This section of the Fidelis Care Provider Manual provides information for providers serving Fidelis HealthierLife Health and Recovery Plan (HARP) members. HealthierLife is presently available in the following counties: Bronx, Kings, New York, Queens, and Richmond.

This manual is reviewed and updated periodically. The manual version and date of review or revision is included in the footer of this document.

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HEALTHIERLIFE MODEL OF CARE

Consistent with the vision put forth by the State of New York, Fidelis Care seeks to create an environment where managed care plans, service providers, peers, families, and government agencies partner to help members prevent chronic health conditions and recover from serious mental illness and substance use disorders. The partnership will be based on the following values:

1. **Person-Centered Care:** Care should be self-directed whenever possible and emphasize shared decision-making approaches that empower members, provide choice, and minimize stigma.

2. **Recovery-Oriented:** The system should include a broad range of services that support recovery from mental illness and/or substance use disorders.

3. **Integrated:** Service providers should attend to both physical and behavioral health needs of members, and actively communicate with care coordinators and other providers to ensure health and wellness goals are met.

4. **Data-Driven:** Providers and plans should use data to define outcomes, monitor performance, and promote health and wellbeing.

5. **Evidence-Based:** The system should incentivize provider use of evidence-based practices (EBPs) and provide or enable continuing education activities to promote uptake of these practices.

DELIVERY OF SERVICE TO MEMBERS

- Each Fidelis HealthierLife Member has a member identification card on which is the name and telephone number of the member’s Primary Care Physician (PCP).

- To verify eligibility, call 1-888-FIDELIS (1-888-343-3547). To obtain eligibility or status of claims please go to [https://providers.fideliscare.org](https://providers.fideliscare.org) to access our secure Provider Portal.

- Fidelis Care is responsible for administering Medicaid approved benefits for members enrolled in our HealthierLife plan. In rendering care to HealthierLife members, you are asked to provide integrated treatment that helps move a person toward his or her individual recovery goals, monitor health status, manage co-occurring chronic diseases, avoid inappropriate hospitalizations, and help beneficiaries move from high risk to lower risk on the care continuum.

MEMBER ELIGIBILITY

**Eligible Populations**

The HealthierLife will be available to individuals who meet all of the following criteria:

1. Adult Medicaid beneficiaries 21 and over who are eligible for mainstream MCOs are eligible for enrollment in the HealthierLife if they meet either:

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1 One exception: individuals in nursing homes for long term care will not be eligible for enrollment in HARPS.
2. Target criteria and risk factors as defined below (Individuals meeting these criteria will be identified through quarterly Medicaid data reviews by Plans and/or NY State); or

3. Service system or service provider identification of individuals presenting with serious functional deficits as determined by:
   a. A case review of individual’s usage history to determine if Target Criteria and Risk Factors are met; or
   b. Completion of HealthierLife eligibility screen.

HealthierLife Target Criteria: The State of New York has chosen to define HealthierLife targeting criteria as:
   1. Medicaid enrolled individuals 21 and over;
   2. SMI/SUD diagnoses;
   3. Eligible to be enrolled in Mainstream MCOs;
   4. Not Medicaid/Medicare enrolled (“duals”);
   5. Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).

HealthierLife Risk Factors: For individuals meeting the targeting criteria, the HealthierLife Risk Factor criteria include any of the following:
   i. Supplemental Security Income (SSI) individuals who received an “organized” \(^2\) MH service in the year prior to enrollment.
   ii. Non-SSI individuals with three or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.
   iii. SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment.
   iv. SSI and non-SSI individuals with 3 or more psychiatric inpatient admissions in the three years prior to enrollment.
   v. SSI and non-SSI individuals discharged from an OMH Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment.
   vi. SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment.
   vii. SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four years prior to enrollment.
   viii. Residents in OMH funded housing for persons with serious mental illness in any of the three years prior to enrollment.
   ix. Members with two or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.
   x. Members with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment.
   xi. Members with two or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD related medical diagnosis-related group and a secondary diagnosis of SUD within the year prior to enrollment.
   xii. Members with two or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.
   xiii. Individuals transitioning with a history of involvement in children’s services (e.g., RTF, HCBS, B2H waiver, RSSY).

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\(^2\) An “organized” MH service is one which is licensed by the NYS Office of Mental Health.
### SUMMARY OF BENEFITS

<table>
<thead>
<tr>
<th>Services Covered in HealthierLife</th>
<th>Home and Community Based Services (HCBS) Covered in the HealthierLife Enhanced Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medically supervised outpatient withdrawal services</td>
<td>• Psychosocial Rehabilitation</td>
</tr>
<tr>
<td>• Outpatient clinic and opioid treatment program</td>
<td>• Community Psychiatric Support and Treatment (CPST)</td>
</tr>
<tr>
<td>• Outpatient clinic services</td>
<td>• Habilitation/Residential Support Services</td>
</tr>
<tr>
<td>• Comprehensive psychiatric emergency program (CPEP)</td>
<td>• Family Support and Training</td>
</tr>
<tr>
<td>• Continuing day treatment program (CDTP)</td>
<td>• Education Support Services</td>
</tr>
<tr>
<td>• Partial hospitalization program (PHP)</td>
<td>• Empowerment Services – Peer Supports</td>
</tr>
<tr>
<td>• Personalized recovery oriented services (PROS)</td>
<td>• Non-Medical Transportation</td>
</tr>
<tr>
<td>• Assertive Community Treatment (ACT)</td>
<td>• Pre-vocational Services</td>
</tr>
<tr>
<td>• Intensive Case Management/Supportive Case Management</td>
<td>• Transitional Employment</td>
</tr>
<tr>
<td>• Health Home Care Coordination and Management</td>
<td>• Intensive Supported Employment</td>
</tr>
<tr>
<td>• Inpatient hospital detoxification service</td>
<td>• Ongoing Supported Employment</td>
</tr>
<tr>
<td>• Inpatient medically supervised inpatient detoxification</td>
<td></td>
</tr>
<tr>
<td>• Inpatient treatment services (OASAS)</td>
<td></td>
</tr>
<tr>
<td>• Rehabilitation services for residential SUD treatment supports (OASAS)</td>
<td></td>
</tr>
<tr>
<td>• Inpatient psychiatric services (OMH)</td>
<td></td>
</tr>
<tr>
<td>• Rehabilitation services for residents of community residences</td>
<td></td>
</tr>
<tr>
<td>• Mobile Crisis Intervention</td>
<td></td>
</tr>
</tbody>
</table>

