Provider Alert #5

April 18, 2023

Preparations for End of National Public Health Emergency

HealthChoices Contracts:

All HealthChoices contracts and UPMC lines of business.

Scope: This Provider Alert applies to all contracted providers.

Purpose: To inform providers about the Department of Human Services (DHS) guidance regarding preparation for the end of the national public health emergency on May 11, 2023.

Pennsylvania is preparing for the end of the national public health emergency on May 11, 2023. The national public health emergency has been in place since the beginning of the COVID-19 pandemic. We continue to partner with our Primary Contractors/county partners and OMHSAS in monitoring the needs of our shared HealthChoices members. We appreciate and acknowledge provider efforts and commitment to creativity in providing access and delivering essential behavioral healthcare to our members during the COVID-19 crisis and beyond.

Although regulatory changes to the waiver are being reinstated on May 11, Community Care will allow a 30-day grace period for all services to return to routine business by June 11, 2023. Following June 11, 2023, we will return to regular practice of issuing Procedural Noncompliance (PNC) denials for untimely or late submissions. Any questions related to Procedural Noncompliance, see our Provider Manual.

Notification/Prior Authorization

To ensure members' timely access to care, and to support providers given the administrative challenges during the COVID-19 pandemic, Community Care suspended certain prior authorization requirements for services.

Effective May 11, 2023, Community Care will continue notification protocol for hospital-based services (IPMH, ASAM Level 4) and non-hospital SUD residential settings (3.7WM, 3.7, 3.5, 3.1) as well as Diversion & Acute Stabilization (DAS), Crisis Residential, Extended Acute and RTF-A. **Community Care will not return to prior authorization for these levels of care.** Community Care will continue to support access for members through the provider notification process, and also

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continue to support initiatives related to monitoring and coordinating care.

In order to ensure continuation of care coordination, high risk monitoring, and discharge planning, we request providers notify Community Care of admission and discharge for the levels of care listed above. This will also facilitate our efforts to engage and support these members after discharge.

Providers will receive a Procedural Non-Compliance (PNC) for notifications made **after 1 calendar day** for 3.7WM (e-Portal) and **after 1 business day** for all other levels of care identified above as a requirement for payment.

Notifications must include, **at minimum**, the following information:

- Facility Location and Address
- Member First and Last Name
- Member MA ID Number
- Member DOB
- Admission Date and Time
- Admitting Diagnosis
- Admitting Physician
- Level of Care Request
- Brief Summary of Admitting Presentation, including assessment of dangerousness
- Commitment Status
- Community Supports
- Legal Parent/Guardian Information
- Social Determinants of Health Factors
- Co-occurring disorders

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NOTE: Additional clinical information will be collected for Out of Network Providers and complex bed searches. This is true regardless of network inclusivity in a different contract.

Community Care care managers and customer service will remain available 24 hours a day, 7 days a week. Care Managers will continue to perform concurrent review; however, reviews will be used to check in and support provider staff with barrier elimination, coordination of care, securing resources, ensuring members and families have access to needed behavioral health services at discharge, as well as confirm medical necessity.

Other Levels of Care Previously Impacted by the PHE/1135 Waiver:

- Services authorized via Community Care's ePortal remain unchanged.
- Community Care will continue to accept information electronically as indicated in Community Care Provider Alert #5 (submission via secure email or fax).
- Family Based will return to prior authorization and not notification. Please see our Family Based Precertification Request Form.
- Prior authorization for Out of Network (OON) Services are required.
- For all other services not identified in this or prior alerts, the review process will remain unchanged.

Intensive Behavioral Health Services (IBHS)

Intensive Behavioral Health Services packets return to full requirements, which can be reviewed in the IBHS Procedures and Authorization Process document on the IBHS section of our provider site.

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1. An IBHS Individualized Treatment Plan (ITP) is required as part of the IBHS packet when requesting IBHS services, i.e., an initial, amended and/or continued stay IBHS authorization.

2. Amended IBHS Service Requests - The following procedures and documentation are required within the timeframes indicated below for an amended IBHS service request:
    - The existing Valid Written Order prescribing IBHS is no more than 12 months prior to the start date of the Amended Plan of Care (POC) time period *and, when necessary*, a Prescriber Collaboration Form
    - The existing Valid Full Formal Assessment *including* the Reassessment performed is no more than 45 days prior to the start date of the Amended POC time period, which provides clear documentation to demonstrate:
        - That significant progress has been made with IBHS thus demonstrating IBHS is an effective treatment for the member; *and,*
        - The need for a new service and/or an increase in services to:
            - reduce a member's new or existing Behavioral Health (BH) symptoms; and/or,
            - enhance member, parent/guardian and/or caregiver skill building, behavior change, generalization or independent use of skills or protocols which have been *demonstrated as effective by the data*

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- An updated ITP completed no more than 45 days prior to the start date of the Amended POC time period that clearly illustrates the following:
    - The progress made to date with IBHS services; and,
    - Evidence of changes to interventions/protocols which have not resulted in significant progress towards goal attainment over any 90-day period during IBHS treatment; and,
    - The methods/interventions/protocols aimed at addressing new or existing BH symptoms, behaviors targeted for change or skill deficits with IBHS services; and,
    - A titration plan aimed at enhancing and supporting member, parent/guardian and/or caregiver independent use of skills/protocols which have been *demonstrated as effective by the data*.
- An Amended POC requesting only the new service(s) and/or increase in service hours/month that ends on the same date as the current authorization period.
- The Amended Packet must be submitted to Community Care prior to the start date of the POC for the amended request.

3. Continued Stay IBHS Service Requests - The following procedures and documentation are required within the timeframes indicated below for a continued stay IBHS service request:
    - A Valid Written Order prescribing IBHS no more than 12 months prior to the start date of the Continued Stay POC *and when necessary*, a Prescriber Collaboration Form
    - A Valid Full Formal Assessment (FFA) completed no more than 45 days prior to the start date of the

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Continued Stay POC *OR* the existing Valid FFA completed no more than 45 days prior to the initiation of the continued services request and a reassessment completed no more than 45 days prior to the start date of the Continued Stay POC, that provides clear documentation to demonstrate:

- That significant progress has been made with IBHS thus demonstrating IBHS is an effective treatment for the member; *and,*
- The need for continued IBHS services to:
  - reduce a member's new or existing BH symptoms; and/or,
  - enhance member, parent/guardian and/or caregiver skill building, behavior change, generalization or independent use of skills or protocols which have been *demonstrated as effective by the data*

- An updated ITP completed no more than 45 days prior to the start date of the Continued Stay POC, that clearly illustrates the following:
  - The progress made to date with IBHS services; and,
  - Evidence of changes to interventions/protocols which have not resulted in significant progress towards goal attainment over any 90-day period during IBHS treatment; and,
  - The methods/interventions/protocols aimed at addressing new or existing BH symptoms, behaviors targeted for change or skill deficits with IBHS services; and,
  - A titration plan aimed at enhancing and supporting member, parent/guardian and/or caregiver independent use of

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skills/protocols which have been *demonstrated as effective by the data*

- A Continued Stay POC requesting services in an hr/per/month format for up to 12 months
- The Continued Stay Packet must be submitted to Community Care no sooner than 45 days and at least 14 days prior to the LCD of the current service period

If there are questions on authorization requirements, timeframes, timely filing, or any other question, please contact the Community Care provider line at 1.888.251.2224, reference our Guidelines for Obtaining Approval, or contact your Provider Relations Representative.

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