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Second Quarter 2025

Carelon Behavioral Health Provider Newsletter

Contents

NEW UPDATE: ACCESS THE LATEST CARELON BEHAVIORAL HEALTH PROVIDER HANDBOOK

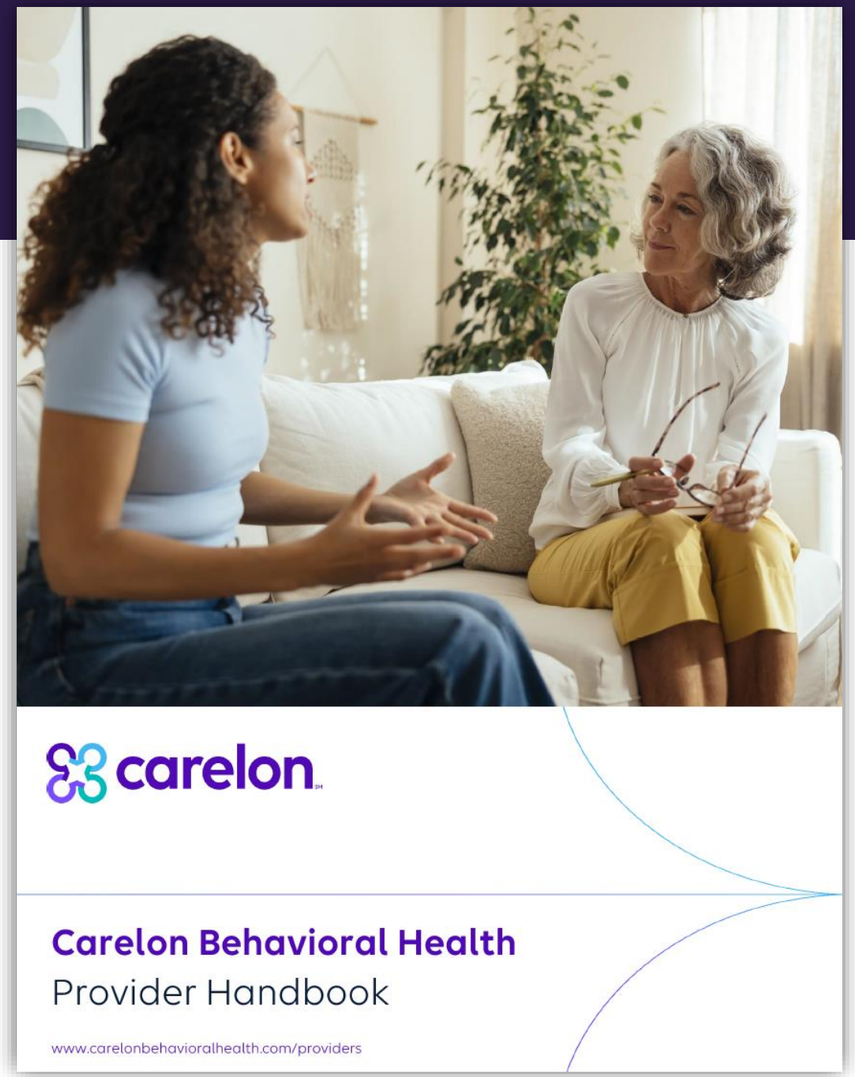
We are pleased to announce that the updated Carelon Behavioral Health Provider Handbook is now available on our website. Designed with your needs in mind, this comprehensive resource covers essential information about our standard policies and procedures, clinical utilization management guidelines, medical necessity criteria, and claim submission guidelines, among other topics.

Our goal is to make your interactions with us as seamless as possible, allowing you to concentrate on delivering exceptional patient care. To ensure you are fully informed, we encourage you to thoroughly review the national handbook as well as any state-specific handbooks applicable to your practice.

For any questions, comments, or suggestions regarding the handbook, please contact our National Provider Services Line at 800-397-1630. Our team is available to assist you Monday through Friday, from 8 a.m. to 8 p.m. Eastern time.

We appreciate your partnership and dedication to patient care. Don't forget to check out the updated handbook today!

Visit www.carelonbehavioralhealth.com/providers/resources/provider-handbook to access our provider handbook.



Click here to access our provider handbook

SIMPLIFY BUSINESS WITH US VIA AVAILITY ESSENTIALS – *YOUR PROVIDER DIGITAL FRONT DOOR*

Availity Essentials is your comprehensive, secure, and self-service multi-payer portal, designed to streamline the day-to-day operations of your office and enhance patient care. As a registered Availity user, you can efficiently handle multiple tasks such as checking patient eligibility and benefits, submitting authorizations, reviewing past authorization requests, and accessing detailed claim information— all without needing to contact Carelon Behavioral Health. **Best of all, registration is free, giving you immediate access to the array of resources Availity provides.**

We have recently introduced exciting new features to Availity, including:

- **Single Sign-On:** Gain easy access to Carelon portals directly through Availity.
- **Authorization Management Dashboard:** Effortlessly search for and request authorizations.
- **Claims Dashboard:** Quickly search for and review detailed claim information.
- **Message Center:** Manage all your web correspondence with us conveniently in one place.

Stay tuned for more innovative features coming soon, designed to make your interaction with us even more seamless!

New to Availity?

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 further assistance, contact Availity Client Services at 1-800-282-4548. Assistance is available Monday through Friday 8 a.m. – 8 p.m. ET.

