Second Quarter 2024

Carelon Behavioral Health
Provider Newsletter

Contents

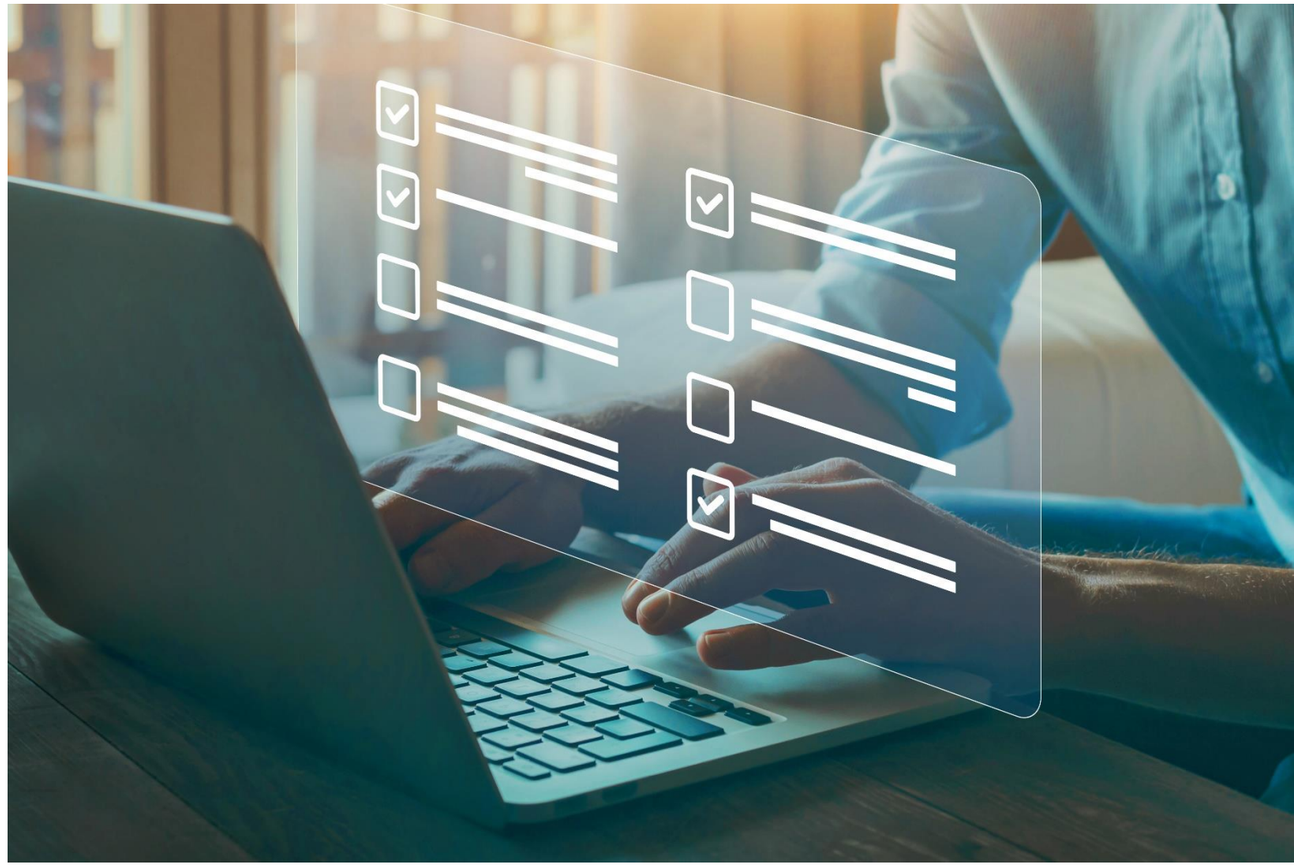
KEEP YOUR DIRECTORY DATA ACCURATE

To best serve our members together, the most up-to-date provider data is essential.

Accurate provider data is members' primary gateway to access care - align with your current availability, your areas of practice and services, and optimize matching members to the right providers – you!

Carelon is committed to helping members find you. In addition to maintaining your provider data with CAQH and CBH's ProviderConnect, you may receive a CBH Provider Data Validation Audit via email or text. Please keep an eye out for these digital audits. By participating in these provider data validations, you will help keep your data up-to-date by validating select directory fields and your current availability to see members. Together we are making a difference!

*CAQH Providers should attest, confirm, or update their data through the CAQH portal. Non-CAQH Providers and Facilities should attest, confirm, or update their data directly with Carelon Behavioral Health.



AVAILITY NEW FUNCTIONALITY: AUTHORIZATIONS CAN NOW BE INITIATED BY LOGGING INTO THE AVAILITY PORTAL

As part of our ongoing efforts to optimize and enhance the Availity Essentials Portal, we recently launched new functionality making it easier to request authorizations. Our existing Authorization Dashboard application was renamed to Authorization Management, as we continue to roll out new features. With this new feature, you can now use our Authorization Management application to **initiate** prior auth requests. Upon initiation, you will then be redirected to the Carelon provider portal (e-Services / ProviderConnect) to complete the authorization. In addition, you still have the ability to search for authorizations and check the status of previously submitted requests. This consolidated view of all your authorization requests makes it simple to track in one location.

Log into Availity to access the Authorizations and Referrals application (on the Multi payer space). From the Patient Registration menu at the top of the screen, select Authorization Request to be directed to the Authorizations page where you can select Organization and Payer. You will then be redirected to the Carelon provider portal (e-Services / ProviderConnect).

We're here to support you along the way

Register for our upcoming training to learn more about this new feature:

» **Tuesday, July 23, 2024 @ 1:00 – 2:00 PM ET** https://attend.webex.com/weblink/register/rd01921ef15564ed5bbfb39f8ad860de0

Availity Essentials offers keyword search assistance with the option to attend live or recorded demos:

› On the Availity Essentials home page, select **Help & Training**, then select **Get Trained** to register for upcoming live and recorded training demos for all Availity Essentials capabilities.
› Use the search bar to locate specific appeals training.
› The Availity Learning Center **user guide** will assist with how to locate training.

New to Availity Essentials?

Providers who are not yet registered with Availity, can learn more, and sign up today, at no charge by visiting Availity.com. If you need registration assistance, contact Availity Client Services at **1-800-282-4548**. Assistance is available Monday through Friday 8 AM – 8 PM ET.
For more information, please visit our website at www.carelonbehavioralhealth.com/providers/resources/provider-portals/availity-essentials.

