Appendix XVIII - Behavioral Health Addendum

I.Primary Care Physicians' Responsibilities

All members enrolled in Healthfirst select a PCP at the time of enrollment. The PCP is responsible for managing and coordinating healthcare services provided to members, including primary and specialty care, hospital care, diagnostic testing, and therapeutic care. If the member is in treatment in a behavioral health clinic that also provides primary care services, the member may select the lead provider to be the PCP. Healthfirst defines the following clinical specialty areas and practitioners as primary care providers.

Physicians	Nurse Practitioners
Adolescent Medicine – GYN	Adolescent Medicine
Adolescent Medicine	Adolescent Medicine – GYN
Family Practice – GYN	Adult Health
Family Practice – OB/GYN	College Health
Family Practice – OB	Family Health
General Practice	Pediatrics
Geriatrics (Medicare and Commercial only)	Women's Health
Infectious Disease (HIV Specialist PCP)	
Internal Medicine	
Pediatrics	

II.Appointment Availability Standards for Behavioral Health Services and HARP Members

Healthfirst will provide appointment and availability times for the following Behavioral Health services, including the newly carved-in services for Mainstream members ages 0–21 and HARP members age 21 and over (for additional information regarding appointment availability standards, please refer to Appendix I of this manual):

For CPEP, inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services will be provided immediately upon presentation at a service delivery site.

For urgently needed Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS-certified residential settings and mental health or Substance Use Disorder outpatient clinics, and Opioid Treatment Programs will be provided within 24 (twenty-four) hours of request. Urgently needed ACT would be immediately referred to SPOA, with mention of the urgent need in order for them to evaluate promptly. PROS referrals would be made within 24 hours, and we would encourage PROS to provide prompt service.

For Behavioral Health specialist referrals which are not urgent:

CDT, IPRT, and Rehabilitation services for residential Substance Use Disorder treatment services will be provided within two (2) to four (4) weeks of request

PROS programs other than clinic services will be provided within two (2) weeks of request

Following an emergency, hospital discharge, or release from incarceration, if known, follow-up visits with a behavioral health participating provider (as included in the benefit package) will be scheduled to occur within five (5) days of request, or as clinically indicated.

Non-urgent mental health or Substance Use Disorder visits with a participating provider that is a Mental Health and/or Substance Use Disorder Outpatient Clinic, including a PROS program with clinical treatment, will take place within one (1) week of request.

(This section is an addendum to Section 9.2 in the Provider Manual.)

III. Authorization, Continued Stay, and Discharge Criteria

Healthfirst clinicians will be utilizing the following criteria sets, all of which contain criteria for initial authorization, continued stay, and discharge:

For mental health inpatient, Partial Hospital, and Intensive Outpatient settings of care, Healthfirst will utilize McKesson InterQual criteria, 2015 version.

For all OASAS services for Substance Use Disorder settings of care, LOCADTR 3.0 will be utilized by providers to determine the most appropriate treatment setting for treatment of a member. All Healthfirst clinical staff have access to the HCS system and have been trained on the LOCADTR 3.0 tool in order to best understand the recommended level of care for the member.

NYS has issued specific criteria for PROS, ACT, and CDT services. These criteria have been adopted and will be utilized by Healthfirst Care Managers in reviewing and managing these services.

NYS has also issued review guidelines and criteria for all adult and child Home and Community Based Services (HCBS).

This process will be followed by Healthfirst Care Managers as members complete the assessment by the Health Home (HH) care manager and recommended services are requested by HCBS providers. The guidance from NYS includes admission, continuing stay, and discharge criteria for each HCBS service.

(This requirement relates to Section 9.4 in the Provider Manual and supplements what is already in that section.)

IV. Behavioral Health Utilization Management

Healthfirst is committed to delivering a full continuum of integrated, person-centered care and provides fluid clinical pathways where individuals may enter treatment at any level and be moved to more- or less-intensive settings or levels of care as their changing needs dictate.

BH utilization management is the vehicle through which Healthfirst ensures that our beneficiaries receive:

A comprehensive assessment

A person-centered, needs-based, goal-oriented plan of care that includes services best suited to support recovery needs and preferences

Timely access to services that will engage and support individuals and families throughout stages of recovery

Cost-effective services in the most appropriate setting

Services consistent with medical necessity criteria and evidence-based practices

Active treatment at every level of care that supports progression toward recovery goals and takes into consideration the individual's readiness to change, readiness to participate in treatment, and family, cultural, and linguistic needs

Integrated, coordinated care that includes services for co-occurring physical, behavioral health, and social conditions

The primary focus of our UM Program is to facilitate access to appropriate, high-quality treatments and

recovery-focused services and to support providers in delivering clinically necessary and effective care. UM activities are conducted in collaboration with providers and with a process improvement mindset enhancing access, retention, and the quality of behavioral health treatment to achieve health, wellness, recovery, and community inclusion for our members and improved medical cost-management. Continuity and coordination of care are important elements of care and as such are monitored. Opportunities for improvement are selected across the delivery system, including settings, transitions in care, patient safety, and coordination between medical and behavioral health care. Where opportunities to improve quality of care and service delivery are identified, recommendations for providers to prospectively adjust practices and policies are made.

