KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Behavioral Health Integration Oversight	**Policy #**	21.11-P
Policy Owner	Behavioral Health	**Original Effective Date**	1/1/2026
Revision Effective Date		**Approval Date**	2/3/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To establish a standardized approach for oversight and coordination of behavioral health (BH) services integrated within Kern Family Health Care Medicare Dual Eligible Special Needs Plan (KFHCM D-SNP). This policy ensures care coordination aligns with the Model of Care (MOC) framework, supporting Members with co-occurring medical, behavioral, and social needs through an interdisciplinary and person-centered approach.

II. POLICY

KFHCM integrates behavioral health within its care management and care coordination framework to achieve whole-person care. All Members with identified behavioral health needs—mental health, substance use disorders, or psychosocial distress—will have those needs reflected in their Individualized Care Plan (ICP) and addressed by their Interdisciplinary Care Team (ICT).

Behavioral health integration oversight will be maintained through the coordinated efforts of the Care Management Department, Behavioral Health Practitioners, and the ICT under the direction of the Medical Director and Clinical Director of Delegation Oversight.

KFHCM shall ensure:

A. Identification and Assessment

1. Behavioral health needs are identified through the Health Risk Assessment (HRA), claims/utilization review, provider referral, or Member self-report.

2. The Care Coordination team stratifies Members based on risk (High, Rising, or Low) and identifies those needing behavioral health interventions.

B. Interdisciplinary Care Coordination

1. Each Member's care coordination includes collaboration between the Nurse Case Manager, Behavioral Health Practitioner, Care Coordinator, and Primary Care Provider.

2. ICTs include a Behavioral Health Practitioner (Licenses Clinical Social Worker (LCSW), Licensed Marriage & Family Therapist (LMFT), Masters in Social Work (MSW)) for Members with mental health or substance use needs.

C. Care Planning and Follow-up

1. The Behavioral Health Practitioner assists in developing the ICP, identifying behavioral barriers to care, linking to mental health/substance use services, and ensuring coordination between physical and behavioral health providers.

2. ICPs are updated at least annually or upon significant change in conditions.

D. Data Integration and Oversight

1. The electronic care management platform serves as a centralized repository for documentation of behavioral health needs, interventions, and outcomes.

2. Oversight reports on BH integration, including timeliness of Health Risk Assessments (HRAs), ICP updates, ICT participation, and follow-up compliance, are reviewed quarterly by the Clinical Quality Committee.

E. Member Engagement and Empowerment

1. Care coordination activities promote engagement, education, and empowerment to support self-management of behavioral health conditions.

2. Care Coordinators facilitate communication in the Member's preferred language and literacy level.

III. DEFINITIONS

TERMS	DEFINITIONS
CMS	Centers for Medicare and Medicaid Services, the Federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program and oversees all Medicare Advantage Plan (MAPD) and Prescription Drug Plan (PDP) organizations.

Care Management Program	Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.
Behavioral Health Practitioner/Social Worker	A healthcare professional with expertise in addressing mental health, substance use disorders, and social determinants of health. These professionals provide a range of services, including assessment, diagnosis, therapy, counseling, and care coordination.
Health Risk Assessment (HRA)	A comprehensive evaluation used to identify the health risks and needs of enrollees in Special Needs Plans.
Individualized Care Plan (ICP)	A Member-centered plan of care that is created to address a Member's medical, behavioral, and social needs. It is a collaborative document developed by Kern Family Health Care Medicare (KFHCM)'s care management team and is communicated with the Member's Interdisciplinary Care Team (ICT). The ICP aims to provide personalized, comprehensive, and coordinated care tailored to the unique needs and preferences of each Member.
Interdisciplinary Care Team (ICT)	A group of healthcare professionals from various disciplines who collaborate to address a patient's comprehensive needs. This team works together to manage the physical, psychological, and social aspects of a patient's care.
Model of Care (MOC)	A comprehensive framework that outlines how the plan will meet the unique needs of its enrollees.
D-SNP/SNP	Dual Special Needs Plan or Special Needs Plan. Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.

IV. PROCEDURES

A. Identification and Referral

1. Care Coordinators review HRA and claims data for behavioral health indicators.

2. Members screening positive for depression, anxiety, substance use, or psychosocial risk are referred to a Behavioral Health Practitioner.

3. The Behavioral Health Practitioner documents findings in the electronic care management system and communicates with the Nurse Case Manager.

B. Interdisciplinary Care Team (ICT) Collaboration

1. The Care Coordinator convenes an ICT for Members with active behavioral health needs.

2. ICT participants may include:

    a. Member and caregiver
    b. Nurse Case Manager (RN)
    c. Behavioral Health Practitioner (LCSW/LMFT/MSW)
    d. Primary Care Provider
    e. Pharmacist
    f. Social Worker or Health Equity Representative

3. The Behavioral Health Practitioner provides recommendations, ensures linkage to community supports, and assists with ICP updates.

4. All ICT actions are documented in the Member's ICP.

C. Behavioral Health Care Coordination Activities

1. Care Coordinators schedule follow-up appointments, link Members to therapy, substance use programs, and community supports.

2. Coordination includes monitoring medication adherence, facilitating communication between PCPs and behavioral health providers, and arranging transportation if needed.

3. Progress is reviewed monthly for high-risk Members and quarterly for rising-risk Members.

D. Oversight and Quality Monitoring

1. The Clinical Director of Delegation Oversight reviews BH integration metrics (e.g., HRA completion, ICT attendance, ICP timeliness, behavioral health referrals).

2. Findings are reported to the D-SNP MOC Committee and incorporated into the annual MOC evaluation.

3. Staff receive annual training on behavioral health integration, MOC requirements, and cultural competency.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	CalAIM Dual Eligible Special Needs Plans Policy Guide CY 2025.
Other KHS Policies	19.50-I MOC Interdisciplinary Care Team (ICT) Policy
Other KHS Policies	19.48-I MOC Health Risk Assessment Policy
Other KHS Policies	19.49-I MOC Individualized Care Plan (ICP) Development Policy
Other	H4057 Module of Care

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	1/1/2026	Policy created to comply with D-SNP	BH

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		