COMING SOON: PROVIDER DIRECTORY ENHANCEMENTS TO OPTIMIZE YOUR PATIENT MATCHES

We're excited to announce a new, highly requested, improvement to the Carelon Behavioral Health (Carelon) Provider Directory! You can now add personalized content you profile to improve patient matches:

- Practitioners can add a headshot, bio, and years of experience.
- Facilities can add a logo and bio.

This feature will help you attract patients whose needs best align with your skills, expertise and treatment styles. Thousands of patients use the Carelon provider directory each month to find in-network providers.

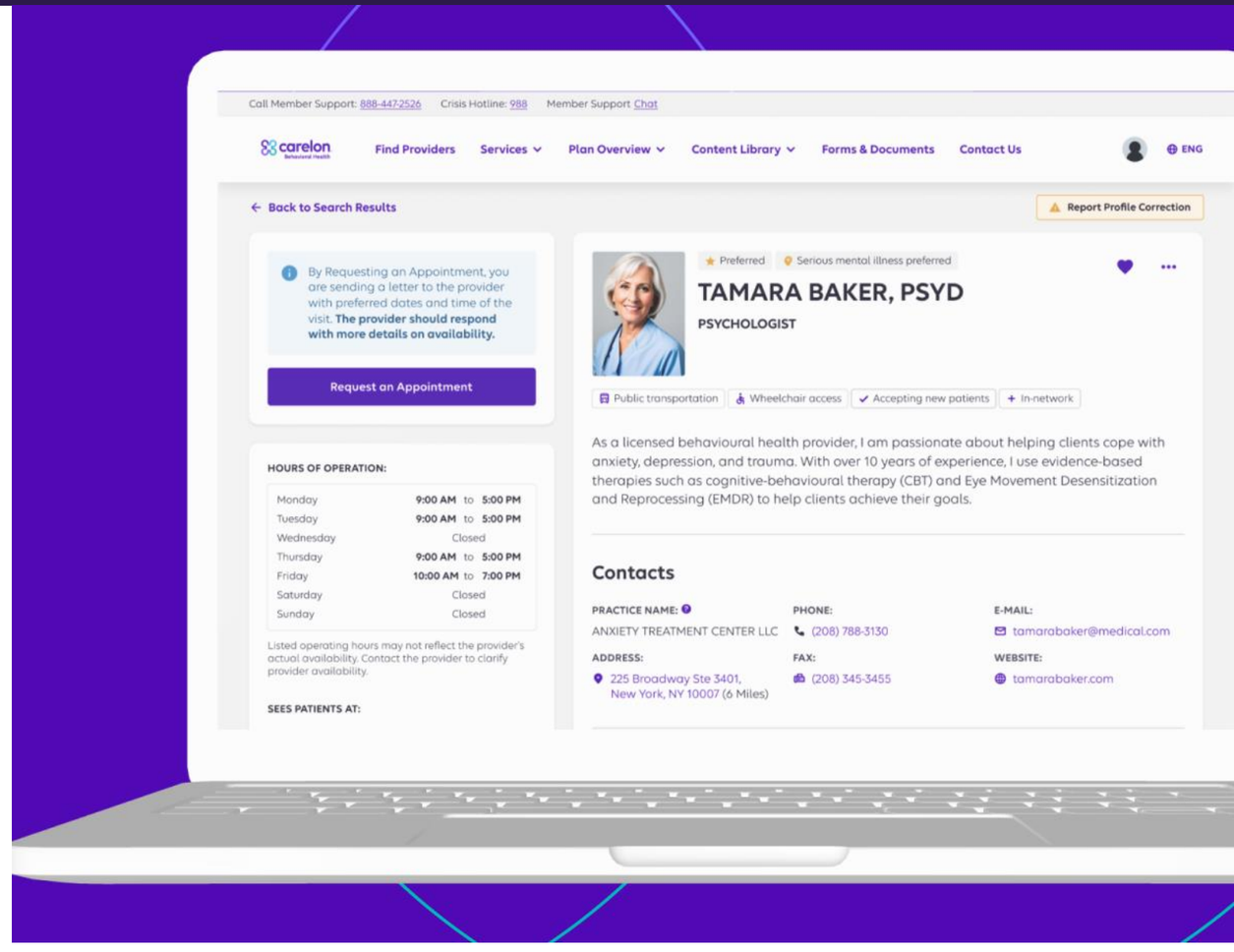
How do I update my profile?

Look out for an email from Carelon in early July. This email will include additional information and a link to update your profile.

What should I prepare ahead of time?

It's recommended to have your bio and headshot / logo ready beforehand.

- Photo requirements (practitioner headshots and facility logos): Allowed formats are JFIF, PJPEG, JPEG, JPG, PJP. Minimum size of 300x400 pixels with a preferred ratio of 3:4. For practitioners, headshots must have a neutral background. For facilities, logos must have a white or solid background.
- Bio: 1000-character limit. For provider profiles, include basic information about yourself, your treatment philosophy, experience/education, and treatment approach. For facilities, include facility information such as mission statement, service offerings, and specialties.



Take advantage of this opportunity to stand out and connect with patients!