*Please see the HCBS Manual for service definitions.*

### ACCESS AND AVAILABILITY STANDARDS

Physical health and behavioral health services:

The following minimum appointment availability standards apply to physical health and behavioral health services:

- For emergency care: **immediately** upon presentation at a service delivery site.
- For urgent care: within **twenty-four (24) hours** of request.
- Non-urgent “sick” visit: within **forty-eight (48) to seventy-two (72) hours** of request, as clinically indicated.
- Routine non-urgent, preventive appointments: within **four (4) weeks** of request.
- Specialist referrals (not urgent): within **two (2) to four (4) weeks** of request.
- Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a provider (as included in the Benefit Package): within **five (5) days** of discharge.
- Non-urgent mental health or substance abuse visits with a provider
included in the Benefit Package): within two (2) weeks of request.
• Provider visits to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding a recipient’s ability to perform work within ten (10) Business days of request.
• Mental Health Clinics must provide a clinical assessment within five (5) days for individuals in the following designated groups:
  • Individuals in receipt of services from a mobile crisis team not currently receiving treatment
  • Individuals in domestic violence shelter programs not currently receiving treatment
  • Homeless individuals and those present at homeless shelters who are not currently receiving treatment
  • Individuals aging out of foster care who are not currently receiving treatment
  • Individuals who have been discharged from an inpatient psychiatric facility within the last 60 days who are not currently receiving treatment
  • Individuals referred by rape crisis centers
  • Individuals referred by the court system.

After Hours:
PCP, Behavioral Health Service, and specialty Participating Provider contracts shall provide on-call coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.
### Table 4. Appointment Availability Standard by BH Service Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non-urgent MH/SUD</th>
<th>BH Specialist</th>
<th>Follow-up to emergency or hospital discharge</th>
<th>Follow-up to jail/prison discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Outpatient Clinic/PROS Clinic</td>
<td>Within 24 hrs of request</td>
<td>Within 1 wk</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td>Within 24 hrs of request</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROS</td>
<td>Within 24 hrs of request</td>
<td>Within 2 wks</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing Day Treatment</td>
<td>2-4 wks</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRT</td>
<td>2-4 wks</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPEP</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis intervention</td>
<td>Upon presentation</td>
<td>Within 24 hours for short term response</td>
<td>Immediate</td>
<td>Immediate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Mental Health Services (These are 569 clinic services offered in the community)</td>
<td>Within 24 hrs of request</td>
<td>Within 1 wk</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OASAS Outpatient Clinic</td>
<td>Within 24 hrs of request</td>
<td>Within 1 wk</td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detoxification</td>
<td>Upon presentation</td>
<td></td>
<td></td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUD Inpatient Rehab</td>
<td>Upon presentation</td>
<td>Within 24 hrs of request</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid Treatment Program</td>
<td>Within 24 hrs of request</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td>Within 5 days of request</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Behavioral health Home and Community Based Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Non-urgent MH/SUD</th>
<th>BH Specialist</th>
<th>Follow-up to emergency or hospital discharge</th>
<th>Follow-up to jail/prison discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial Rehabilitation, CPST, Habilitation, and Family Support and Training</td>
<td>n/a</td>
<td>n/a</td>
<td>Within 2 weeks of request</td>
<td>Within 5 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short Term and Intensive Crisis Respite</td>
<td>Immediately</td>
<td>Within 24 hours</td>
<td>n/a</td>
<td>Immediate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational and Employment Support Services</td>
<td>n/a</td>
<td>n/a</td>
<td>Within 2 weeks of request</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Supports</td>
<td>n/a</td>
<td>Within 24 hours for symptom management</td>
<td>Within 1 week of request</td>
<td>Within 5 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PROVIDER TRAINING

The Fidelis Care HARP/HealthierLife Provider Training Program is a comprehensive provider training and support program designed for network providers to gain appropriate knowledge, skills, and expertise and receive technical assistance to comply with the requirements under managed care. The development and coordination of the annual training will be done with the Regional Planning Consortium (RPCs) and will include input from members and their families. Fidelis Care will work with these individuals to the extent possible to incorporate their insights and provide support in delivering the trainings themselves.

This training will be made available at a variety of times and modalities to ensure all providers have an opportunity to participate. Materials and training schedule will be made available on the website and will be updated as needed (and at least annually).

- Technical assistance on billing, coding, data interface, documentation requirements, UM requirements, (re)credentialing
- Training on person-centered planning
- Use of evidence-based practices and specific levels of quality outcomes
- Linguistically- and culturally-competent services
- Clinical training as appropriate by specialty and provider type

Consistent with the guiding principles of the Health and Recovery Program (HARP), Fidelis Care is dedicated to insuring that the provider network adheres to recovery-oriented principles, including provision of person-centered services. Training opportunities will coordinated with Health Homes and other resources such as the Regional Planning Partnerships to enshrine person-centered, recovery-oriented services are delivered in a culturally competent fashion.