Behavioral health care management is integrated with our physical health care management program to improve coordination of care between physical and behavioral health providers. As such, BH utilization management functions are designed to help identify and close gaps in care through evidence-based approaches to care planning and service delivery.

With oversight and clinical guidance from the CMO, the Executive Medical Director of Behavioral Health and the HARP Medical Director support the development and implementation of the UM Program through annual review of policies, criteria, and behavioral health utilization. They, along with additional board-certified peer reviewers, serve as physician reviewers for medical necessity determinations and consultations for quality-of-care concerns. Peer reviewers making determinations for denials, grievances, and appeals are board-certified psychiatrists, licensed doctoral-level psychologists, and physicians certified in addiction medicine or addiction psychiatry, as well as child, adolescent, and geriatric specialties. A physician board certified in child psychiatry will review all inpatient denials for psychiatric treatment for children under the age of 18. A physician certified in addiction treatment must review any inpatient denials for Substance Use Disorder services. A physician will review any denials for services for medically fragile children, and such determinations will consider the needs of the family and/or caregiver.

A. Utilization Management Level of Care Guidelines

UM Level of Care Guidelines are provided to Behavioral Health Care Managers. These tools serve as guidelines for review of medical necessity and appropriateness of services implemented and approved. All medical necessity criteria and level of care guidelines will be used as clinical tools to support decisions to determine components of person-centered plans of care.

Behavioral Health UM criteria tools include:

- McKesson's behavioral health criteria, InterQual ™, which is embedded in the online medical management system. The McKesson behavioral health criteria are proprietary and can be made available upon request.
- OASAS LOCADTR 3.0 criteria for SUD treatments
- New York State OASAS Clinical Guidance (https://www.oasas.ny.gov/AdMed/recommend/reommendations.cfm)
- The NYS HCBS Provider Manual. This manual outlines how HCBS care planning and utilization management emphasizes attention to member strengths, goals, and preferences, and also ensures member choice of service options and providers (latest version available at https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/)
- New York State OMH Clinic Standards of Care: (www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html)
- New York State OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013 (https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf)
- New York State OCFS Working Together: Health Services for Children/Youth in Foster Care Manual (http://ocfs.ny.gov/main/sppd/health_services/manual.asp)

New York State Principles for Medically Fragile Children

Authorization for traditional in-network outpatient Behavioral Health services delivered by Healthfirst providers is not required. Traditional outpatient Behavioral Health services, as defined by Healthfirst for this purpose, include individual, group, and family therapy and medication management, provided alone or in any combination, to treat a behavioral health condition in a manner consistent with established clinical guidelines and provided at a frequency not exceeding five (5) hours a week.

Authorization is required for admissions, Home and Community Based-Services (HCBS), all out-of-network care, and select outpatient services such as ECT, neuropsychological testing, and others. Members in need of care, or providers wishing to arrange these services for Healthfirst members, should call the Healthfirst Medical Management department at 1-888-394- 4327 for assistance.

BH Care Managers use these tools to support clinical decision making and authorizations for admission, continued stay, step-down, and community-based service level of care decisions to ensure the right intensity of treatment at the least restrictive level to meet the member's needs. The goal is to provide appropriate resources to support the member and sustain him/her in the community, reducing ED visits and re-admissions to acute care, while facilitating access to essential person-centered, integrated, health- and recovery-oriented services in the community.

In addition to authorization reviews, BH Care Managers coordinate discharge-planning activities, including review of the member's clinical status, reassessment of need for care, services, and support; risk assessment; changes in condition or treatment that would require updates to the Individual Care Plan; and referral and authorization of any needed care, service, or community supports, including follow-up visits, health home services, medications, DME, medical supplies, or home care that the member needs for a successful and sustained transition back into the community or to a lower level of care.

BH Care Managers at Healthfirst are trained and encouraged to consistently provide active care management as they do utilization concurrent reviews; their focus is obtaining appropriate clinical information in order to update and enhance the treatment plan for the member, and they collaborate with the provider on building out a complete plan of care for the member that extends beyond the current episode of care.

V. Clinical Practice Guidelines for Behavioral Health

Clinical practice guidelines (found in Appendix A) are systematically developed standards that help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. The use of clinical practice guidelines gives Healthfirst the ability to measure the impact of guidelines on outcomes of care and may reduce practice variations in diagnosis and treatment. In addition to guidelines and recommendations required by CMS, the NYSDOH, OHIP, and the local departments of health, participating providers are expected to comply with the guidelines adopted by Healthfirst.

Healthfirst has adopted preventive care and practice guidelines that are based on nationally accepted guidelines that are reviewed and updated every two (2) years unless otherwise specified. Healthfirst adopts guidelines upon the recommendation and approval of the Health Care Quality Council. They are communicated to providers—along with performance indicators chosen by the clinical members of the Council—through the Provider Manual, annual mailings, newsletters, and the Healthfirst website.