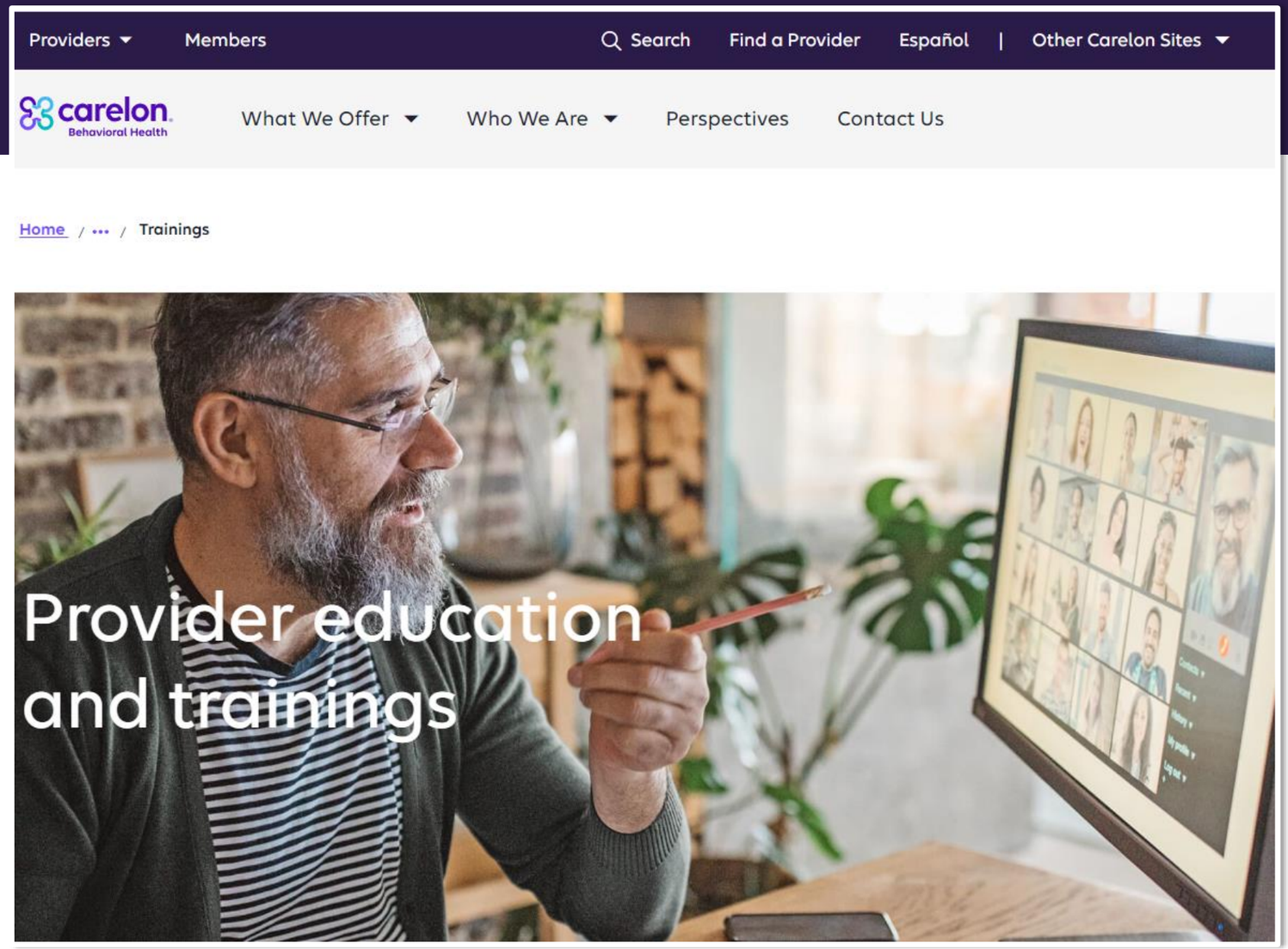
PROVIDER TRAININGS

We provide a full range of trainings year-round to educate, inform, and share industry-wide best practices and policies.

Trainings cover a variety of topics ranging from claim submission guidelines and provider portal support to behavioral health in youth and motivational interviewing.

Registration is on a first come first serve basis. To see our upcoming trainings and to register for a training, visit www.carelonbehavioralhealth.com/providers/resources/trainings.

For questions, please contact your local contracting entity.