LANGUAGE LINES

The Fidelis Care HealthierLife Plan makes resources available (such as language lines) to medical, behavioral, community-based and facility-based LTSS, and pharmacy providers who work with Members that require culturally, linguistically, or disability-competent care.

Providers may provide and be reimbursed for translator services using Code T1013. If a translator is not available, a language line or TTY line can be accessed by calling the Fidelis Care Provider Call Center at 1-888-FIDELIS (1-888-343-3547).

INTERDISCIPLINARY CARE TEAM

A HealthierLife Care Manager will be assigned to each HealthierLife member to assist with care coordination. In coordination with the assigned Health Home, the Care Manager will develop an initial person centered service plan (PCSP), ensure that requested services are appropriate and authorized, and will ensure that acceptable, appropriate and accessible alternative services are coordinated and authorized when the requested services are not congruent with the Member’s individual recovery goals.

HealthierLife is a recovery-oriented, person-centered model of care. The member is at the center of the inter-disciplinary team and all activities of the team are focused on identifying needs and providing for the whole health and well being of the member. In the HealthierLife model, the team is comprised of individuals who will provide person-centered care coordination and care management to members. In HealthierLife, each member will be eligible for Health Home services, and the Health Home care manager will be the lead in coordinating both physical and behavioral healthcare needs, as well as assessing the need for and coordinating the member’s...
HCBS services. The Fidelis Care Manager will support this effort, identify any gaps, and ensure that any gaps have been adequately addressed. The collective activities are done in collaboration to promote the Member’s physical and behavioral health and wellness, improve social and occupational functioning, sustain community tenure, and maximize self-determination.

The interdisciplinary team facilitates timely and thorough coordination between the HealthierLife Plan, the Health Home, the behavioral and physical health providers, HCBS other providers, and the member’s natural supports. The PCSP will be based on the assessed needs and articulated preferences of the member, and delineate coverage determinations consistent with this Plan. The finalized PCSP will articulate service authorizations, and are appealable by the member, their providers, and their representatives.

PCSPs shall include Home and Community Based Services (HCBS) eligibility assessment process including use of InterRAI tool, guidance on care planning process, guidance on care management, care coordination, and working with health homes. Assessments must be conducted by a health home or state designated entity in compliance with conflict free case management requirements.

Collaboration/Coordination of Care

Effective working relationships between providers and other treatment partners and service sites is an evidence-based practice, and thus will result in improved member health outcomes, improved continuity and coordination of care, increased quality, efficiency and effectiveness of services, and increased member satisfaction. All collaboration efforts should be documented in the medical record.

Why Collaboration with Primary Care Physicians (PCPs) is Necessary:
Persons with mental illness die on average 25 years sooner than the average population. Members may remain untreated or under-treated if PCPs do not recognize members at risk for or with active mental or addictive disorders. Physical symptoms or general medical co-morbidity complicates most behavioral conditions. Psychotropic medications may interact adversely with other medications or cause physical side effects. Medical laboratory or physical examinations may be necessary for members on psychotropic medications. The PCP may prescribe psychotropic medications themselves.

In addition to mitigating the physical health risks associated with mental illness, promoting healthy behaviors also requires close collaboration and coordination with PCPs and other health professionals for member safety and optimal quality of care.

Behavioral health care providers should communicate with the member’s PCP:

1. For the exchange of clinical information, when necessary, that may aid in diagnosis and/or treatment;

2. When the PCP’s support for a treatment plan would enhance member satisfaction and/or compliance;

3. When there are possible medical co-morbidities and/or medication interactions that need to be considered; and

4. When PCP has requested immediate feedback.
If the member is using behavioral health services in a clinic that also provides primary care services, enrollee may select lead behavioral health provider to function as their PCP.

**First Episode Psychosis (FEP):** The provider, in collaboration with Fidelis Care and the Health Home (when involved), will utilize available data to identify members with FEP. Appropriate resources, such as those available through OnTrack NY (through the Center for Practice Innovations) will be engaged to assure comprehensive and integrated aftercare planning designed to facilitate prompt, extended follow up of these members to identify and address barriers to successful community tenure and avoidance of readmission.

Fidelis Care staff conducts annual site visits to selected providers' offices to provide education and performs a chart review to verify that collaboration of care is occurring and clinical documentation is meeting industry standards.

**PRIOR AUTHORIZATION**

Expeditied and standard requests for prior authorization of services not already authorized as part of the HealthierLife member’s PCSP may be submitted through the traditional prior authorization process. Primary care physicians and other providers can call or fax a treatment request that Fidelis Care may use as a basis for authorizing services.

When referring for services covered in the service benefits package, ensure that the provider is contracted and participating in the network. If you have any questions, please contact Fidelis Care.

Members can choose any participating hospital or specialist they wish; however, please contact the member's HealthierLife Care Manager. This will aid the Care Manager in properly coordinating services.

Once a request has been approved by Fidelis Care, authorizations will be issued for each service.

A licensed Behavioral Health Case Manager will be available after regular business hours, from 5:00pm to 8:30am and on weekends and holidays, in order to arrange care and coverage 24 hours a day for physical health and behavioral health care, respectively. Please call 1-877-533-2404.

Providers shall have policies and procedures addressing enrollees who present for unscheduled non-urgent care with aim of promoting enrollee access to appropriate care in the most appropriate setting in order to meet the recovery needs of the person seeking care.