Please note: Healthfirst disclaims any endorsement or approval of these guidelines for use as substitutes for the individualized clinical judgment and decision making that is required in the treatment and management of our members. These guidelines provide a tool for objective comparison of clinical practices among network providers and ensure appropriateness of care to our members. These guidelines are readily available by virtue of their already broad publication and distribution.

To obtain a copy of the list of guidelines required by the NYSDOH and the list of guidelines adopted by Healthfirst, visit www.healthfirst.org/providers.

For the management and treatment of BH conditions, Healthfirst utilizes CPGs developed and published by the following organizations:

American Psychiatric Association

American Academy of Child and Adolescent Psychiatry

American Academy of Pediatrics – Attention Deficit Hyperactivity Disorder (ADHD)

Healthfirst also incorporates OMH, OASAS, OHIP, and OCFS clinical standards, as appropriate, to support clinical decisions and care planning. These standards are found below:

OMH Standards: www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html

OASAS Standards: www.oasas.ny.gov/treatment/documents/ClinicalGuidance-Final.pdf

OHIP Standards for Children in Foster Care: www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf

OCFS Standards for Children in Foster Care: http://ocfs.ny.gov/main/sppd/health_services/manual.asp

OHIP Principles for Medically Fragile Children

Healthfirst also has experience with the following clinical practice guidelines:

Tobacco Cessation

Seeking Safety

Motivational Enhancement Therapy

Integrated Care and Management of Depression

Integrated Care and Management of Anxiety Disorders

The aim of the Healthfirst Clinical Partnerships program is to leverage relationships with providers caring for all aspects of a member's care experience—primary care, specialists, mental health and behavioralists, community-based organizations, and ancillary to achieve the triple aim. Technical assistance and capacity building is available through face-to-face meetings, webinars, conferences, town hall meetings, workshops, and symposia. Evidence-based medicine and best clinical practice is promulgated through bulletins, email blasts and advisory workgroups. Training is offered to clinicians and office staff on specific topics of interest and importance such as SBIRT, improving the patient experience, and smoking cessation.

VI. Behavioral Health Care Management Automatic Call Distribution

During business hours, Healthfirst's Member Service staff and other Healthfirst staff have been trained to utilize a Behavioral Health Care Management Automatic Call Distribution queue. If an emergency or crisis call presents, the Member Service agent will activate the queue which looks for the first available Healthfirst behavioral health licensed Care Manager (CM), keep the member on the phone until the Care Manager responds, and do a warm transfer of the member to the CM who will immediately handle the call. In the unlikely event that all CMs are on calls, a Supervisor or Manager who is also logged in and monitoring the queue will receive the call. Once the call is received and handled, the CM will work with the member to ensure appropriate actions are taken; e.g., 911 if needed, assistance getting to an Emergency Room, an immediate face-to-face assessment with a Behavioral Health Provider if the emergency does not present imminent risk, and ongoing follow-up as to the result of these action steps.

Vibrant is Healthfirst's after-hours crisis manager. They use licensed, trained clinicians as their agents, who respond immediately to calls that are warm transferred from Concentrix, Healthfirst's call center after-hours vendor. Concentrix agents are trained to warm transfer to Vibrant for any behavioral health issue, and they understand the importance of keeping the member on the phone and completing the warm transfer. Vibrant agents utilize the Healthfirst medical management online system to enter notes and actions taken. They also send (via a reminder queue) the case to the day team of clinicians at Healthfirst so follow up and further

actions on the member's behalf can be seamlessly taken.

VII. Emergent Care

Healthfirst members are covered for inpatient and outpatient emergency care services within the Healthfirst geographic operating area and also when members are traveling in or visiting out-of-area locations. Emergency services are reimbursed when an emergency medical condition exists or when a Healthfirst provider instructs the member to seek emergency care either in- or out-of-network as is appropriate to the member's situation. Services must be provided by facilities or healthcare professionals qualified to render emergency medical care.

Prior authorization from Healthfirst is never required for reimbursement of an emergent medical condition.

Definition of an Emergency Medical Condition

As set forth in Section 4900(3) of the New York State Public Health Law, an "emergency condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, which a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy

Serious impairment to such person's bodily functions

Serious dysfunction of any bodily organ or part of such person

Serious disfigurement of such person

Emergency Guidelines

When a Healthfirst member presents in the emergency room or CPEP (Comprehensive Psychiatric Emergency Program) for care, the hospital is responsible for providing medically necessary and appropriate treatment. The hospital must contact the PCP as soon as possible to obtain clinical information that may be necessary to provide appropriate treatment. If a member presents in the emergency room with a non-emergent condition, the hospital should contact the PCP and document that contact. The hospital is then responsible for deciding and carrying out the necessary and appropriate course of action. Referral to the PCP for non-emergency treatment may be arranged.

If the PCP is referring the member for emergency care, the PCP should send the member to his or her assigned hospital whenever possible or to the emergency room of the closest hospital. The PCP should contact the emergency room by telephone or fax to provide necessary medical information. Members should be instructed to return to the PCP's office for follow-up, when appropriate, after an emergency room visit. If the member has received emergency care and the follow-up care cannot be safely postponed until the member returns, the member should be instructed to seek follow-up care from the appropriate out-of-area provider.