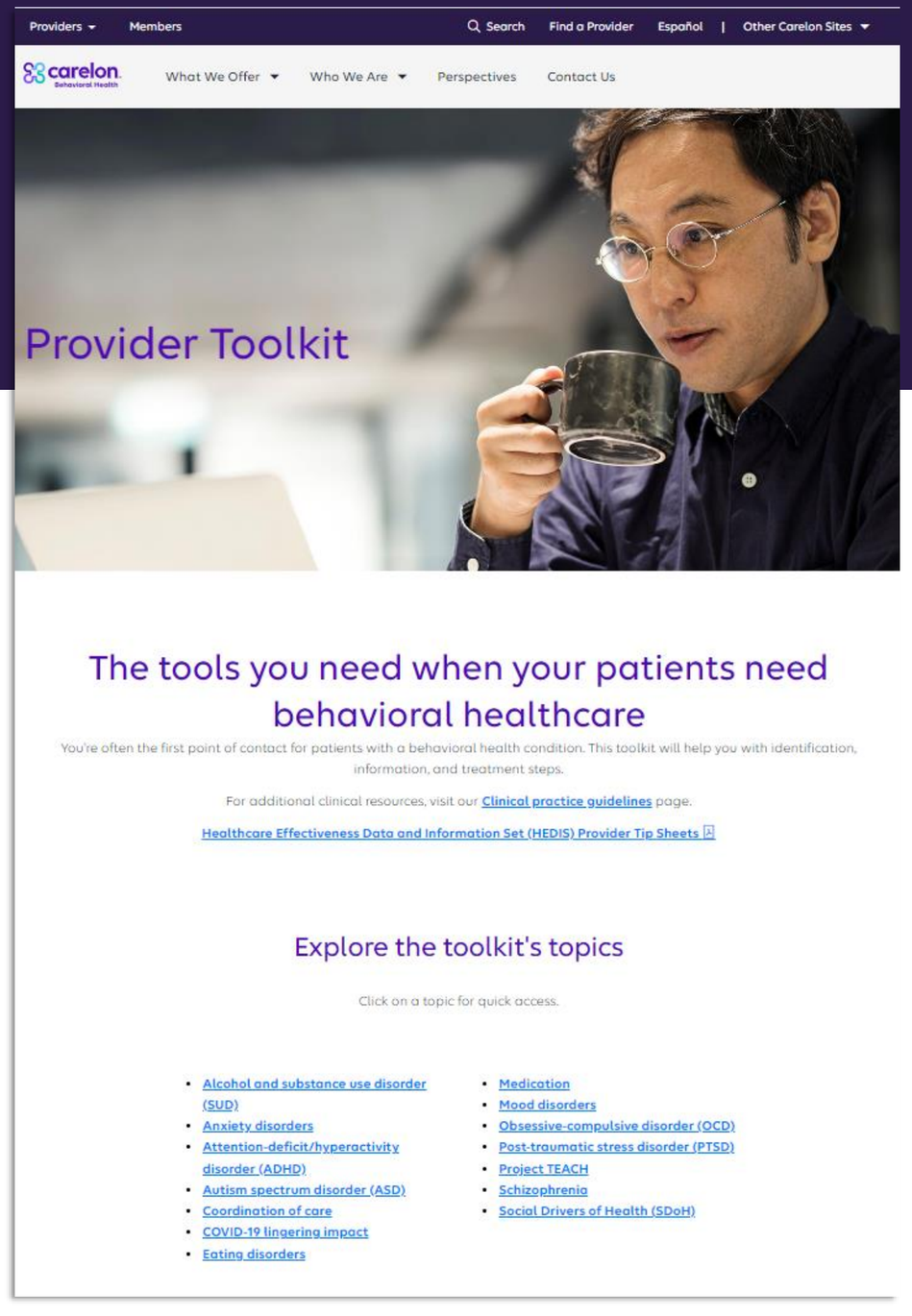


THE PROVIDER TOOLKIT

The Provider Toolkit is intended to support primary care clinicians by providing a quick guide to behavioral health references. The toolkit is also a great resource for behavioral health providers and our health plan partners. The toolkit is useful for managing populations with co-occurring disorders. The toolkit promotes an integrated healthcare approach encouraging whole person health by offering provider resources they can use with the members they serve.

The toolkit includes resources for the management of attention-deficit/hyperactivity disorder, alcohol and substance use disorders, anxiety disorders, autism spectrum disorder, mood disorders (depression and bipolar disorder), eating disorders (including binge-eating disorder), obsessive-compulsive disorder, post-traumatic stress disorder, and schizophrenia disorder. The toolkit also includes information as it pertains to coordination of care, COVID-19, behavioral health medications, and social determinants of health, and Project TEACH. All sections include resources that the provider can use with the member including screening tools.

Click here to access the Provider Toolkit



HELPFUL REMINDERS

Member Rights and Responsibilities

Carelon Behavioral Health's Member Rights and Responsibilities Statements are available in English and Spanish for download from our website.

Providers and practitioners are encouraged to ensure your practice supports the Rights and Responsibilities of our Members.

Learn more

Reminders Regarding Carelon's Ethical Approach to Utilization Management Decisions

Licensed behavioral health care professionals work cooperatively with practitioners and provider agencies to ensure member needs are met. Utilization management decisions are based on the clinical needs of the members, benefit availability, and appropriateness of care. Objective, scientific-based criteria and treatment guidelines, in the context of provider or member-supplied clinical information, guide the decision-making process.

Carelon Behavioral Health does not provide rewards to any of the individuals involved in conducting utilization review for issuing denials of coverage or service. There are no financial incentives to encourage adherence to utilization targets and discourage under-utilization. Financial incentives based on the number of adverse determination or denials of payment made by any individual involved in utilization management decision making are prohibited.

Appointment Access Reminder

Carelon Behavioral Health strives to provide members with accurate, current Provider Directory information. Participating providers are expected to maintain established office hours and appointment access. Carelon Behavioral Health's provider contract requires that the hours of operation of all network providers be convenient to the members served and not discriminatory. Participating providers are required to maintain the following access standards:

If a member has a:	They must be seen:
Life-threatening emergency	Immediately
Non-life threatening emergency	Within 6 hours
Urgent needs	Within 48 hours
Routine office visit	Within 10 business days
Routine Follow-up office visit (non-prescriber)	Within 30 business days of initial visit
Routine Follow-up office visit (prescriber)	Within 90 business days of initial visit

The table above reflects the access standards that are the minimum standards for Appointment Accessibility for all states. Some state or market specific requirements may be stricter.

As a reminder, if at any time your practice is not able to meet the appointment access requirements, please update your Provider Directory information:

- Practitioners: Visit CAQH, update, and attest
- Provider Groups and Facilities: Visit our provider portal or call our National Provider Service Line at 1-800-397-1630

MH/SUD ACCESS AND AVAILABILITY REQUIREMENTS

Rule 1300.74.72 was approved by the Department of Managed Health Care (DMHC) on January 12, 2024 and repeals and replaces previous Rule 1300.74.72. Effective April 1, 2024, Rule 1300.74.72 requires, in part, health care service plans, like Carelon, maintain a provider network sufficient to provide all medically necessary services, including services to treat mental health and substance use disorders (MH/SUD), within geographic and timely access standards. If Carelon is unable to demonstrate that it is able to offer an in-network appointment within timely and geographic access standards, Carelon shall provide and arrange coverage for medically necessary MH/SUD services from an out of network provider or providers.

Further, Rule 1300.74.72(c)(3) requires Carelon to schedule the appointment or arrange for the admission with the out-of-network provider for an enrollee within the following timeframes, unless 1367.03(a)(5)(H) or (a)(5)(I) apply:

- No more than 10 business days after the initial request for non-urgent MH/SUD services
- Within 15 business days of a request for a specialist physician MH/SUD services
- Within 48 hours of the initial request for urgent MH/SUD services if no prior authorization is required
- Within 96 hours of the initial request for urgent MH/SUD services if prior authorization is required

Providers are contractually required to notify Carelon in the event that Provider (a) is no longer accepting new Members; (b) is available during limited hours or only in certain settings; (c) has any other restrictions on treating Members; or (d) is temporarily or permanently unable to meet the above standards above for appointment access. CAQH Participating Providers can update this information at https://proview.caqh.org/login/. Non-CAQH Participating Providers can update this information by logging in to the Carelon Provider Portal at https://providerportal.carelonbehavioralhealth.com/index.html#/login.

The full language of the regulation can be found at https://wpso.dmhc.ca.gov/regulations/docs/regs/57/1705417175168.pdf

UPDATE ON CARELON ASSOCIATE CREDENTIALING AND BILLING GUIDELINES

As of January 1, 2024, Carelon Behavioral Health aligned its credentialing policy with the National Committee for Quality Assurance (NCQA) and will no longer require practitioners who are under the direct supervision of a clinician to be credentialed. Associate marriage and family therapists, associate professional clinical counselors, associate clinical social workers and psychology assistants may render psychotherapy services under a Carelon credentialed supervising clinician. The claim must list the associate or assistant's name in the Additional Claim Information field (Box 19) along with the supervising clinician's National Provider Identifier (NPI) number as the "billing provider".

Q: Do I need to notify Carelon of new associates?
A: No. Carelon does not publish associate information in the Provider Directory, therefore no notification is required.