Fidelis Care is responsible for coordinating, arranging, and authorizing payment to providers for the member’s medically and clinically necessary covered services. Covered services are provided through a network of participating healthcare providers as listed in Fidelis Care's Provider Directory.
<table>
<thead>
<tr>
<th>Mental Health Service</th>
<th>Prior Auth</th>
<th>Concurrent Review</th>
<th>Medical/Clinical Necessity Criteria</th>
<th>Additional Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient clinic services (OMH services)</td>
<td>No</td>
<td>No</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td>Internal report of Outpatient visits to identify utilization that might indicate a need for additional supports and recovery services, quality issues, and/or changes in services.</td>
</tr>
<tr>
<td>Intensive Outpatient (OMH)</td>
<td>No</td>
<td>Yes</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td>7 service days, then concurrent</td>
</tr>
<tr>
<td>Mental Health Continuing Day Treatment (CDT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – See Section 21 Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization (PHP)</td>
<td>Yes</td>
<td>Yes</td>
<td>Milliman Care Guidelines, most recent edition</td>
<td></td>
</tr>
<tr>
<td>Personalized Recovery Oriented Services (PROS) Pre-Admission</td>
<td>No</td>
<td>No</td>
<td>NYS guidelines – See Section 21 Behavioral Health</td>
<td>Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.</td>
</tr>
</tbody>
</table>
| Personalized Recovery Oriented Services (PROS) Admission: Individualized Recovery Planning | Yes | No | NYS guidelines – See Section 21 Behavioral Health | Admission begins when ISR is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for:  
• Clinical Treatment;  
• Intensive Rehabilitation (IR); or  
• Ongoing Rehabilitation and Supports (ORS). Prior authorization will |
<table>
<thead>
<tr>
<th>Service</th>
<th>Available</th>
<th>Covered</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalized Recovery Oriented Services (PROS)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – See Section 21 Behavioral Health</td>
</tr>
<tr>
<td>Active rehabilitation</td>
<td></td>
<td></td>
<td>begins when IRP is approved by Plan. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/Community Rehabilitation and Support (CRS) and Clinic Treatment services.</td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – See Section 21 Behavioral Health</td>
</tr>
<tr>
<td>New ACT referrals must be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness consistent with ACT guidance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Psychiatric Rehabilitation Treatment (IPRT)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – See Section 21 Behavioral Health</td>
</tr>
<tr>
<td>Comprehensive Psych Emergency Room (CPEP)</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Inpatient Psychiatric Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Milliman Care Guidelines, most recent edition</td>
</tr>
<tr>
<td>Mobile Crisis Intervention</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services for residents of community residences</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – See Section 21 Behavioral Health</td>
</tr>
<tr>
<td>Internal report of crisis visits to identify utilization that might indicate a need for additional supports and recovery services, quality issues, and/or the need for changes in services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Service</td>
<td>Prior Auth</td>
<td>Concurrent Review</td>
<td>Medical/Clinical Necessity Criteria</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>SUD Outpatient Clinic Services (non-intensive)</td>
<td>No</td>
<td>No</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
</tr>
<tr>
<td>OASAS Part 822 Outpatient Clinic Services, including off-site clinic</td>
<td>No</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
</tr>
<tr>
<td>Substance Use Disorder Intensive Outpatient</td>
<td>No</td>
<td>No</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
</tr>
<tr>
<td>OASAS Part 822 Outpatient Clinic Services, including off-site clinic</td>
<td>No</td>
<td>No</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
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<tr>
<td>Medically Supervised Outpatient Withdrawal</td>
<td>No</td>
<td>No</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
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<tr>
<td>Opioid Treatment Program Services</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>OASAS Part 822 Opioid Treatment Program (OTP) Services</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Outpatient Substance Use Disorder Rehabilitation Services</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Inpatient Hospital Detoxification (OASAS service)</td>
<td>Yes</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
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<tr>
<td>Inpatient Medically Supervised Inpatient Detoxification (OASAS service)</td>
<td>Yes</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
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<tr>
<td>Inpatient Treatment (OASAS service)</td>
<td>Yes</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
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<tr>
<td>Rehabilitation Services for Residential SUD Treatment Supports (OASAS service)</td>
<td>Yes</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
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<tr>
<td>Inpatient Rehabilitation Services</td>
<td>Yes</td>
<td>Yes</td>
<td>LOCADTR 3.0 <a href="http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm">http://www.oasas.ny.gov/treatment/health/locadtr/index.cfm</a></td>
</tr>
</tbody>
</table>
### Home and Community Based Services – Review Guidelines and Criteria

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in a Health and Recovery Plan (HealthierLife) to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans (Plans), Health Home care

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<table>
<thead>
<tr>
<th>Home &amp; Community Based Service</th>
<th>Prior Auth</th>
<th>Concurrent Review</th>
<th>Medical/Clinical Necessity Criteria</th>
<th>Additional Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Community Psychiatric Support and Treatment (CPST)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Habilitation/Residential Support Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Family Support and Training</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Short Term Crisis Respite</td>
<td>No</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td>3 service days, then concurrent. No HCBS Assessment Required</td>
</tr>
<tr>
<td>Intensive Crisis Respite</td>
<td>No</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td>3 service days, then concurrent. No HCBS Assessment Required</td>
</tr>
<tr>
<td>Education Support Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Empowerment Services-Peer Supports</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Prevocational Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Transitional Employment</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Intensive Supported Employment (ISE)</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Ongoing Supported Employment</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Community Residential Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
<tr>
<td>Supportive Living Services</td>
<td>Yes</td>
<td>Yes</td>
<td>NYS guidelines – see below</td>
<td></td>
</tr>
</tbody>
</table>
managers, service providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders. These review guidelines provide a framework for discussion between HCBS providers and Plans. The review process is a collaboration between all pertinent participants including but not limited to the Health Home Care Manager, HCBS provider, Plan and member to review progress and identify barriers or challenges that may be interfering with a reasonable expectation of progress towards the member’s chosen goals. These conversations will focus on the member’s needs, strengths, and history in determining the best and most appropriate fit of the services. These review guidelines are applied to determine appropriate care for all members. In general, services will be authorized if they meet the specific criteria for a particular service. The individual's needs, choice, and characteristics of the local service delivery system and social supports are also taken into consideration.