ALL-IN-ONE ACCESS: HOW AVAILITY'S SINGLE SIGN-ON CONNECTS YOU TO CARELON

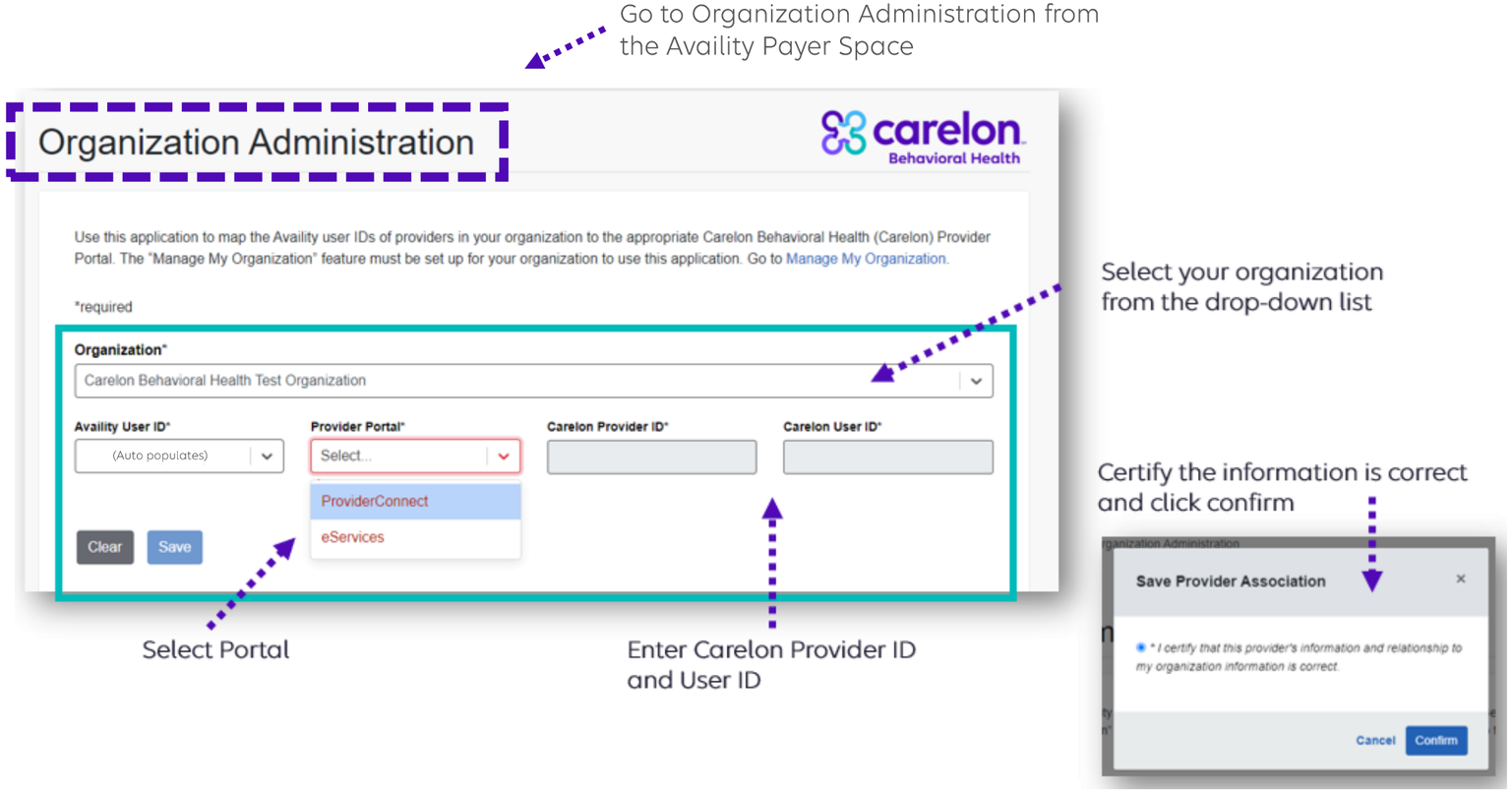
Availity's single sign-on, makes it easier for you to access features within Carelon portals (ProviderConnect / eServices)!

To simplify your access and set up single sign-on, please follow the five simple steps outlined below. Please note, you only need to do this once to establish single sign-on. These steps can only be completed if you are already registered with Availity and have a ProviderConnect / eServices account with us. If you are not yet registered with Availity or have a ProviderConnect / eServices account, please register before proceeding with the single sign-on setup.

**Only account administrators can link ProviderConnect / eServices to Availity

How to setup single sign-on via Availity

1. In the Availity Payer Space application, select **Organization Administration**
2. Select your **organization** from the drop-down list
3. Select **Portal** (ProviderConnect / eServices)
4. Enter Carelon **Provider ID** and **User ID**
5. Certify the information is correct and click **confirm**



Click here to register for ProviderConnect / eService

Click here to register for Availity

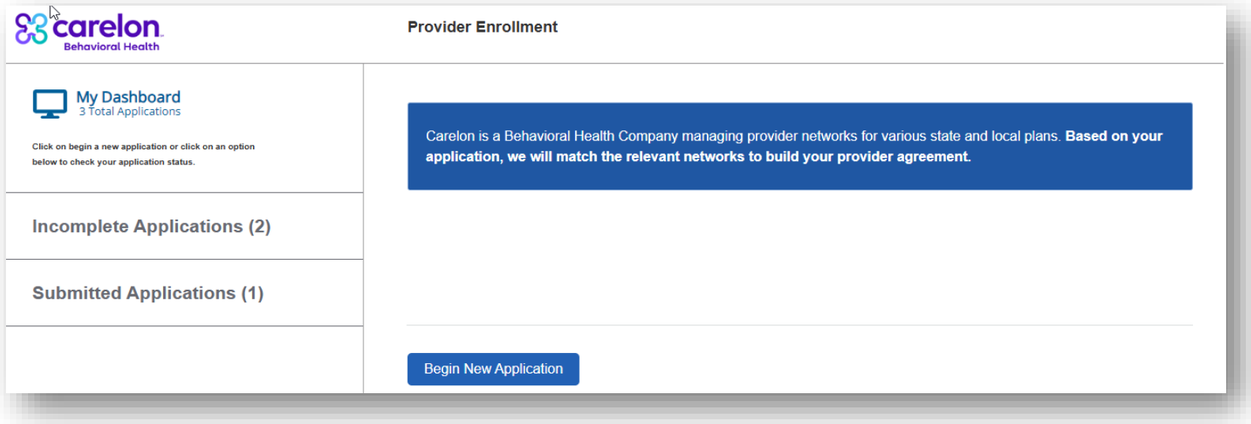
LAUNCH OF THE NEW CARELON BEHAVIORAL HEALTH ENROLLMENT APPLICATION

We are thrilled to announce the launch of our new Carelon Behavioral Health Enrollment Application, which went live in May 2025. In our continued effort to streamline and enhance the provider experience, we have introduced this new application within Availity Essentials, serving as Carelon's Provider Digital Front Door. This state-of-the-art application is designed to streamline the process for all providers wishing to join our network—whether as individuals, groups, or as a provider joining an existing group.