Q: Can an associate submit claims as the "billing provider"?
A: No. Carelon has adopted the Department of Health Care Services (DHCS) billing guidelines. Claims billed by clinicians under the direct supervision of a clinician as the "billing provider" will be denied.

Q: My associate was credentialed prior to January 1, 2024. What will happen next?
A: Carelon will retain the credentialing profile for an associate until the next credentialing cycle or until the associate becomes fully licensed, whichever happens first. Associates who do not become fully licensed within three years of their initial credentialing date will be removed from Carelon's credentialing system and can continue to render psychotherapy services under a supervising clinician.

2024 MEDICAL NECESSITY CRITERIA- CALIFORNIA

Carelon Behavioral Health of California, Inc. is a professional corporation duly organized under the laws for the State of California and operated as a Behavioral Health Knox-Keene Licensed Health Plan, which enters into agreements with organizations such as managed health care service plans, employer groups, preferred provider organizations, exclusion provider organizations and other purchases of medical services (collectively referred to as "Plans") for the arrangement of the provision of health care services to subscribers or members of the Plans. Carelon Behavioral Health provides Utilization Management for Mental Health services and Substance Use related conditions. Medical Necessity Criteria can vary according to individual contractual obligations, state/ federal requirements and member benefit coverage. Carelon Behavioral Health uses the following as a guide based on plan type and the type of service being requested:

1. For all Medicare members, identify relevant Centers for Medicare and Medicaid (CMS) National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.
2. If no CMS criteria exists for Medicare members, Change Healthcare's Interqual® Behavioral Health Criteria or MCG would be appropriate.
   * Exceptions if criteria sets not found in 1 or 2 above:
     - Either Carelon Behavioral Health of California's Medical Necessity Criteria or relevant Elevance Clinical UM Guidelines may be appropriate to use.
3. For **behavioral health services**, custom criteria is often state or plan/contract specific:

- California Commercial Plans utilize LOCUS, CALOCUS-CASII and ECSII criteria.
  * Exceptions for Commercial plans due to there being no non-profit criteria currently available:
    - InterQual® Behavioral Health Criteria or Elevance Clinical UM Guidelines are utilized for Behavioral Health Treatment (BHT) services.
    - MCG may be used for Transcranial Magnetic Stimulation (TMS) services
- County Medi-Cal Plans utilize:
  Specialty Mental Health Services (SMHS): Title 9 California Code of Regulations
  Non-Specialty Mental Health Services (NSMHS): The most current guidance provided by the state's All Plan Letter.
  * Exceptions for Medi-Cal plans due to there being no non-profit criteria currently available:
    - InterQual® Behavioral Health Criteria or Elevance Clinical UM Guidelines are used for Behavioral Health Treatment (BHT) services.

4. For **substance use related services**, Carelon Behavioral Health of California uses the American Society of Addiction Medicine (ASAM) criteria for all lines of business.
   * Exception for Medicare membership:
     - InterQual® Behavioral Health Criteria (Substance Use Lab Testing Criteria) and NCD criteria (Detoxification and/or Rehabilitation).

2024 Medical Necessity Criteria- California *continued*

Carelon Health IPA (CHIPA) is a professional corporation duly organized under the laws for the State of California and operated as an independent practice association, which enters into agreements with organizations such as health care service plans, preferred provider organizations, exclusion provider organizations and other purchases of medical services (collectively referred to as "Plans") for the arrangement of the provision of health care services to subscribers or members of the Plans. CHIPA provides Utilization Management for Mental Health services and Substance Use related conditions. Medical Necessity Criteria can vary according to individual contractual obligations, state/ federal requirements and member benefit coverage. CHIPA uses the following as a guide based on plan type and the type of service being requested:

1. For all Medicare members, identify relevant Centers for Medicare and Medicaid (CMS) National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.
2. If no CMS criteria exists for Medicare members, Change Healthcare's InterQual® Behavioral Health Criteria would be appropriate.
   * Exceptions if criteria sets not found in 1 or 2 above:
   - CHIPA's Medical Necessity Criteria may be appropriate to use.
3. For **behavioral health services**, custom criteria is often state or plan/contract specific:

➢ California Commercial Plans utilize LOCUS, CALOCUS-CASII and ECSII criteria.
   * Exceptions for Commercial plans due to there being no non-profit criteria currently available:
   - InterQual® Behavioral Health Criteria are used for Behavioral Health Treatment (BHT) services.

➢ County Medi-Cal Plans utilize:
Specialty Mental Health Services (SMHS): Title 9 California Code of Regulations
Non-Specialty Mental Health Services (NSMHS): The most current guidance provided by the state's All Plan Letter.
   * Exceptions for Medi-Cal plans due to there being no non-profit criteria currently available:
   - InterQual® Behavioral Health Criteria are used for Behavioral Health Treatment (BHT) services.

4. For **substance use related services**, CHIPA uses the American Society of Addiction Medicine (ASAM) criteria for all lines of business.
   * Exception for Medicare membership:
   - InterQual® Behavioral Health Criteria is used for Substance Use Lab Testing.

Carelon Behavioral Health of California and CHIPA have adopted the World Professional Association for Transgender Health (WPATH) Standards of Care as a practice guideline for individuals with Gender Dysphoria.

An updated copy of the criteria is available on your health plan's website.
» Carelon Behavioral Health of California at www.carelonbehavioralhealthca.com/medical-necessity-criteria
» CHIPA at www.chipa.com/providers

Providers from either health plan can also email provider.inquiry@carelon.com to request a printed copy of the appropriate MNC, free of charge, or contact your health plan at:
» Carelon Behavioral Health of California at (800) 228-1286
» CHIPA at (833) 969-2190

NCQA ACCREDITATION REQUIREMENTS

The National Committee for Quality Assurance (NCQA) accreditation standards (MBHO 2024 Standard UM2 Element A, Factor 4: Involves appropriate practitioners in developing, adopting, and reviewing criteria) requires accredited health plans to seek annual non-staff network practitioner feedback on the development, adoption and review of clinical criteria used to make utilization management decisions:

"Non-staff network practitioners must also be involved in developing, adopting, and reviewing criteria, because they are subject to application of the criteria. The organization may have practitioners review criteria if it does not develop its own UM criteria and obtains criteria from external entities."