HCBS eligibility will be guidelines using a standard needs assessment tool, typically administered by the individual's Health Home (HH) care manager. Provision of Home and Community Based Services requires a person-centered approach to care planning, service authorizations, and service delivery. MCO utilization management for HCBS must conform to guidelines listed in the NYS HCBS Provider Manual (latest version available at: https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/). 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.

The following is a description of the various HCBS services.

1) Community Rehabilitation Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum, and as such, Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) are designated as a cluster.

a. Psychosocial Rehabilitation (PSR):
PSR services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their behavioral health condition (i.e., SUD and/or mental health). Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s Recovery Plan. The intent of PSR is to restore the individual's functional level to the fullest possible (i.e., enhancing SUD resilience factors) and as necessary for integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention.

b. Community Psychiatric Support and Treatment (CPST):
CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the individual's Plan of Care and CPST Individual Recovery Plan. The following activities under CPST are designed to help persons with serious mental illness to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to individuals who have difficulty engaging in site-based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional
treatment or might benefit from more active involvement of their family of choice in their treatment.

2) Vocational Services

Many of the HCBS services are designed to be provided in clusters that promote recovery along a spectrum and as such, Employment Support Services are grouped as a cluster and include Pre-vocational Services, Transitional Employment, Intensive Supported Employment, and Ongoing Supported Employment.

a. Pre-vocational Services:

Pre-vocational services are time-limited services that prepare a participant for paid or unpaid employment. This service specifically provides learning and work experiences where the individual with mental health and/or disabling substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in competitive work environment as well as in the integrated community settings. Pre-vocational services occur over a defined period of time and with specific person centered goals to be developed and achieved, as guidelines by the individual and his/her employment specialist and support team and ongoing person-centered planning process as identified in the individual’s person-centered plan of care, Pre-vocational services provide supports to individuals who need ongoing support to learn a new job and/or maintain a job in a competitive work environment or a self-employment arrangement. The outcome of this pre-vocational activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

b. Transitional Employment (TE)

This service is designed to strengthen the participant’s work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of individual supported employment, only when the person specifically chooses this service and may only be provided by clubhouse, psychosocial club program certified provider or recovery center. This service specifically provides learning and work experiences where the individual with behavioral health and/or substance use disorders can develop general, non-job-task-specific strengths and soft skills that contribute to employability in the competitive work environment in integrated community settings paying at or above minimum wage. The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

c. Intensive Supported Employment (ISE)

ISE services that assist individuals with MH/SUD to obtain and keep competitive employment. These services consist of intensive supports that enable individuals to obtain and keep competitive employment at or above the minimum wage. This service will follow the evidence based principles of the Individual Placement and Support (IPS) model. This service is based on Individual Placement Support (IPS) model which is an evidence-based practice of supported employment. It consists of intensive supports that enable individuals for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to participants who need ongoing support.
support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support. Services that consist of intensive supports that enable participants for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

d. Ongoing Supported Employment
This service is provided after a participant successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along is support available for an indefinite period as needed by the participant to maintain their paid employment position. Individual employment support services are individualized, person centered services providing supports to participants who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Participants in a competitive employment arrangement receiving Individual Employment Support Services are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this activity is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

3) Short-Term Crisis Respite Services

a. Short-term Crisis Respite
Short-term Crisis Respite is a short-term care and intervention strategy for individuals who have a mental health or co-occurring diagnosis and are experiencing challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the person’s home and community environment without onsite supports including:

- A mental health or co-occurring diagnosis and are experiencing challenges in daily life that create imminent risk for an escalation of symptoms and/or a loss of adult role functioning but who do not pose an imminent risk to the safety of themselves or others
- A challenging emotional crisis occurs which the individual is unable to manage without intensive assistance and support
- When there is an indication that a person’s symptoms are beginning to escalate

Referrals to Crisis Respite may come from the emergency room, the community, self-referrals, a treatment team, or as part of a step-down plan from an inpatient setting. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Short-Term Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service. Crisis respite is provided in site-based residential settings. Crisis Respite is not intended as a substitute for permanent housing arrangements.
b. Intensive Crisis Respite
Intensive Crisis Respite (ICR) is a short-term, residential care and clinical intervention strategy for individuals who are facing a behavioral health crisis, including individuals who are suicidal, express homicidal ideation, or have a mental health or co-occurring diagnosis and are experiencing acute escalation of mental health symptoms. In addition, the person must be able to contract for safety. Individuals in need of ICR are at imminent risk for loss of functional abilities, and may raise safety concerns for themselves and others without this level of care. The immediate goal of ICR is to provide supports to help the individual stabilize and return to previous level of functioning or as a step-down from inpatient hospitalization. An HCBS Eligibility Screening or Full Assessment is not a prerequisite to receiving Intensive Crisis Respite Services. A Health Home Individual Plan of Care is not required to access this service.

4) Education Support Services
Education Support Services are provided to assist individuals with mental health or substance use disorders who want to start or return to school or formal training with a goal of achieving skills necessary to obtain employment. Education Support Services may consist of general adult educational services such as applying for and attending community college, university or other college-level courses. Services may also include classes, vocational training, and tutoring to receive a Test Assessing Secondary Completion (TASC) diploma, as well as support to the participant to participate in an apprenticeship program. Participants authorized for Education Support Services must relate to an employment goal or skill development documented in the service plan. Education Support Services must be specified in the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. Examples of these goals would include, but not be limited to: tutoring or formal classes to obtain a Test Assessing Secondary Completion (TASC) diploma, vocational training, apprenticeship program or formal classes to improve skills or knowledge in a chosen career, community college, university or any college-level courses or classes.