Providers must be registered with Availity to utilize this new enrollment process. If you have not yet registered, please visit Availity.com to register.

Key Highlights of the New Enrollment Application:

- **Standardized Application**: Our application now aligns more closely with CAQH data elements, ensuring a more consistent and simplified enrollment process.
- **Online Submission Using CAQH Information**: Providers can now conveniently submit their enrollment applications online, using pre-existing CAQH data. This feature is designed to save time and reduce redundancies.
- **Real-time Application Status**: Stay informed every step of the way! You can now view your application status as it progresses, including updates on credentialing and agreement status.



To access the Enrollment Application in Availity, **select your state** from the Availity homepage, then select the "**Carelon Behavioral Health**" **payer space** to access the **Provider Enrollment Dashboard**.

Welcome to a new era of simplified enrollment with Carelon Behavioral Health!

AVAILITY PAYER SPACE MESSAGE CENTER FUNCTIONALITY

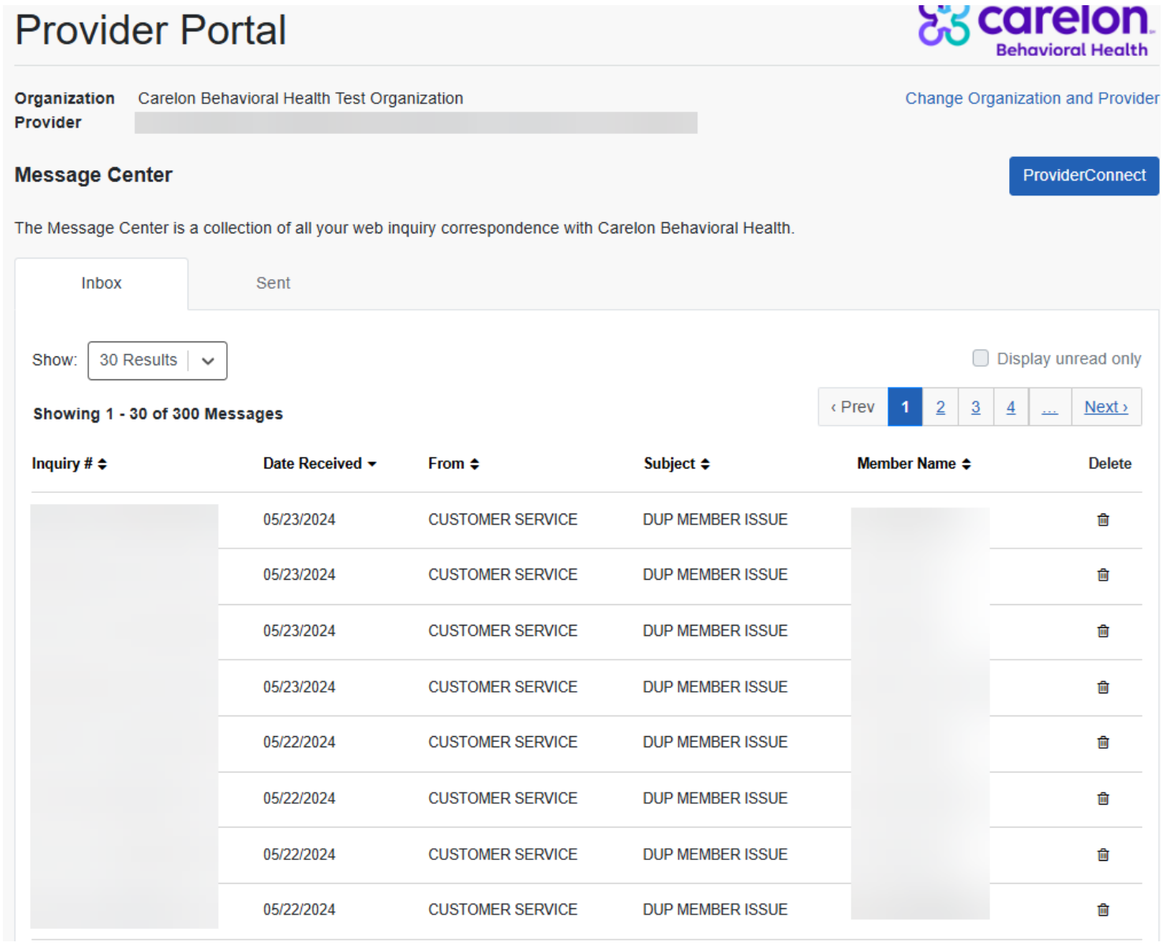
We recently introduced the Message Center as a new functionality within the Provider Portal payer space application. The Message Center is a collection of all your web inquiry correspondence with Carelon Behavioral Health. This new feature makes it easier for providers to access their web inquiry correspondence via the Availity payer space.

This functionality delivers quick access to previously submitted web inquires. Within the Message Center, you can also review responses from our team to your inquires.

For the Message Center, login to Availity and select **Payer Spaces** > **Provider Portal** > select your **Organization** and **Provider**. The Message Center Inbox and Sent tabs will show the same messages available in ProviderConnect. Upon clicking on the message, you will be able to view the message in Availity. Upon clicking "ProviderConnect" in the message, you will be directed to the ProviderConnect application, where you can respond or take any action on the message.

Please note: The Message Center is specific to ProviderConnect users

What is a web inquiry? Today, providers can send/initiate an inquiry for any of the functionalities they are using in ProviderConnect such as authorization, claims, member information (demographics, enrollment, etc.…). Our team receives and responds to these inquiries.



BIG CHANGE AHEAD: PAYMENTS TRANSITIONING TO ZELIS PLATFORM

Zelis recently acquired Payspan, combining two leaders in healthcare payments to create a more powerful and unified platform. As a result, Carelon Behavioral Health will transition its payment processing from Payspan to Zelis later this year. This change is designed to streamline your experience and provide faster, more secure access to payment data and remittances.