Practitioners with clinical expertise in the use of criterion sets used by Carelon Behavioral Health of California and Carelon Health IPA of California are asked to provide commentary on either the development and adoption of these criterion sets, or on the instructions for applying these criterion sets.

- **Carelon Behavioral Health of California MNC**
- **Carelon Health IPA of California MNC**

**Disclosure Statement: All feedback and recommendations about the medical necessity criteria (MNC) will be aggregated and shared in a de-identifiable format with the organization, governmental entity or 3rd party vender that issued the MNC.*

The following questions may help to guide provider feedback but are not meant to be limiting
(please identify which criteria set you are referencing)

1. Do you use the criteria when requesting prior authorization or concurrent review?
2. Do you have any suggestions for improving either one or both of the medical necessity criteria noted above?
3. Have you had any difficulty using either one or both of the medical necessity criteria?
4. Is there any new scientific evidence that would support a change to either one or both of the existing criteria?
5. Any additional comment/feedback on either one or both of the medical necessity criteria noted above?

Submit comments or feedback to:
provider.inquiry@carelonbehavioralhealthca.com

TAKE THE SURVEY ON TIMELY ACCESS

Kaiser Permanente administers the Provider Appointment Availability Survey (PAAS) annually to assess our network's ability to provide care within timely access standards.

Some providers will receive a survey by email. If there is no response within 5 business days, providers will receive a survey call. **Kaiser Permanente and Carelon require your participation in PAAS to meet regulatory requirements. Repeated non-responses by your group will result in corrective action by Carelon.** You may receive survey requests from multiple health plans.

Telehealth appointments demonstrate the means to provide timely access and should be included in your responses.

Timely access standards monitored through the PAAS include:

Urgent Care Appointments	**Wait Times**
Services that do not require prior authorization (PA)	48 hours
Specialty services that require PA	96 hours
Non-Urgent Care Appointments	**Wait Times**
Non-Physician Mental Health Providers	10 business days
Follow-Up Care Appointments	**Wait Times**
Mental Health/Substance Use Disorder	10 business days

CREATING A CULTURE OF CELEBRATION

In 2023, Carelon Health of Pennsylvania focused greatly on *creating a culture of* ***communication*** with our targeted and archived provider alerts, a new and improved quarterly newsletter, invitations to Orientation Groups for new provider staff not just new providers and our partnership visits designed to support the success of our provider network.

As we look to 2024, you'll see our efforts expand to *creating a culture of* ***celebration***!

Is there a team or program you would like to celebrate? Are you producing outcomes that are making a positive impact on our members? Is there a service delivery that is new and innovative that you believe will produce a positive impact? Are you successfully collaborating with our members' physical health provider/s? If so, I encourage you to share your outcomes, stories, and the stories behind the stories.
Our partnership is a shared journey; we look forward to learning from you and celebrating with you.

Please remit your submissions to
providerrelationsgeneralinbox@carelon.com

Celebrating Carelon Staff Recognition!

We were thrilled to learn that Mental Health Association of Washington County recognized our very own Sue Klaus as the recipient of the Robert A. Harms Professional of the Year. As the Manager of Prevention, Education & Outreach, Sue has managed Carelon's educational programs by incorporating lived experience and member voice into a meaningful education culture that includes a wellness and recovery focus. A well-deserved honor as we also remember Bob Harms and the impact he had on Washington County and the greater community.

REMINDER TO SCREEN EMPLOYEES AND CONTRACTORS

MA Bulletin 99-11-05 requires all providers to screen employees and contractors at the time of hire and on a monthly basis. Subsequently, MA Bulletin 99-11-05 and Carelon Health of Pennsylvania requires all providers to include and document the following processes with the providers' compliance programs:

1. Develop policies and procedures for screening of all employees (including administrative staff) and contractors (both individuals and entities) at time of hire or contracting and, thereafter, on an ongoing monthly basis to determine if they have been excluded from participation in a federal health care program.
2. Use the following required databases to screen:
   - The Office of Inspector General's List of excluded Individual and entities https://oig.hhs.gov/exclusions/exclusions_list.asp
   - The General Services Administration's Excluded Parties List System ("EPLS") https://sam.gov/search/?index=ex&page=1&pageSize=25&sort=&sfm%5BsimpleSearch%5D%5BkeywordRadio%5D=ALL&sfm%5BsimpleSearch%5D%5BkeywordEditorTextarea%5D=&sfm%5Bstatus%5D%5Bis_active%5D=true&sfm%5Bstatus%5D%5Bis_inactive%5D=false
   - The Pennsylvania Department of Human Service Medicheck list of Precluded Providers https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/Medicheck-List.aspx
3. Immediately self-report any discovered exclusion of an employee or contractor, either an individual or entity, to Carelon Health of PA using the self-audit referral form under reporting procedures https://pa.carelon.com/fraud-waste-and-abuse/.
4. Develop and maintain auditable documentation of screening efforts, including for each employee: dates the screenings were performed and the source data checked and its date of most recent update.
5. Periodically conduct self-audits to determine compliance with this requirement.

XYLAZINE

Xylazine is a drug that was first developed as a sedative for animals. It is also known as “tranq,” “zombie drug,” or, “sleep cut”. It is a very strong medicine used by veterinarians to relax or sedate large animals like horses. It has been found in the supply of street drugs. It is often found in combination with the drug fentanyl.

In June of 2023, The PA Department of Health reported:

- As of May 2023, Xylazine was reported to have contributed to 644 deaths in PA. An increase of 1000% since 2018.
- Healthcare providers should be ready to respond to wound care or overdose response caused by the use of Xylazine.
- Use naloxone to reverse any suspected overdose.

Xylazine Facts

- Xylazine can cause drowsiness, unresponsiveness, low blood pressure, slowed heart rate and decreased breathing.
- Xylazine has only been approved by the Food and Drug Administration for use in animals.
- Xylazine is often mixed with fentanyl. Although Fentanyl is a long-acting opioid, adding Xylazine makes it last even longer.
- Most people do not know Xylazine is in the drugs they buy.
- You can overdose on Xylazine.
- Xylazine is not an opioid. Naloxone (Narcan) does not reverse its effects. Since Xylazine is almost always found with opioids – if you think someone is having an overdose, give them Narcan, lay them on their side and call 911. The Narcan will reverse the effects of the opioids, even if the person is drowsy from the xylazine.
- People who regularly use Xylazine may develop skin ulcers and abscesses. Skin wounds caused by Xylazine use may worsen faster and take longer to heal

For additional information on xylazine, visit https://www.cdc.gov/drugoverdose/deaths/other-drugs/xylazine/faq.html

Sources:
https://www.health.pa.gov/topics/Documents/HAN/2023-705-6-15-ADV-Xylazine.pdf
https://www.nyc.gov/assets/doh/downloads/pdf/basas/xylazine-faq.pdf

VICARIOUS TRAUMA

Vicarious Trauma is also known as “compassion fatigue.”