Emergency Inpatient Admissions

For emergency admissions, prior authorization is not required, but the treating facility or physician should contact Healthfirst within 48 hours of the admission or as soon as possible (to ensure proper post-stabilization care and discharge planning). Providers should contact Medical Management via the telephone and fax numbers listed in Section 1. In addition, hospitals are responsible for contacting the member's PCP to advise of the proposed admission and to obtain any relevant information regarding the member's condition, medical history, and other relevant information. Healthfirst PCPs who practice in private, community-based settings and do not have admitting privileges at Healthfirst hospitals (Level III providers) should contact their hospital liaison to arrange for admission to the appropriate participating hospital in emergency situations as well as in elective cases.

If a Healthfirst member is hospitalized for emergency care in a nonparticipating institution, Healthfirst will cover the cost of the emergency services and the cost of all medically necessary inpatient days until such time as the member may be safely transported to a participating facility. Healthfirst's Medical Management staff will work with staff at both hospitals to arrange the transfer when it is judged to be safe by the member's attending provider.

VIII. Behavioral Health Services

Members may make unlimited self-referrals to a participating Behavioral Health Specialist for assessment or treatment of a mental health or substance use disorder. Healthfirst members may obtain assistance regarding behavioral health services by contacting the Intake Unit at 1-888-394-4327.

Authorization for routine in-network outpatient behavioral health services and crisis intervention services is not required.

IX. Behavioral Health Quality Improvement Utilization Management Committee (BH QI-UMC)

The Behavioral Health Quality Improvement Utilization Management Committee (BH QI-UMC) is a multidisciplinary Committee that meets on a quarterly basis. The BH QI-UMC is responsible for carrying out the planned activities of the BH QM and UM programs and is accountable to and reports regularly to the governing board or its designee concerning BH QM activities. The BH QI-UMC reports to the Quality Improvement Committee (QIC) at least quarterly to review behavioral health quality, utilization, and operational metrics, and to promote behavioral health programs and initiatives. Attendees include Vice President & Executive Medical Director, Behavioral Health (chairperson); Medical Director, Behavioral Health – HARP; Medical Director, Physical Health – HARP; Assistant Vice President, Business Operations, Behavioral Health; Director, Behavioral Health Clinical Services – HARP; Director, Pharmacy; Director, Clinical Quality; Director, Clinical Informatics; Director of Children's Services; Director, Clinical Program Management, BH; Senior Manager of BH Quality Improvement; stakeholders (one member, one family member, one peer specialist); provider representative; and other Healthfirst clinical and nonclinical staff members.

A. Healthfirst has expanded its Behavioral Health Quality Improvement Utilization Management Committee to meet the quality requirements and standards for Children's Medicaid Redesign to address the populations, benefits, and services carved into plan. Accordingly, the Children's Quality Improvement Utilization Management Committee has been established.

B. Children's Quality Improvement Utilization Management Committee (Children's QI-UMC)

The Children's QI-UMC is a multidisciplinary committee that will meet on a quarterly basis. It is responsible for carrying out the planned activities of the Children's QM and UM programs. The Children's QI-UMC reports to the BH QI-UMC at least quarterly.

Attendees include:

Vice President & Executive Medical Director, Behavioral Health (Chairperson)

Medical Director, Physical Health, HARP

Medical Director, Medical Management

The Medical Director, Children's BH/Physical Health

Assistant Vice President, Appeals and Grievances (or designee)

Director, Behavioral Health Services (or designee)

Director, Children's Services (or designee)

Director of Clinical Operations, Children (or designee)

Director, Clinical Quality (or designee)

Director, Clinical Informatics (or designee)

Senior Manager, BH Quality Improvement (or designee)

Pharmacy Director (or designee)

Manager, Network/Ancillary Operations (or designee)

Network provider

Stakeholders in an advisory capacity:

- Member representative
- Family member representative
- Peer Specialist
- Advocate
- Health Home representative
- Providers
- Subcontractors
- Regional Planning Consortium
- Member-serving agencies
- Other Clinical and nonclinical staff from Healthfirst

Responsibilities:

The Children's QI-UMC reviews behavioral health quality, utilization, and operational metrics and promotes children's health and BH programs and initiatives. This committee is responsible for carrying out the planned activities for children with BH conditions who access BH benefits and/or HCBS. The Children's QI-UMC reviews and analyzes child-specific data, interprets variances, reviews outcomes, and develops and approves interventions based on the QM Work Plan, including the following findings:

Critical-incident reports and trends including abuse, neglect, and exploitation occurrences

Complaint tracking and resolution for both members and providers

Over- and underutilization of costs and services

Readmission rates, trends, post-discharge follow-up and average length of stay (ALOS) for mental health inpatient, and residential substance use disorder inpatient stays and RTCs

Inpatient civil commitments and outpatient civil commitments (AOT)