5) Empowerment Services - Peer Supports
Peer Support services are peer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g. hope and self-efficacy, and community living skills). Peer support uses trauma-informed, non-clinical assistance to achieve long-term recovery from SUD and Mental health issues. Activities included must be intended to achieve the identified goals or objectives as set forth in the participants individualized recovery plan, which delineates specific goals that are flexibly tailored to the participant and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, sustaining recovery and enhancing the quality of personal and family life in long-term recovery. The structured, scheduled activities provided by this service emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

6) Habilitation / Residential Support Services
Habilitation services are typically provided on a 1:1 basis and are designed to assist participants with a behavioral health diagnosis (i.e. SUD or mental health) in acquiring, retaining and improving skills such as communication, self-help, domestic, self-care, socialization, fine and gross motor skills, mobility, personal adjustment, relationship development, use of community resources and adaptive skills necessary to reside
successfully in home and community-based settings. These services assist participants with developing skills necessary for community living and, if applicable, to continue the process of recovery from an SUD disorder. Services include things such as: instruction in accessing transportation, shopping and performing other necessary activities of community and civic life including self-advocacy, locating housing, working with landlords and roommates and budgeting. Services are designed to enable the participant to integrate full into the community and ensure recovery, health, welfare, safety and maximum independence of the participant.

7) Family Support and Training
Training and support necessary to facilitate engagement and active participation of the family in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. This service is provided only at the request of the individual. A person-centered or person-directed, recovery oriented, trauma-informed approach to partnering with families and other supporters to provide emotional and information support, and to enhance their skills so that they can support the recovery of a family member with a substance use disorder/mental illness. The individual, his or her treatment team and family are all primary members of the recovery team. For purposes of this service, “family” is defined as the persons who live with or provide care to a person served on the waiver and may include a parent, spouse, significant other, children, relatives, foster family, or in-laws. “Family” does not include individuals who are employed to care for the participant. Training includes instruction about treatment regimens, elements, recovery support options, recovery concepts, and medication education specified in the Individual Recovery Plan and shall include updates, as necessary, to safely maintain the participant at home and in the community. All family support and training must be included in the individual’s recovery plan and for the benefit of the Medicaid covered participant.

<table>
<thead>
<tr>
<th>Admission Criteria:</th>
<th>Continued Stay Criteria:</th>
<th>Discharge Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the following criteria must be met:</td>
<td>All of the following criteria must be met:</td>
<td>Criteria #1, 2, 3, 4, or 5 are suitable; criteria #6 is recommended, but optional:</td>
</tr>
<tr>
<td>1. The member must be deemed eligible to receive HCBS using the HCBS Eligibility Assessment tool.</td>
<td>1. Member continues to meet admission criteria and an alternative service would not better serve the member.</td>
<td>1. Member no longer meets admission criteria and/or meets criteria for another more appropriate service, either more or less intensive.</td>
</tr>
<tr>
<td>2. Where the member has been deemed eligible to receive services, a full HCBS Assessment has been completed to determine these services are appropriate for that individual.</td>
<td>2. Interventions are timely, need based, and consistent with evidence based/best practice and provided by a designated HCBS provider.</td>
<td>2. Member or parent/guardian withdraws consent for treatment.</td>
</tr>
<tr>
<td>3. A Plan of Care has been developed, informed and signed by the member, Health Home care manager, and others responsible for implementation. The POC has been approved by the Plan.</td>
<td>3. Member is making measurable progress towards a set of clearly defined goals; Or There is evidence that the service plan is modified to address the barriers in treatment progression Or Continuation of services is necessary to maintain progress already achieved and/or prevent deterioration.</td>
<td>3. Member does not appear to be participating in the ISP.</td>
</tr>
<tr>
<td>4. The HCBS provider</td>
<td>4. There is care coordination with</td>
<td>4. Member’s needs have changed and current services are not meeting these needs. Member’s self-identified recovery</td>
</tr>
</tbody>
</table>
develops an Individual Care Plan (ICP) that is informed and signed by the member and HCBS provider staff responsible for ISP implementation.

5. The ISP and subsequent service request supports the member’s efforts to manage their condition(s) while establishing a purposeful life and sense of membership in a broader community.

6. The member must be willing to receive home and community based services as part of their ISP.

7. There is no alternative level of care or co-occurring service that would better address the member’s clinical needs as shown in POC and ISP.

physical and behavioral health providers, State, and other community agencies.

5. Family/guardian/caregiver is participating in treatment where appropriate.

goals would be better served with an alternate service and/or service level. As a component of the expected discharge alternative services are being explored in collaboration with the member, family members (if applicable), the member’s Health Home and HCBS provider and MCO.

5. Member’s ISP goals have been met.

6. Member’s support system is in agreement with the aftercare service plan.

HCBS Criteria:

All provider agreements will have procedures for monitoring Home and Community Based Services utilization for each enrollee.

Home and Community Based Services – Allowable billing combinations: State and federal regulations limit members’ access to certain HCBS when the member is receiving certain state plan behavioral health services as noted in the table below:

## NYS Allowable Billing Combinations of OMH/OASAS State Plan Services and HCBS

<table>
<thead>
<tr>
<th>HCBS/State Plan Services</th>
<th>OMH Clinic/OLP</th>
<th>OASAS Clinic</th>
<th>OASAS Opioid Treatment Program</th>
<th>OMH ACT</th>
<th>OMH PROS</th>
<th>OMH IPRT/CDT</th>
<th>OMH Partial Hospital</th>
<th>OASAS Outpatient Rehab</th>
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</thead>
<tbody>
<tr>
<td>PSR</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>CPST</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Quality Programs

Fidelis Care has identified the following goals for our HealthierLife Members.
- Improving access to essential services such as medical, mental health, and social services
- Improving access to affordable care
- Decreasing utilization of inpatient and emergency services through provision of comprehensive, person centered, and integrated community based services
- Improving coordination of care through an identified point of contact
- Improving access to preventive health services
- Assuring appropriate utilization of services

In addition, Fidelis Care has a robust quality program that supports providers in achieving HEDIS/QARR measures. Detailed information on this program can be found on Provider Access Online, as well as the Fidelis Care Website in the Quality Management section.