How does it happen?

- Listening to individuals talk about their own trauma.
- Seeing a traumatic scene
- Hearing about or responding to traumatic events.
- Obsession with social media or the news.

Who can it effect?

- Police
- Emergency Medical Services
- Medical staff
- Mental Health and other professions

Symptoms may include but are NOT limited to

- Problems with emotions and feeling numb.
- Being tired, not sleeping or having problems falling asleep.
- Physical problems (aches, pains, increased sickness).
- Irritable
- Easily distracted.
- Worrying that the trauma may happen to them or a loved one.
- Feeling like there is no hope.
- Avoiding things that make them happy or that they enjoyed before.
- A combination of symptoms that may lead to Post traumatic stress disorder (PTSD)

Suggestions to Cope

- Talking to professionals who have experience in vicarious trauma treatment.
- Home and work balance
- Basic needs like sleep, healthy eating, hygiene, and exercise
- Getting support from family, friends, and coworkers.
- Limit watching the news or social media.
- Relaxing methods; as yoga, meditation or writing in a journal.

Resources and additional information on Vicarious Trauma:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8925925/
https://ovc.ojp.gov/program/vtt/what-is-vicarious-trauma

ADVANCE DIRECTIVES FREQUENTLY ASKED QUESTIONS

Q. What is a Mental Health Advance Directive?
A. A Mental Health Advanced Directive is a document that allows a person to make preferences regarding mental health treatment known in the event that the person is incapacitated by his/her mental illness. In effect, the person is giving or withholding consent to treatment in advance of when treatment is needed. This allows a person to make more informed decisions and to communicate his/her wishes more clearly. A new law was passed in Pennsylvania, effective January 28, 2005, that makes it possible for a person to make and enforce a mental health advance directive. Pennsylvania law allows for three types of mental health care advance directive: a declaration, a power of attorney, or a combination of both.

Q. What are my responsibilities as a provider?
A. You must do the following things:

- Inquire whether or not a person has a mental health care advance directive.
- Inform people who are being discharged from treatment about mental health care advance directives as part of discharge planning.
- You may not choose whether to accept someone as a patient based solely on the existence or absence of a mental health care advance directive.
- Upon notification of the existence of an advance directive, you must place a copy in the person's mental health care record.
- You must make any revocation or amendments part of the person's mental health care record.
- You must comply with the instructions unless the instructions are contrary to accepted clinical practice and medical standards or because medical treatment is unavailable, or if the policies of the provider preclude compliance.
- If you are the mental health care provider that makes a determination regarding capacity to mental health care decisions, you must make that determination part of the person's mental health record.

Advance Directives Frequently Asked Questions *continued*

Q. What if I can't comply with the instructions in the mental health care advance directive?
A. As soon as the possibility of non-compliance becomes apparent, you must inform the person, agent, guardian, and/or any other legal representative. It may be possible to discuss and resolve the issue with the person or agent. If compliance is still not possible, you must make every reasonable effort to transfer the person to another mental health care provider who will comply with the instructions. While the transfer is pending, you must treat the patient in a way consistent with his/her advance directive. If all efforts to transfer fail, you may discharge the patient.
Remember that just because consent is provided in advance to a particular medication or treatment, that you will not prescribe that treatment or drug unless it is appropriate treatment at the time of the person's illness. Consent only means that consent is given to treatment if it is a suitable choice at that time within the standards of medical care. You will also have to consider if a particular treatment option is covered by the person's insurance. If, for example, the HMO does not cover a certain drug on its formulary, you may prescribe a drug that is similar, but is on the HMO formulary (unless the person has specifically withheld consent to that drug).

Q. What if compliance with the instructions could cause irreparable harm or death?
A. You may file a petition with the court seeking a determination that following the instructions may cause irreparable harm or death. The court may invalidate some or all of the provisions of the mental health advance directive and issue an appropriate order within 72 hours from the filing of the petition. Even if the court invalidates some of the provisions of the directive, the remaining provisions will remain in effect.

Q. What if there is a conflict with instructions in another power of attorney or declaration?
A. If there is a conflict, the provisions of the document latest in date of execution must be followed.

Q. How does a Mental Health Advance Directive affect commitment under the Mental health Procedures Act?
A. The voluntary and involuntary commitment provisions of the Mental Health Procedures Act are not affected by having a mental health care advance directive. What is affected is the provision of treatment after a person is committed.

*Instructions and forms for Mental Health Advanced Directives for Pennsylvanians https://www.dhs.pa.gov/docs/For-Providers/Documents/Behavioral%20Health%20Services/Instructions%20%20Forms%20-%20English.pdf

FOLLOW-UP CARE FOR CHILDREN WITH ADHD

We are continuing to focus on maintaining Parkland Community Health Plan's high rating for FOLLOW UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (HEDIS® ADD) MEASURE.

What is the HEDIS® ADD measure looking at?

The rate of members aged 6 – 12 on ADHD medication who had at least 3 follow up care visits within 10 months (one within 30 days) of the first ADHD medication being dispensed.

There are two best-practices being evaluated:

- Initiation Phase: Members receiving a follow up visit with a prescribing provider within 30 days of receiving their medication.
- Continuation & Maintenance Phase: Members who continue taking ADHD medication during the nine months after the initiation phase and receiving two additional follow up visits within those nine months.

What can providers do to help improve HEDIS® ADD rates?