Follow-up after discharge rates from mental health inpatient, substance use disorder (SUD) inpatient, and RTC

Rates of SUD IET initiation and engagement

Emergency department utilization and crisis service use

Behavioral Health prior authorization/denial and notices of action

Psychotropic medication utilization a well as separate analysis for children in foster care

Addiction medication utilization

Recovery outcomes (i.e., housing, homeless, criminal justice)

Avoidable hospital admissions and readmission rates and the average LOS for all MH, SUD, residential levels of care, and medical inpatient facilities

Use of crisis diversion services

Pharmacy utilization, including psychotropic, addiction, and physical health medications

All applicable physical health measures required by the MCO model contract

All applicable behavioral health measures determined by the State

Rates of initiation and engagement of individuals with FEP in services

Health Home utilization and quality measures

Discussion, tracking/trending, analysis, and follow-up related to PH services for medically fragile children with complex conditions

Prior authorization/denials and notices of action

Maintains records (documenting attendance, committee findings, recommendations, and actions)

Implements a process to collect, monitor, analyze, evaluate, and report utilization data consistent with all reporting requirements

Informs of child-specific training needs for providers and staff

For children eligible for HCBS, the Child QI-UMC will report, monitor, and recommend appropriate action on the following metrics:

Use of crisis diversion and crisis intervention services

Prior authorization/denial and notices of action

HCBS utilization

HCBS quality assurance measures as determined by the State

X. Behavioral Health Credentialing Criteria

Healthfirst credentialing criteria for OMH and OASAS behavioral health providers include the following:

Healthfirst will accept OMH license, OASAS licenses, and other state designations of providers, in place of Healthfirst's credentialing process, for individual employees, subcontractors, or agents of such providers. Healthfirst will collect and accept program integrity–related information as part of the licensing and certification process.

When contracting with NYS-designated providers, Healthfirst will not separately credential individual staff members in their capacity as employees of these programs.

Healthfirst requires that OMH and OASAS providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid programs.

XI. Confidentiality

Policies and procedures regarding confidentiality requirements for mental health and substance use information are covered in the main provider manual, Section 5.3.

XII. Provider Training

Providers are required to be trained on Healthfirst policies and procedures. These include all contracted providers. Such policies and procedures cover any additional policies or reference documents about the needs for special-needs members and how to assist in the access of covered services. Such policies will ensure that providers are fully cognizant and compliant with federal and State regulations and program standards. Healthfirst requires that providers meet the applicable State minimum training requirements, including minimum hours and topics of training.

Healthfirst Behavioral Health Network Representatives (BH Reps) are assigned to service providers based on the Network Management Organizational chart and region. Each BH Rep can service hospitals, ancillary providers, or community-based providers. As BH Reps they are fully available throughout the week for the following purposes: provider education, technical support, and other service issues that either the provider or Healthfirst may identify to warrant discussion in the appropriate face-to-face meeting. Other avenues of education can be through phone, email, webinar, or other appropriate mode of communication that the provider and representatives find most convenient and effective.

Below are examples of items that are reviewed and re-reviewed according to the various needs and requirements of the provider or the plan:

- Demographic Confirmation
- Introduction to Healthfirst
- Documentation Requirements
- Cultural Competence in Practice
- Authorization Requests and UM Protocols
- HCBS Eligibility Criteria and Processes for Adults and Children
- Healthfirst Provider Portal and other Online Tools
- Claims Submission

In addition to training provided by BH Reps, BH clinical training will be made available to providers.

Healthfirst regularly monitors the adherence of Health Homes, PCPs, and BH providers to offered trainings.

XIII. Quality Assurance

Healthfirst tracks any deficiencies in performance and corrective action taken with OMH and OASAS licensed, certified, or designated providers. Upon discovery, any serious or significant health and safety concerns will be immediately reported to OMH and OASAS.

Healthfirst follows a protocol to ensure that clinical quality of care issues/sentinel events are addressed and investigated in a timely manner. When the review/investigation has been completed, the outcome/recommendation is communicated to relevant parties; provider-level outcome data is forwarded to the Credentialing Unit annually for inclusion in the provider's file, as appropriate. A summary report of all clinical quality-of-care referrals, including classification, disposition, recommendations, and status, will be presented to the HCQC/QIC as a standing agenda item.

XIV. First-Episode Psychosis

OnTrack-NY is an evidence-based program to address the specific needs of those suffering a first-episode psychosis. As HF expands its behavioral health management programs, we look to initially have the OTNY program available for our members 18–30 who are experiencing their first episode of psychosis. We anticipate identifying the initial cohort of members through our care management/utilization management (UM) of inpatient admissions, provider referrals, and member/family referrals. Once identified, we will offer

OTNY programs to these members as a potential transition service, as described below.

Members identified through the Healthfirst Care Management Program will be referred to an HF Behavioral Health Case Manager and evaluated to determine if they meet criteria for first-episode psychosis (FEP). The member and his/her care team (including providers and support persons) will be educated about OTNY, and members who are interested in the program will be assisted with making a referral to facilitate engagement in services. HF Case Managers will provide appropriate, alternative treatment referrals to all members who are not interested in participating in OTNY.