What you need to know:

- **For Providers Not Enrolled with Zelis**: To continue receiving your claim payment data and remittances electronically at no fee to you, please register through carelon.epayment.center or call 855-774-4392.
- **For Providers Already Enrolled with Zelis:** You'll continue to receive payments as usual – just log into the Zelis Portal to access your data and remittances. Need help? Call 877-828-8770 or email ClientService@zelispayments.com (8 a.m. – 7 p.m. ET, Mon – Fri).

Please note you will still be able to access historical payment data at payspanhealth.com.

Zelis will be reaching out directly with additional information and guidance to help you through this transition.

GET READY FOR EASIER ROSTER SUBMISSIONS – NEW AUTOMATION LAUNCHING FALL 2025

We're making it easier for you to submit and manage your rosters – less hassle, fewer errors, and quicker updates.

Beginning September 2025, Carelon Behavioral Health will launch a new automated roster solution designed to simplify and centralize roster submissions, starting with provider groups. Facilities will be included in the rollout shortly thereafter.

This upcoming enhancement will transform how we intake, process, and update provider data. By automating the intake of roster files, we'll reduce the manual effort – ensuring faster, more accurate updates to our core systems.

What this means for you:

- **Enhanced communications**: Automated email updates to keep you informed on progress
- **Faster turnaround:** Automation speeds up processing and integration
- **Higher accuracy:** Data errors and inconsistencies are minimized
- **One centralized intake:** A single, streamlined entry point for roster submissions

For providers with delegated credentialing, this means that your monthly delegated rosters will be loaded into our systems in a timely manner, and you'll receive feedback if a provider record cannot be created.

This is part of our broader effort to improve the provider experience, reduce administrative burdens, and ensure the data in our systems reflect your network accurately and efficiently. To fully benefit from this new automation, providers must adhere to roster data guidelines, ensuring seamless integration and processing.

***Stay tuned** – we'll be sharing more details soon, including how to prepare, training resources, and what to expect as we move toward the September launch.*

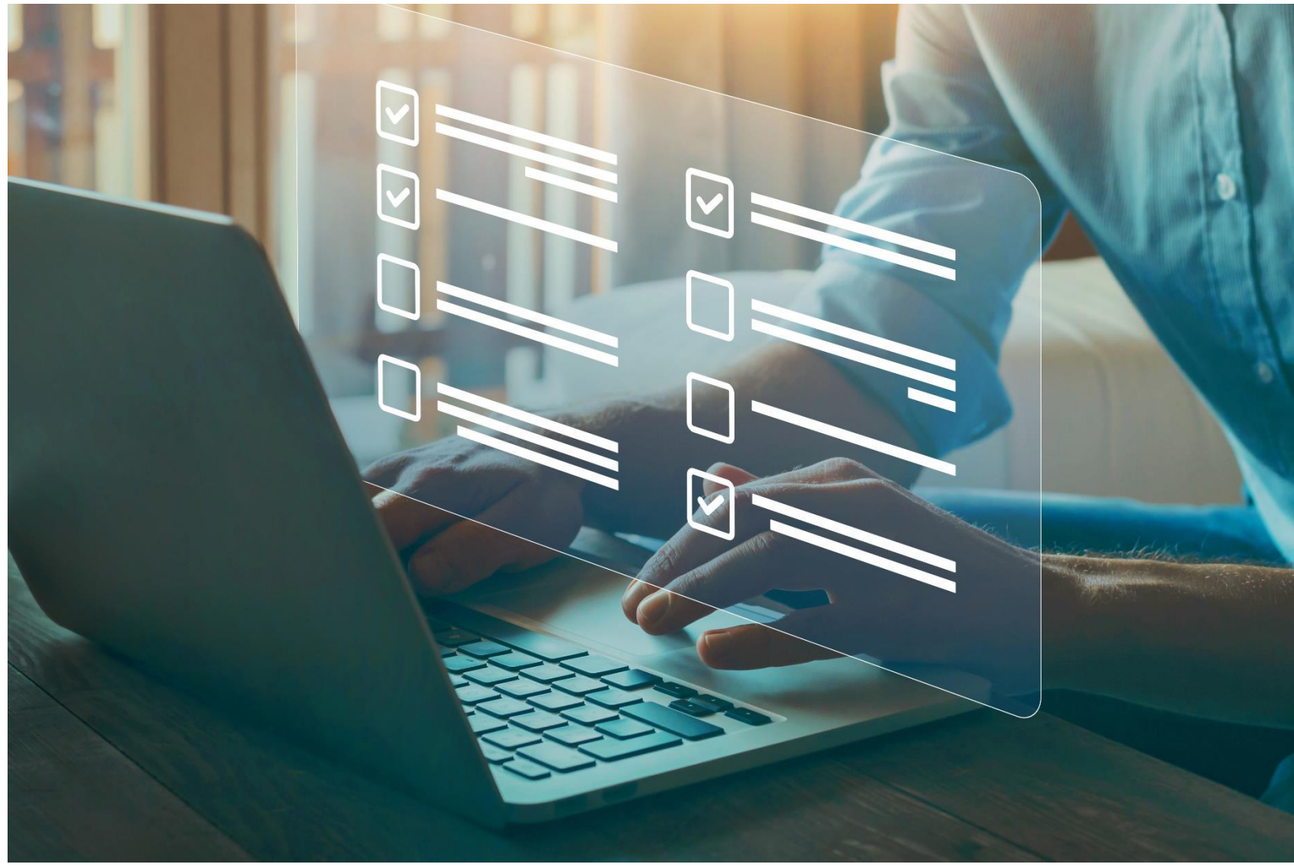
KEEP YOUR CARELON DIRECTORY DATA ACCURATE

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

Accurate provider data is our 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 Carelon Behavioral Health's (CBH) 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.



MEDICAL NECESSITY CRITERIA

Medical Necessity Criteria Available Online

Carelon Behavioral Health's clinical criteria, also known as medical necessity criteria, are based on nationally recognized resources and updated at least annually.

The National Committee for Quality Assurance (NCQA) accreditation standards (UM2 Factor 4: Practitioner Involvement) 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 it if does not develop its own UM criteria and obtains criteria from external entities."

