned to assist with developing care plans, collaborating with other team members and providing recommendations for the management of the Member's care. The representative of the team and the mode of communication are determined by the needs of the Member. Typically the team can be made up of Member and/or his or her designee, designated care manager, primary care physician, behavioral health professional, the Member's home care aide or LTSS Provider and other Providers either as requested by the Member or his/her designee or as recommended by the care manager or primary care physician and approved by the Member and/or his/her designee.

The Member is an important part of the team and is involved in the planning process. The Member's participation is voluntary and they can choose to decline at any time. The case manager is the coordinator of the team and reaches out to Providers and other team members to coordinate the needs of the Member. Important information about the Member including the assessment and

care plan details are available to you through the secured provider portal. Health care practitioners and Providers of care in the home or community are also very important members of the team and help to establish and execute the care plan. All case management and ICT are person-centered and built on the Member's specific preferences and needs, ensuring transparency, individualism, accessibility, respect, linguistic and cultural competency and dignity.

The figure below demonstrates the person-centricity of the model. Depending on Member conditions, needs and desires, a team comprised of experts in Physical Health, Behavioral Health, LTSS, Social Work works with the Member, their representative (if desired) and the PCP and Specialists as required. Communication among all the constituents is critical and is supported by **HealthKeepers, Inc.** systems.