During the course of utilization review of higher levels of care, HF Care Managers will collaborate with providers to determine if individuals meet criteria for FEP. Once a member has been identified as an individual with a first-episode psychosis, the HF care management staff will inform and educate the referring entity (i.e., inpatient treatment team, outpatient provider, family, etc.) of the availability of OTNY as a transition plan for the member and will assist with the referral. The member and family will also be educated and informed of other in-network services available to them.

If the member prefers not to attend OTNY, the HF staff will work with the treatment team and member to design and institute an appropriate plan for services. However, if the member wishes to attend OTNY, the HF staff will work to effectuate a referral to the appropriate OTNY program.

XV. Emergency Pharmacy Protocols for Enrollees with Behavioral Health Conditions

Except where otherwise prohibited by law, Healthfirst will allow a pharmacy to dispense, without prior authorization, up to a 72 (seventy-two)-hour emergency supply of the prescribed drug or medication when an individual with a behavioral condition experiences an emergency condition, defined by New York State as:

A. Placing the health or safety of the person afflicted with such condition or other person or persons in serious jeopardy;

B. Serious impairment to such person's bodily functions;

C. Serious dysfunction of any bodily organ or part of such person;

D. Serious disfigurement of such person; or

E. Severe discomfort – for enrollees with a behavioral condition, a determination of severe discomfort shall include a situation where the enrollee is:

Experiencing substantial discomfort or the expectation that such discomfort will result without the medication;

Stable on a medication that is prescribed by the enrollee's current provider but is transferring to a new provider or to a new level of care;

Stable on a medication and is changing healthcare plans; and/or

Experiencing a return or worsening of behavioral health symptomatology as a result of the anticipation of cessation of the medication.

Healthfirst will also allow a pharmacy to dispense up to a seven-day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization (e.g., buprenorphine, buprenorphine/naloxone).

XVI. Healthfirst Care Manager Responsibilities

The Care Manager for UM will make authorizations for admission, continued stay, and step-down level of care decisions to ensure the right intensity of treatment at the least restrictive level to meet the member's clinical needs. The goal is to provide appropriate resources to support the member and sustain him/her in the community, reducing ED visits and re-admissions to acute care while facilitating access to essential person-

centered, integrated, health and recovery-oriented services in the community. If a medical necessity denial for a level of care takes place because the treatment plan is felt not adequate or appropriate for the member, and Healthfirst cannot reach an agreement on length of stay or adequacy of the treatment plan, the clinician managing this member will work with the facility on next steps for continued care for the member which might be at a higher or lower intensity setting of care and will collaborate to ensure that the member is referred and connected to the services that will be most appropriate for his/her clinical and psychosocial needs. The clinical staff is committed to continuing to follow the member's care so long as the clinical needs exist, and matching services and settings of care to those needs will be the priority.

XVII. Continuity of Care

A. Section 12.6 of this manual addresses the continuity of care transition period for when a new member is currently undergoing a course of treatment with a non-participating provider as well as when a member's current provider terminates their agreement with Healthfirst. In all cases, continuation of care with a non-participating provider depends upon the provider's acceptance of state-mandated reimbursement rates as payment in full. The provider must also agree to do the following:

i. Adhere to Healthfirst's quality assurance requirements;

ii. Abide by all Healthfirst policies and procedures;

iii. Provide Healthfirst with medical information related to the member's care;

iv. Obtain prior authorization from Healthfirst Clinical teams for applicable services;

v. Agree not to "balance-bill" the member for services provided.

B. Healthfirst will execute Single Case Agreements (SCAs) with non-participating adult and child providers to meet clinical needs of members when in-network services are not available. Healthfirst will pay at least the FFS fee schedule for 24 months following any BH carve-in for all SCAs.

C. Healthfirst will pay at least the Medicaid FFS fee schedule for 24 months after the carve-in date, or as long as New York State mandates (whichever is longer) for the following children's services/providers:

i. New EPSDT SPA services, including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports

ii. OASAS clinics (Article 32 certified programs)

iii. All OMH Licensed Ambulatory Programs (Article 31 licensed programs)

iv. Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

D. Providers who historically delivered children's care management services under one of the 1915(c) waivers being eliminated, and who will provide care management services that are being transitioned to Health Home:

i. May receive a transitional rate for no more than 24 months after the carve-in date

ii. The transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home

E. Healthfirst will contract with OASAS residential programs and pay their allied clinical service providers on a single-case or contracted basis for members who are placed in an OASAS-certified residential program to ensure access to and continuity of care for patients placed outside of Healthfirst's service area.

F. Adult and child HCBS providers will be paid according to the NYS fee schedule as long as Healthfirst is not at risk for the service costs

i. At least two years after the carve-in date for adults and children, or until HCBS are included in the capitated rates

XVIII. Behavioral Health Care Management Program – Supplement to Provider Manual Section 13.1

Healthfirst uses data analytics, HRAs, and pharmacy management tools to identify members for care management who are at risk for poor health outcomes due to persisting or unstable mental health or substance use disorders, complex care needs, or social risk factors such as homelessness, poverty, or lack of adequate supports.