Practitioners with clinical expertise in the use of criteria sets are asked to provide commentary on either the development and adoption of these criteria sets, or on the instructions for applying these criteria sets Medical necessity criteria vary according to individual state and/or contractual requirements and member benefit coverage.

Learn more

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?

To find out more information about the development of Carelon Behavioral Health's Medical Necessity Criteria, submit feedback or to obtain copies free of charge Please email Provider.Inquiry@carelon.com

*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 vendor that issued the MNC.

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

CONTACT US

Claims general questions

If you have general questions about claims, call 800-888-3944. For questions regarding claims submission addresses, please reference the member's identification card, as the address may vary based on payment location.

For claims questions related to Anthem members, please refer to Anthem's claim process.

Claims payment disputes

To file an appeal based upon the denial of a payment request, please use the Provider Claims Based Dispute Resolution Request form and mail to the address given in the PSV or mail to:

Provider Dispute Resolution
P.O. Box 1850 Hicksville, NY 11802-1850

For Anthem members, please refer to Anthem's claims payment dispute process.

Credentialing status

To obtain information pertaining to your network status, contact our National Provider Services Line at **800-397-1630**, Monday to Friday, 8 a.m. to 8 p.m. Eastern time.

Update your contact information

If you are a participating Council for Affordable Quality Healthcare (CAQH) provider, please update your information with CAQH. If you do not participate with CAQH, please log into ProviderConnect and select the "Update Demographic Information" option.

Carelon Behavioral Health Provider Relations: Contact your assigned provider relations management associate or reach out to our regional mailboxes

» **East:** provider.relations@carelon.com » **West:** provider.inquiry@carelon.com

Please include the following information in your email:
Provider Name, **TIN**, **NPI**, **Brief Description of Issue** and **Dates of Service**

For more information, click here to access our provider handbook or visit www.carelonbehavioralhealth.com/providers/resources/provider-handbook

NEW GUIDELINES FOR TIMELY ACCESS TO HEALTHCARE SERVICES IN MEDI-CAL MANAGED CARE

In an ongoing effort to enhance healthcare accessibility, the California Department of Health Care Services (DHCS) has issued updated guidance for Medi-Cal Managed Care Plans (MCPs) under All Plan Letter 25-006, dated April 25, 2025. The directive outlines the compliance measures Managed Care Plans must adopt to meet timely access standards for healthcare services, a mandate reinforced by recent Senate Bills 221 and 225 as well as the implications for providers participating in Medi-Cal Managed Care Plans. Here are the key impacts:

1. **Appointment Scheduling Standards**: Providers must comply with strict appointment scheduling standards to ensure timely access. Urgent care appointments must be available within 48 to 96 hours, while non-urgent appointments have specific time frames depending on the provider type, ranging from 10 to 15 business days.
2. **Interpreter Services**: Providers are required to ensure that interpretation services are available at all appointments without causing scheduling delays, ensuring accessibility for members with limited English proficiency.
3. **Quality of Provider Data**: Providers must maintain accurate and up-to-date information, such as phone numbers, office hours, and whether they are accepting new patients. Any inaccuracies identified during the Timely Access Survey must be corrected promptly.
4. **Timely Access Survey Participation**: Providers are expected to participate fully in the annual Timely Access Survey administered by all Managed Care Plans they're contracted with. This may require updates to agreements between providers, subcontractors, and Managed Care Plans to include mandatory participation clauses.
5. **Monitoring and Compliance**: Providers' compliance with timely access standards will be monitored regularly. Non-compliance may result in corrective actions or sanctions imposed by the Department of Health Care Services (DHCS).
6. **Enforcement Actions**: Providers could face enforcement actions, including Corrective Action Plans or monetary sanctions, if they fail to meet the timely access standards or other related requirements.
7. **Telehealth Options**: Providers may offer telehealth appointments, which can be taken into account for compliance with access standards, provided that members have the option to choose in-person visits.

Overall, the guidelines emphasize the importance of timely, equitable access to healthcare services and require providers to adopt comprehensive measures to ensure compliance with these standards. Providers need to be proactive in adjusting their practices and policies to align with these updated regulations.

MEDICAL NECESSITY CRITERIA

Carelon Behavioral Health of California, Inc. is a professional corporation duly organized under the laws of the State of California and operated as a Behavioral Health Knox-Keene Licensed Health Plan. Carelon Behavioral Health of California enters into agreements with organizations such as managed health care services plans, employer groups, preferred provider organizations, exclusive provider organizations and other purchasers 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 of California provides Utilization Management for Mental Health services and Substance Use related conditions. Medical Necessity Criteria can vary according to the individual contractual obligations, state/federal requirements and the member benefit coverage.

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. CHIPA enters into agreements with organizations such as health care services plans, preferred provider organizations, exclusive provider organizations and other purchasers 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 the individual contractual obligations, state/federal requirements and the member benefit coverage.

Carelon Behavioral Health of California and CHIPA's clinical criteria, also known as medical necessity criteria, are based on nationally recognized resources and updated at least annually.

An updated copy of the criteria is available on your health plan's website.

- Carelon Behavioral Health of California MNC
- CHIPA MNC

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:

- 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 (UM2 Factor 4: Practitioner Involvement) require 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 criteria sets used by Carelon Behavioral Health of California and Carelon Health IPA (CHIPA) are asked to provide commentary on either the development and adoption of these criteria sets or on the instructions for applying these criteria sets.

- Carelon Behavioral Health of California MNC
- CHIPA 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 vendor 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(s) you are referencing):

1. Do you use the criteria when requesting prior authorization or concurrent review?
2. Do you have any suggestions for improving one or more of the medical necessity criteria used by either of these organizations?
3. Have you had any difficulty using one or more of the medical necessity criteria?
4. Is there any *new* scientific evidence that would support a change to one or more of the existing criteria?

   NOTE: Cal. Code Regs. Tit. 28, § 1300.74.721(c)(d) requires full-service Commercial plans in California use clinical criteria developed by nonprofit professional associations, or a successor organization thereto, to make utilization review determinations that are within the scope of the criteria. A health plan shall not apply utilization review criteria other than those set forth in subdivision (c) of this Rule unless the circumstances in Health and Safety Code section 1374.721(c)(1) or (c)(2) apply.
5. Do you have any additional comment/feedback on one or more of the medical necessity criteria used by either of these organizations?