The Fidelis Behavioral Health Quality Management Committee will meet monthly to review quality of care measures, accessibility to care and other issues of concern. Membership and attendance will be documented and include, at a minimum, the HARP Behavioral Health Medical Director and Clinical Director, Director of Quality Improvement and peer, provider, family or member representation. Fidelis will submit to OMH and OASAS a quarterly report of any deficiencies in performance and corrective action taken with respect to OMH and OASAS licensed, certified or designated providers. Fidelis Care will report any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

### HealthierLife Stakeholder Regional Advisory Sub-Committees

HealthierLife Stakeholder Regional Advisory Sub-Committees are composed of HealthierLife Members, Peers, Family Members, Advocates, Providers, Local and State Agency Representatives, Community Group Representatives, and other Key Stakeholders, such as Regional Consortium Planning representatives. One sub-committee will be convened for each...
NYSDOH region as enrollment goes live in that area. The purpose of this committee is for Fidelis to ensure a 360 degree perspective on HealthierLife quality, and to obtain consensus with key stakeholders on next steps in advancing all aspects of quality for HealthierLife. This committee performs the following functions:

- Provide the guidance on crisis intervention, recovery and rehabilitation services in that region, including HCBS and Health Home services.
- Assists in the development of level of care specific performance standards, measures and measurement methodologies, root-cause analyses, QI intervention, and implementation plan development
- Provides input on policies, procedures, protocols and guidelines
- Informs about access and availability of regionally based services, including wait times and capacity
- Assists with identifying and devising plans to remove any barriers to care for HealthierLife and Mainstream Medicaid enrollees
- Reviews and assists with monitoring performance measures for access, service quality, quality of care, utilization, customer service and health plan operations
- Advises on quality improvement initiatives including initiatives aimed at improving the integration of physical and behavioral health care
- Ensures an emphasis is maintained on the clinical outcomes of care
- Identifies regionally-specific challenges and opportunities for performance improvement

All parties in attendance are expected to bring to this committee information, data and their specific perception on all matters presented on the agenda related to Fidelis’ HealthierLife. These Committees will report to the HealthierLife Quality Management Committee, meet at minimum quarterly.


BILLING AND CLAIMS

Timely Filing
All claims must be submitted to Fidelis Care within the timeframes specified by your Fidelis Care provider contract. Claims for services provided to HealthierLife enrollees must be submitted within 90 days. Acceptable reasons for a claim to be submitted late are: litigation, retro-active eligibility determination, and rejection of the original claim for reason(s) other than timely filing. Claims that are submitted must be accompanied by proof of prior billing to another insurance carrier or a letter that specifies an acceptable reason for the delay.

Instructions for Submitting Claims
The physician’s office should prepare and electronically submit a CMS–1500 claim form. Hospitals should prepare and electronically submit a UB04 claim form.

Electronic Claims Submission
Fidelis Care receives electronic claims submission. For a complete list of vendors, visit the Fidelis Care website at fideliscare.org.

The unique payer ID for Fidelis Care is 11315 and is used for all submissions.

All Medicaid billing guidelines must be followed when submitting your Claims to Fidelis. Physicians must include the National Provider Identifier and Tax Identification Number on all claims.
Fidelis Care receives electronic claims submission, for a complete list of vendors; visit the Fidelis Care website at fideliscare.org

Mailing Address For Direct Claims Submission:

Fidelis Care HealthierLife
Corporate Claims Department
P.O. Box 1205
Amherst NY 14226

Balance Billing

**BALANCE BILLING NOTE:**

Participating providers may not under any circumstances bill a Fidelis Care member.

For additional Billing and Claim information, please refer to Section 12 of the Fidelis Care Provider Manual.

**INTEGRATED PHYSICAL AND BEHAVIORAL HEALTH**

People with mental illness die younger than the general population, and have more co-occurring conditions such as hypertension, diabetes, heart disease, obesity, tobacco use and asthma. One in five adults with mental illness also have a co-occurring substance use disorder (SUD). Only 20 percent of adults with mental health disorders are seen by mental health specialists and many prefer to receive treatment in primary care settings. The evidence clearly shows that improving health, improving the patient experience, and driving down costs is no longer possible without attending to both physical and behavioral health.

Though HealthierLife is an integrated physical and behavioral health program, at Fidelis Care, its administrative operations reside within the Behavioral Health Department, which is part of the Quality Health Care Management Department. The department is staffed by licensed clinical staff as well as paraprofessional associates who can assist with accessing behavioral and physical health services. A provider or member may contact the department through 1-888-FIDELIS (1-888-343-3547) and following the voice prompts to connect directly to Behavioral Health.

All HealthierLife Members will have their HCBS service needs guidelines through the New York State Department of Health approved assessment tool. Members can also self identify problems and needs through the Fidelis Care Health Risk Assessment. Members, providers or the member’s representatives who feel additional behavioral health needs require assessment or treatment can bring those concerns to their Health Home and/or their Fidelis Care Case Manager. They can assist in determining the screening and assessment tools, treatment and/or community services that are available to fit the HealthierLife member’s needs. Members can also self refer for behavioral health services.