Members are also identified for BH care management and targeted outreach through the following sources:

A. Utilization data identifies:

i. Members with chronic conditions; physical health, mental illness and/or substance use disorders

ii. Members with frequent emergency department (ED) utilizations

iii. Members with frequent hospitalizations

iv. Members with high-risk comorbidities

v. Other high-risk groups such as members with first-episode psychosis, pregnant, I/DD or older adults with a BH condition, individuals with a SUD in need of medication-assisted treatment

B. Demographic, encounter, and other data identify high-risk populations such as homeless individuals, transition age youth, individuals with AOT orders.

C. Community referrals

D. Internal referrals (e.g., Member Services, network, UR, A/G)

E. External referrals (e.g., PCP, specialist, home care agency, hospital discharge planners)

F. Member /Family self-referrals

Members who may qualify for HARP are notified of their option to review this possibility with the state-identified HARP enrollment broker.

Healthfirst regularly screens members to determine their eligibility to participate in New York State's Health Home program. Members meeting program criteria established by the state are assigned to a Health Home for outreach and engagement in health home care management.

XIX. Peer Reviewers

Peer reviewers making determinations for denials, grievances, and appeals are board-certified psychiatrists, licensed doctoral-level psychologists, and physicians board certified in addiction medicine or addiction psychiatry, as well as child, adolescent, and geriatric specialties. Denials for services for medically fragile children will be reviewed by a physician.

All inpatient level of care determinations for psychiatric treatments will be made by a board-certified physician in general psychiatry. Furthermore, all inpatient level of care determinations for substance use disorders will be made by a physician certified in addiction treatment.

XX. Health Home Care Management

The Healthfirst (HF) Health Home Program promotes access to primary, specialty, and behavioral health care, social services, and community supports for members who meet program eligibility criteria defined by the New York State Department of Health (NYSDOH).

Through collaboration between Healthfirst and contracted Health Homes, the HF Health Home Program provides member assignment, data to support engagement and enrollment, member assessment, care planning and performance monitoring, and care coordination support as indicated.

Healthfirst reviews key clinical indicators within our membership, and initiates the assignment of eligible members to the Health Home that best suits the needs of the member.

Healthfirst Physical Health and Behavioral Health Care Managers collaborate with Health Home Care Managers on complex member issues, providing condition management support, navigation assistance, health and benefit information, and referrals. The HF Care Managers act as liaisons to other network providers and facilitate bidirectional communication between members of the care team to ensure effective coordination and delivery of services.

Healthfirst monitors performance of the Health Home program and meets regularly with Health Home partners to review key processes and quality indicators driving the achievement of program objectives. Healthfirst tracks, monitors, and analyzes Health Home data for discussion during monthly meetings including, but not limited to:

Volume and transition of enrollment statuses of high-risk members;

Health Home Care Management Agency network participation and outstanding issues;

Quality-of-care issues (e.g., coordination of care efforts, access to care, reduction of gaps in care, etc.);

Plan of Care creation, review, submission, and monitoring processes;

Claims submission and quality of documentation

These meetings are designed to enhance the working relationship between HF, health homes, and the providers serving our members. The meetings are led by the HF Health Home Program team with members of HF's clinical team also attending. The designated Health Home Program team is available for Health Homes and network providers to facilitate referrals and service coordination.

XXI. Children's Medicaid Redesign

Consistent with New York State's vision to promote better access to integrated services for children and youth with complex needs, Healthfirst will promulgate evidence-based practice guidelines that emphasize early identification and intervention, health maintenance, person- and family-centered care, and effective care coordination activities. This encompasses an expanded array of benefits in addition to the inclusion of some populations and services previously carved out of Medicaid Managed Care for individuals under age 21. On or after October 1, 2019, children covered under the following waivers will be transitioned into Medicaid Managed Care:

OMH Serious Emotional Disturbance (SED) 1915c waiver (NY.0296)

Bridges to Health (B2H) SED 1915c waiver (NY.0469)

Bridges to Health (B2H) Medically Fragile 1915c waiver (NY.0471)

Bridges to Health (B2H) DD 1915c waiver (NY.0470)

DOH Care at Home (CAH) I/II 1915c waiver (NY.4125)

Office for People With Developmental Disabilities (OPWDD) Care At Home (CAH) waiver #NY.40176

Additionally, children in Voluntary Foster Care Agencies (VFCA) will begin to be enrolled no earlier than October 1, 2019. Medicaid eligibility criteria will be expanded to children who meet at-risk Level of Need criteria and are determined to be Medicaid eligible through Family of One and receive HCBS no earlier than January 1, 2020.

A. Continuity of Care: Healthfirst enrollees transitioning from Medicaid FFS who were receiving medical, Behavioral Health, Health Home Care Management, and/or HCBS will be allowed to continue with their same providers for continuity-of-care purposes. This will continue for the first 24 months of the transition, and it applies to episodes of care that were ongoing during the transition period. A Single Case Agreement (SCA) will be completed for any provider working with a transitioning member that is not contracted with Healthfirst.