Submit comments or feedback to: provider.inqiry@carelon.com

MEDI-CAL PROVIDER ENROLLMENT

Medi-Cal Enrollment Requirements and Procedures for Qualified Autism Service (QAS) Provider Organizations and Individuals Offering Behavioral Health Treatment Services

- Effective May 5, 2025, QAS provider organizations and individuals offering behavioral health treatment services **may** apply for enrollment with the Department of Health Care Services (DHCS) through the Provider Application and Validation for Enrollment (PAVE), however providers are not required to do so.
- To enroll, QAS provider organizations and individual applicants must submit an electronic application through the Provider Application and Validation for Enrollment (PAVE) online enrollment portal, along with all supporting documentation.
- The QAS provider organizations and individuals (referred to as QAS applicants) must report all QAS providers, QAS professionals, and QAS paraprofessionals to the DHCS in their enrollment application and must also attest that all QAS providers, QAS professionals, and QAS paraprofessionals for whom they will bill meet the qualifications and follow supervision requirements listed in accordance with the State Plan for Behavioral Health Treatment Services.
- Please note, QAS provider organizations **will not enroll as groups, but as Healthcare Businesses** in PAVE. When beginning the application in PAVE, be sure to select the "I am a Healthcare Business" option (do not select the options for Group or Mixed Group).

Updated Medi-Cal Enrollment Requirements and Procedures for Community-Based Organizations (CBO), Local Health Jurisdictions, and County Children and Families Commissions (Amended on May 5, 2025, for CBO Providers Offering Behavioral Health Treatment Services)

- Effective May 5, 2025, CBO applicants may enroll to bill for behavioral health treatment services provided by Qualified Autism (QAS) providers, QAS professionals, and QAS paraprofessionals. This option will be available to both first-time CBO applicants and currently enrolled CBO providers submitting a supplemental application.
- If you are enrolling as a CBO offering behavioral health treatment services provided by QAS providers, QAS professionals, and QAS paraprofessionals, then the CBO must be a public or private non-profit organization with a 501(c)(3) status or a fiscally sponsored entity of a 501(c)(3) non-profit organization. However, if you are enrolling as a QAS provider organization or individual, then the QAS provider organization or individual does not have to be a non-profit with a 501(c)(3) status.

Additional Resources

- Link to provider bulletins
- Stakeholder Hearing Video (3/14/2025)
- Stakeholder Hearing Questions and Answers

REGIONAL NEWS
Maine

ENHANCING CRISIS SUPPORT: CARELON OF MAINE PARTNERS WITH SWEETSER

Carelon of Maine is pleased to announce our partnership with Sweetser, an esteemed provider of comprehensive behavioral health services. This collaboration focuses on delivering crisis stabilization services to both adults and children experiencing behavioral health emergencies.

Sweetser's innovative approach offers several key services designed to provide timely and effective care outside of traditional emergency room settings. Their mobile crisis team offers the flexibility of in-home evaluations, while the crisis stabilization units provide short-term therapeutic placements tailored to individual needs. These units are instrumental in resolving crises within the community, helping to reduce reliance on emergency room visits by developing robust, personalized crisis resolution plans.

Providers interested in referring patients to Sweetser's programs can reach out via the dedicated referral line at 1-800-434-3000, available Monday through Friday from 8:00 am to 5:00 pm. Referrals can also be sent via email to info@sweetser.org.

Sweetser

REGIONAL NEWS
Pennsylvania [Medicaid]

GABAPENTIN (NEURONTIN): AN UPDATE ON THE RISKS OF USE AND OVERUSE

From the Medical Director's Desk – Mark G. Fuller MD

Gabapentin (brand name, Neurontin) is a medication that has seen a significant increase in use in both the mental health field and the substance use treatment field. Most of these uses are off label but many physicians have seen significant benefits from them. This is especially true in the substance use field to treat chronic pain with non-opioid medications. However, two recent articles, one in the Journal of the American Medical Association and the other in the Center for Disease Control's Morbidity and Mortality Weekly Report (references listed below), have suggested caution in the use of this medication.

The increasing use of gabapentin, particularly off-label, presents notable hazards that call for careful examination and intervention. Gabapentin, originally approved by the US Food and Drug Administration (FDA) for the treatment of seizures and nerve pain associated with shingles, has seen its prescription rates double from 2009 to 2016. By 2019, it had become the seventh most prescribed drug in the United States. However, this burgeoning popularity highlights several risks, particularly concerning its role in drug overdoses.

One of the primary hazards linked to the increased use of gabapentin is its involvement in overdose deaths. Between 2019 and 2020, postmortem toxicology tests detected gabapentin in nearly 10% of overdose cases in the US. More alarmingly, in about half of these incidents, medical examiners identified gabapentin as a causative factor in the deaths. This makes the rise of gabapentin-related fatalities a significant public health concern. Data suggest that the number of overdose deaths involving gabapentin doubled from 2019 to 2020, underscoring an urgent need to monitor and address its use.

Continues on the following page

Gabapentin (Neurontin): An Update on The Risks of Use and Overuse *continued*

Gabapentin's interaction with other substances further compounds its danger. It is often used to enhance the effects of illicit opioids, notably fentanyl. The combination poses a significant risk due to potential respiratory depression, which can lead to fatal outcomes. In late 2019, the FDA issued a warning about the potential for serious breathing difficulties when gabapentin is used alongside central nervous system depressants, including opioids, antianxiety medications, and antidepressants. This warning highlights the critical need to educate users about the compounded respiratory risks and potential for death when these drugs are combined.

The demographics of those affected by gabapentin-related deaths also provide insights into addressing its misuse. About 83% of these cases occurred among White adults aged 35 to 54 years, with nearly 90% involving opioids. This suggests a particular need to focus public health interventions and educational efforts within this demographic to mitigate further risks.

In conclusion, while gabapentin remains a valuable medication for certain conditions, it's expanded off-label use, particularly in conjunction with opioids, presents significant hazards. Increased awareness, proper education on its risks, and stringent regulatory measures are crucial to ensure patient safety and curb the rising tide of overdose deaths. Effective intervention strategies must target both healthcare providers and patients to reduce the incidence of gabapentin-related fatalities and ensure that its benefits do not come at an unacceptable cost to society.