- Monitor dosage of meds after 30 days to make adjustments if needed.
- Remind patients of their follow up appointments.
- Explain to parents the medication options and side effects to come to a joint agreement on a treatment plan.
- Discuss behavioral therapy, psychotherapy, family therapy, support groups, social skills training and/or parenting skills training in addition to medication therapy.
- Promote continuity of care between primary care physicians, other providers and schools to ensure quality healthcare.
- Use telehealth and telephone visits, where appropriate, when in-person services are not possible or telephone services are preferred

SUBSTANCE USE MEDICAL NECESSITY CRITERIA

In accordance with the repeal of the Texas Administrative Code Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency (Title 28, Part 1, Chapter 3, Subchapter HH), Carelon will transition to the American Society of Addiction Medicine's (ASAM) Medical Necessity criteria, 3rd Edition beginning June 12, 2024. Carelon will continue to use InterQual for mental health medical necessity decisions.

LPC AND LMFT PROVIDERS MUST ENROLL IN MEDICARE EFFECTIVE MARCH 1, 2024

New Medicaid Providers

Newly enrolling LMFT and LPC providers and those with any pending PEMS enrollment applications (New, Revalidation, Reenrollment, and Existing) submitted before March 1, 2024, will be required to respond to the Enrolling with Medicare question and provide their Medicare information under the Program Specifics Questions section of the Program and Service Participation Details page within PEMS or submit a Medicare Waiver Request.

Existing Medicaid Providers

Existing LMFT and LPC Texas Medicaid providers that provide services to dually eligible clients will be required to respond to the Enrolling with Medicare question during their revalidation period or submit a Medicare Waiver Request. The Medicare question can be found under the Program Specifics Questions section of the Program and Service Participation Details page within PEMS. LMFTs and LPCs must provide their Medicare information through an Existing Enrollment to continue providing services to dually eligible clients.
For more information, call the TMHP Contact Center at 800-925-9126.

LPC and LMFT Providers Must Enroll in Medicare Effective March 1, 2024 | TMHP

TEXAS MEDICAID PROVIDERS THAT HAVE NOT COMPLETED THE MEDICAID REVALIDATION PROCESS BY THEIR DEADLINE WILL BE DISENROLLED

Providers must complete their revalidation enrollment before the end of their enrollment period. Providers that have not completed the revalidation process by their deadline will be disenrolled from all Texas state health care programs.

The disenrollment date will be the revalidation expiration date and not a future date.
Providers can revalidate their enrollment in the Provider Enrollment and Management System (PEMS) up to **180 **calendar days** before their current revalidation due date.

Providers may find more information and begin their revalidations in PEMS through the TMHP website How To Apply for Enrollment page under “Determine Your Application Type.”

Texas Medicaid Providers That Have Not Completed The Medicaid Revalidation Process By Their Deadline Will Be Disenrolled *continued*

Important: Email Validation

To ensure that enrollment notifications are sent to the correct person, confirm that your email address is up to date in PEMS. The Provider Information tab of your National Provider Identifier (NPI) Enrollment Record displays an email address field.

Providers can access Verifying An Email In PEMS.

To learn more about revalidation and the end of the COVID-19 public health emergency (PHE), refer to the web article that was posted to tmhp.com on March 4, 2023.

For more information, call the TMHP Contact Center at 800-925-9126.

More information can be found by visiting Providers That Have Not Completed the Revalidation Process By Their Deadline Will Be Disenrolled | TMHP

** Effective May 31, 2024, the provider enrollment revalidation timespan has been extended from 120 days to 180 days. Providers can now revalidate their enrollment in the Provider Enrollment and Management System (PEMS) up to 180 days before their revalidation due date.
Due to this change, updates are made to the timeline of the revalidation notifications that are sent to providers. Providers will now receive a 180-day notification to inform them that revalidation is open. Additional reminders will be sent 120, 90, and 45 days before the revalidation due date.

To receive the revalidation reminder notifications through email, providers should ensure that the email address in their PEMS profile is current. To update the email address, providers should enter their Enrollment Record in PEMS, select **Edit Enrollment Record** on the top header, and select **Create Request** for the request type of Maintenance – Provider Information – Change Email.

For more information, call the TMHP Contact Center at 800-925-9126.

OPT OUT NOTICE: MEDICAID MATERNAL MENTAL HEALTH TREATMENT NETWORK

In accordance with Senate Bill (S.B.) 750, 86 Legislature, Regular Session, 2019, HHSC established MCO requirements around the referral of members with MMH conditions to an identified network of maternal mental health providers.

HHSC is allowing for a phased approach for MCOs to identify and add providers to their MMH treatment networks. Phase 1 must be implemented by **July 26, 2024**, and includes listing behavioral health providers who have been identified to serve women with MMH conditions in MCOs' online provider directories and informing impacted providers.

The goal of the MMH treatment network is to increase the accessibility of clinical postpartum services for Medicaid members, ultimately improving maternal health outcomes and promoting overall well-being for mothers and their families. To help achieve this goal, MCOs and providers will collaborate to facilitate the referral of members who screen positive for a MMH condition to identified MMH providers in their Networks to confirm diagnosis and provide treatment as deemed medically necessary. Further information around MMH implementation requirements can be found in the UMCM 3.34 Online Provider Directory and UMCM Chapter 16.1.15.3.9 Maternal Mental Health Treatment Network.

ACTION:

- If you agree to be designated as a MMH provider, you don't need to take any action at this time. We will follow up with you for the next steps.
- If you want to opt out of providing MMH services, please notify Carelon by July 5, 2024.
  - To opt out, please contact TexasProviderRelations@carelon.com

NOTE: Informing Carelon that you don't want to provide MMH services after July 5, 2024, will result in your being noted as a MMH Provider in the online provider directory of Carelon, until the directory can be updated.

If you participate in multiple networks, you'll need to follow up with each of one of them separately.
Please direct questions about this notice to TexasProviderRelations@carelon.com

TEXAS MEDICAID CODE UPDATES

Effective for dates of service on or after March 1, 2024, substance use disorder procedure code J0570 is no longer a benefit of Texas Medicaid.

The following Texas Medicaid rates changed effective 3/1/2024

Posted rates can be found here: [FeeSchedules (tmhp.com)]

PROC CODE	FEE CHANGE
90791	Decrease
90792	Increase
Q3014	Increase
90833	Increase
90836	Increase
90838	Increase
90847	Increase
96116	Decrease
96121	Decrease
96132	Increase
96133	Decrease
96136	Decrease
96137	Decrease
H0038HQ	Increase
H0038	Increase
H0033U1	Decrease
H0033UA	Decrease
J2315	Increase
Q9991	Increase
Q9992	Increase