B. Utilization Management: Please see sections IV, V, VII, and VIII of the Behavioral Health Addendum (Addendum A) for further guidance. Please also note the following:

i. Healthfirst will not apply utilization review criteria for a period of 180 days from the implementation date of the transition for all children's services newly carved into managed care. However, this prohibition will not apply to services already covered before the transition.

ii. For children transitioning from a 1915c waiver, Healthfirst will authorize all covered HCBS and LTSS in accordance with the most recent Plan of Care (POC) for at least 180 days following the transition date of children's specialty services. This means that service frequency, scope, level, quantity, and existing providers at the time of the transition will remain unchanged. Additionally, Healthfirst will authorize any children's specialty services that are added to the POC under a person-centered planning process without conducting utilization review during the initial 180 days of the transition. After 180 days, a new Plan of Care is to be developed.

iii. For a period of 24 months from the date of transition of children's specialty services, Medicaid Fee For Service children receiving HCBS upon enrollment into Healthfirst will be authorized for all services covered in the most recent POC for 180 days without utilization review.

C. Medically Fragile Children: Healthfirst will make every effort to contract with providers who have expertise in caring for Medically Fragile (MF) children, to ensure that MF children, including children with co-occurring developmental disabilities, receive services from appropriate providers. Network providers will refer to appropriate network community and facility providers to meet the needs of MF children. In the event that network providers are unable to make such referrals, they will seek authorization to refer to out-of-network providers.

i. Healthfirst will authorize services for MF children in accordance with established timeframes in the Medicaid Managed Care Model Contract; OHIP Principles for Medically Fragile Children (Attachment G); under EPSDT, HCBS, and CFCO rules; and with consideration for extended discharge planning.

D. Children in Foster Care: Healthfirst will endeavor to contract with providers servicing children in Foster Care, including but not limited to Voluntary Foster Care Agencies (VFCA), primary care and other healthcare providers, and Behavioral Health providers in its service area. Healthfirst will execute Single Case Agreements with any provider for a child placed outside its service area, in order to ensure there is no disruption of the care plan in place for that child. Healthfirst will permit the enrollee to access a new primary care provider and other healthcare providers, including those with expertise treating children involved in Foster Care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services. Healthfirst will ensure there is no disruption in the Plan of Care.

E. Transition Period (90 days before go-live):

i. Healthfirst will begin accepting Plans of Care (POCs) for children receiving HCBS during the transition period, beginning July 1, 2019 for already enrolled members; and for families

who have completed the selection process, chosen Healthfirst as their plan, and have consented to share the POC with Healthfirst.

ii. Beginning August 1, 2019, Healthfirst will accept POCs for children in the care of a LDSS/licensed VFCA, where Healthfirst has been selected as the plan

iii. After the transition period ends, Healthfirst will continue to accept POCs for children receiving HCBS in advance of the effective date of enrollment when notified by another plan, a Health Home Care Manager, or the independent entity that there is consent to share the POC with Healthfirst and the family has demonstrated the plan selection process has been completed, or the child is in the care of a LDSS/licensed VCFA and it has been confirmed that Healthfirst has been selected as the plan.

F. Home and Community-Based Services (HCBS) for Children

HCBS will be managed in compliance with CMS HCBS Final Rule and any applicable State guidance. For children who are deemed eligible, access to an enhanced benefit package will be offered in addition to all Medicaid behavioral health and physical health benefits. The enhanced benefit package of Home and Community-Based Services (HCBS) is designed to assist children/youth in their recovery and continued tenure in the community. In order to receive HCBS, members must receive an initial assessment, with follow-up assessments annually. The process for referral and HCBS eligibility assessment is described below:

i. For members enrolled in a Health Home, the Health Home Care Manager (HHCM) will use the State-designated CANS-NY tool to conduct an HCBS Eligibility Determination. If eligible for HCBS, the HHCM will assist the member and family in selecting relevant HCBS providers from Healthfirst's network.

ii. For members who opt out of Health Home care management, a State-designated Independent Entity (IE) will conduct the HCBS Eligibility assessment.

iii. When a member is found eligible for HCBS, the HHCM or IE will develop a fully integrated person-centered Plan of Care (POC) in collaboration with the member, and in consultation with providers, family members, and legal guardians as necessary. This plan will be shared with Healthfirst as a request to access HCBS. Healthfirst Care Managers will review the POC and issue an initial "level of service determination."

iv. When an initial POC is received, and on an ongoing basis, Healthfirst will review and make determinations regarding the appropriateness of the POC submitted by the HHCM or IE. Healthfirst Care Managers will review Plans of Care to assure that all federal and state HCBS regulations are addressed in the member's care

v. Ongoing determinations regarding the appropriateness and utilization of HCBS will be made utilizing the OMH-approved UM guidelines for HCBS, taking into account the member's preferences and desired outcomes. Healthfirst CMs will review care plans, along with authorization and claims data, to ensure appropriate utilization of HCBS as delineated in the POC.