References:
"Gabapentin increasingly implicated in overdose deaths." JAMA, June 28, 2022: Vol327(24) 2387.
Mattson CL, Chowdhury F, Gilson TP. "Notes from the field:Trends in gabapentin detection and involvement in drug overdose deaths-23 states and the district of columbia", 2019-2020; MMWR 2022:71:664-666.

MENTAL HEALTH ADVANCED DIRECTIVES FOR PENNSYLVANIANS

The Pennsylvania Department of Human Services offers assistance to you and your clients with a booklet that include forms and instructions to create advance directives. Instructions Forms - English.pdf

Other resources include:

- **Pennsylvania Mental Health Consumers' Association**
  1-800-88PMHCA
  pmhca@pmhca.org

- **Pennsylvania Protection & Advocacy / Disabilities Law Project**
  1-800-692-7443
  717-236-8110
  1-877-375-7139 (TDD/TTY)

- **Mental Health Association in Pennsylvania**
  1-866-578-3659
  717-346-0549
  info@mhapa.org

REGIONAL NEWS
Pennsylvania [Medicaid]

NEW REQUIREMENT FOR DEPRESSION SCREENING CLAIMS SUBMISSIONS

Effective June 1, 2025, it is mandatory for all in-scope providers to document depression screenings through claim submissions. This requirement is crucial for The Office of Mental Health and Substance Abuse Services (OMHSAS) to perform statewide data analysis. The data collected will play a vital role in improving mental health services across Pennsylvania by enabling precise tracking and management of depression across our communities.

Providers, including Mental Health Outpatient Clinics, Psychologists, Psychiatrists, and Substance Use Disorder Outpatient Clinics, are reminded to use the appropriate G codes when a qualifying service that includes depression screening is conducted. Please ensure that the documentation reflects whether the screening was positive or negative, and that any follow-up plans for positive screenings are noted.

To support you in this transition, we have gathered valuable resources available on our website. These include detailed guides on how to properly capture and submit depression screening information, along with a comprehensive Question and Answer document prepared by OMHSAS to assist you with any queries or uncertainties you might have in implementing these procedures.

For any additional inquiries or support, do not hesitate to reach out to our provider relations team members directly or via PAMedicaidProviderRelations@carelon.com. This is an essential initiative to improve mental health care services for all members, and your cooperation and diligence are greatly appreciated.

Stay informed and supported with our resources as we advance together toward a healthier Pennsylvania! https://pa.carelon.com/providers/provider-alerts/

REGIONAL NEWS
Pennsylvania [Medicaid]

BEYOND DEPRESSION: ADDRESSING SUICIDALITY

Pennsylvania is addressing mental health with a statewide plan to improve suicide prevention and community resilience. Suicide is the third leading cause of death for ages 10-34 and fifth for ages 35-44, with one person dying by suicide every five hours. This initiative aims to tackle this crisis with comprehensive strategies.

Led by PA DHS OMHSAS, the initiative focuses on suicide screens, risk assessments, care plans, and follow-up visits after emergency or hospital care due to mental illness or self-harm. These efforts help identify and support individuals at risk, encouraging timely intervention and care.
The project addresses social determinants of health and promotes health equity. This includes screening for social needs, focusing on high-risk groups like veterans, older adults, LGBTQ+ members, and Black youth to ensure inclusive mental health care.

This statewide plan is an urgent call to action, highlighting mental health as a collective priority. By working together, we'll strive to build healthier and more resilient communities. Let us all commit to this vital effort, ensuring a future where every individual has access to the support they need to thrive.

DOCUSIGN RESOURCES AND GUIDANCE

Carelon of PA has been using DocuSign Platform to send out contract amendments and single case agreements.

This platform digitizes the process in real time and eliminates the wait time involved with executing and obtaining a copy of the signed document.

Here is a summary of the benefits of using DocuSign:

- Faster contract turnaround time.
- Reduced time spent in collecting signatures
- Streamline the contract workflow process
- Reduces manual tasks
- Improve Flexibility that you can sign documents anywhere with internet access.
- Enhances security- DocuSign has advanced encryption protection and maintains the document integrity.

Here is a summary of the benefits of using DocuSign:

- Instructions on how to add an e-signature can be found The Signing Experience
- If you need to reassign signing responsibility, from the envelope, click OTHER ACTIONS, then click Assign to someone else. Enter the new signer's email address, name and reason for the changing the responsibility. When finished, click Assign to someone else.
- Should you choose to, you can download a mobile application through DocuSign to further add to the efficiency.
- You can learn more about DocuSign by visiting their website

WHAT IS A CSP?

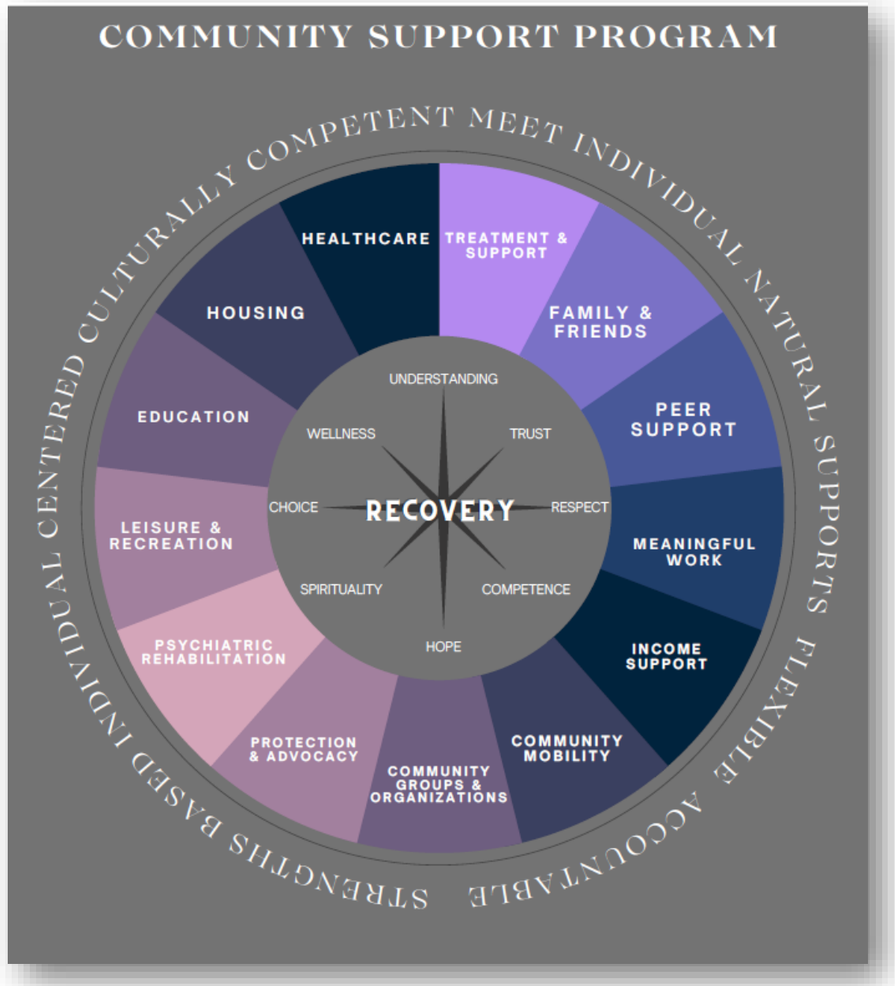
A community support program, also known as a "CSP" was created to "assist states and communities in improving opportunities and services for adults with serious disabling mental illnesses," according to the National Institute of Mental Health (NIMH). It is a recovery model for people with behavioral health and co-occurring disorders to help people in the community engage with agencies and gain resources and support. A CSP hopes to improve their community's quality of life by looking beyond a person's disability and focusing on their potential and experiences to help eliminate stigma and discrimination.

In 1984, the State Office of Mental Health in PA awarded the National Institute of Mental Health Technical Assistance Grant to help adopt the CSP model in the state planning process. This then formed the PA State CSP Advisory Committee. Currently, there are local, regional and state meetings occurring. Most of the 67 counties in Pennsylvania have a local CSP. A few counties are still creating local programs.

- **Local CSP**: These monthly meetings occur in local counties and many of the 67 counties across the state have a CSP. To find a CSP in your area, visit: www.pmhca.org/Community-Support-Program

- **Regional**: Counties meet to report updates, share ideas and utilize seed grants. Regions include Central, Northeastern, Southeastern and Southwestern. Regional CSPs offer technical assistance to local CSPs. We're part of Southwestern Region CSP, and it encompasses 23 counties. Southwestern CSP meetings are held the 2nd Friday monthly and run from 10 a.m. – 12 p.m. To be put on the distribution list, call 724-822-0181.

- **State**: Regions provide quarterly updates to the Office of Mental Health & Substance Abuses Services (OMHSAS) for their knowledge and consideration.



ENHANCING PATIENT CARE THROUGH INTEGRATION OF SPIRITUAL AND RELIGIOUS NEEDS

In our ever-diverse world, understanding and addressing the cultural, social, and linguistic needs of patients is not just beneficial—it is essential. Cultural competence is a critical framework that enables healthcare providers to effectively meet these needs while working towards eliminating racial and ethnic health disparities. By fostering a culturally competent healthcare environment, we can significantly enhance both the patient experience, and the quality of care delivered.

For many individuals, language, culture, and religion are deeply intertwined, and misunderstandings in these areas can contribute to poor health outcomes and increased readmission rates. As healthcare providers, it's vital to recognize that spirituality and religion are integral aspects of multicultural diversity. These dimensions overlap with race, ethnicity, and culture, intersecting further with gender and sexual orientation. The challenge lies in understanding that patients often rely on their religious and spiritual beliefs when engaging with healthcare providers as well as making medical decisions.

Understanding the significance of spirituality and religion for the majority of patients seeking care is crucial. Many patients find comfort in their faith during healthcare challenges, which can reduce anxiety and contribute to overall well-being. Therefore, healthcare providers should respectfully accommodate a patient's religious and spiritual needs. Allowing patients to discuss their beliefs and adapting evaluations and treatments to align with their specific needs can play a key role in successful healthcare delivery.

A substantial body of evidence highlights the relevance of spirituality and religious backgrounds, beliefs, and practices in promoting psychological well-being. Active involvement in religious and spiritual practices is linked to reduced depression, anxiety, suicide ideation, and attempts, as well as lower rates of post-traumatic stress disorder (PTSD) and substance abuse. It is also associated with a higher sense of purpose, hope, optimism, and self-esteem. Providing patients with opportunities to integrate their spiritual and religious practices into their care can offer adaptive benefits including self-regulation, positive attachment, emotional comfort, meaning, and spirituality.

As providers, your ability to incorporate patients' spiritual and religious needs into assessment and treatment planning can yield significant benefits. Recognizing this aspect of cultural competence enhances the therapeutic alliance and supports patients in navigating healthcare decisions with dignity and respect.

Please see below resources regarding religious diversity and cultural competent practice:

- Religious Diversity: Practical Points for Health Care Providers
- Carelon of PA Provider Cultural Competency Training
- Improving Cultural Competency for Behavioral Health Professionals by HHS

CREATING A CULTURE OF CELEBRATION

This quarter we invite you to celebrate the Washington County Drug and Alcohol Commission's (WDAC) new Recovery Center and the vital care the are providing to our members and their community! Launching in September of last year, the WDAC Recovery Center is dedicated to providing a safe, judgement free space for those living with or affected by substance use disorder. The Recovery Center champions recovery, resilience, and community, fostering wellness and lasting change for the people of Washington County. The Center is comprised of both a Center of Excellence (COE) and Certified Recovery Specialists.

The Center of Excellence provides coordinated care for individuals suffering from opioid use disorder (OUD). The Care Management Team helps ensure individuals with OUD stay in treatment, receive follow-up care and are supported in their community.

Additionally, the Certified Recovery Specialist unit provides a person-centered approach to those struggling with substance use disorder (SUD). Certified recovery specialists recognize each individual's unique needs when making referrals to treatment, linking individuals to services, and providing advocacy throughout the recovery process.