Behavioral health providers and community services can be located in the Fidelis Care Online Provider Directory. For additional information on Community Support providers, call the Behavioral Health Department, which can assist with identifying appropriate services available.
Fidelis Care encourages the use of validated behavioral health screening tools in primary care settings. In addition to your observations and patient self-report, there are a number of free, valid and reliable screening tools available:


**PHARMACY**

Please visit [http://www.fideliscare.org](http://www.fideliscare.org) for a comprehensive list of covered drugs and supplies listed on our formulary. Fidelis Care has contracted Caremark (a pharmacy management company) to provide pharmacy services. Contact Caremark directly at 800-345-5413

For additional information on Pharmacy Services please refer to Appendix II of the Fidelis Care Provider Manual.

**RENTENTION OF MEDICAL RECORDS**

Medical records must be retained for at least ten (10) years. For additional information on medical record retention, please refer to Section 7 of the Fidelis Care Provider Manual, page 7.2.

**CONFIDENTIALITY**

For information on Confidentiality, please refer to Section 3 of the Fidelis Care Provider Manual, page 3.2.


**MEMBER RIGHTS AND RESPONSIBILITIES**

HealthierLife Members have the right to:

During the course of any contact with an enrolled member, employees will not encourage an enrollee to dis-enroll because of challenging behavior, complex care needs, or high medical expenses.
Fidelis Care adheres to laws that protect members from discrimination or unfair treatment and does not tolerate discrimination based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. Furthermore, Fidelis Care ensures that:

- Members have the right to be treated with respect, dignity, and in a considerate manner. They have the right to be cared for with respect without regard of health status or medical/genetic history, insurability, sex, race, color, religion, national origin, age, marital status, sexual orientation, medical condition (including physical and mental illness), claims experience, receipt of health care, or disability.

- Members have the right to receive information from a physician or other provider necessary to give informed consent prior to the start of any procedure or treatment.

- Members are ensured confidential handling of information concerning their diagnosis, treatment prognosis, and medical and social history.

- Members have the right to obtain complete current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms the member can be reasonably expected to understand. When it is not advisable to give such information to the member, the information shall be made available to an appropriate person on the member’s behalf.

- Members are given the opportunity to participate in decisions involving their health care unless contraindicated. Members are allowed to appoint someone (relative, friend, lawyer) to speak for you if you are unable to speak for yourself about your care and treatment.

- Members are ensured auditory and visual privacy during a visit.

- Members are afforded the opportunity to approve or refuse the release of information except when release is required by law. Members are also given the right to know how Medical Information about them may be used and disclosed and how they may get access to this information from Fidelis.

- Members who refuse treatment or therapy will be counseled relative to the consequences of their decision, and documentation entered into the medical record accordingly.

- Members have the right to formulate Advance Directives.

- Members have the right to change Primary Care Physicians.

- Members have a right to reasonable accommodations. Members also have a right to understand their ADA-related rights, to what extent reasonable accommodations are provided, and grievances and appeals related to those rights. Members will be informed of their right to reasonable accommodations and how to obtain reasonable accommodations from the plan and providers, including the process, who decides whether the accommodations will be provided, and the process for appealing any decisions.
Section Twenty Four

HealthierLife - Health and Recovery Plan (HARP)

- Members have the right to file a complaint with the Plan. Members can complain to the NY State Department of Health or the local Department of Social Services any time they feel they were not treated fairly and without retaliation from the Plan.

- Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

- Members have the right to request a copy of their medical records, and request that they be amended or corrected.

- Members have the right to receive information including all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood.

- If a Member Service Associate does not speak the primary language requested, a member may have access to a language translation service which provides access to foreign language translators.

- Members have the right to disenroll.

Health and Recovery Plan (HealthierLife), members shall not be balanced billed. Should a provider balance bill a member inappropriately, Fidelis Care will investigate the situation and when required, inform the provider to cease the balance billing. Some Members may have applicable spend-down/NAMI for Medicaid.

Fidelis Care has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.

A Choice of Plans and Providers
Members will maintain their choice of plans and providers, and may exercise that choice at any time, effective the first calendar day of the following month. This includes the right to choose an alternative package of Medicaid services through 1) a different HealthierLife Plan or 2) a qualified mainstream plan.

Continuity of Care
For all items and services other than nursing facility services, Fidelis Care HealthierLife members can maintain current providers and service levels, including prescription drugs, for the current episode of care at the time of enrollment for up to 90 days after enrollment. Members will not be required to change Health Homes at the time of enrollment.

Fidelis Care will cover emergent or urgent services provided by out-of-network providers and may authorize other out-of-network services to promote access to continuity of care. For services that are part of the traditional Medicaid benefit package, Fidelis Care will reimburse non-contracting providers at least the lesser of the providers’ charges or the Medicaid FFS rate, regardless of the setting and type of care for authorized out-of-network services.

Enrollment Assistance and Options Counseling
The State will provide HealthierLife-eligible members with independent enrollment assistance and options counseling to help them make an enrollment decision that best meets their needs. The State will work with the independent Enrollment Broker to ensure ongoing outreach, education and support to individuals eligible for HealthierLife.
MEMBER COMPLAINTS AND APPEALS

All Fidelis Care members have a right to file a complaint at any time if they are dissatisfied with Fidelis Care, a Fidelis Care provider, or with the care or services they have received. If a complaint involves a physician or provider, a Provider Relations Representative will contact the provider to discuss the complaint. The findings will be reported to the Quality Healthcare Management (QHCM) Department for consideration as to action or disposition.

Members are advised to call Member Services to file a complaint. Fidelis Care will attempt to resolve complaints immediately by taking prompt corrective action and educating members regarding Fidelis Care policies and procedures. The substance of the complaint and the agreed upon disposition will be documented.

Complaints are submitted in writing or recorded by Fidelis Care staff on behalf of members. All complaints are logged and acknowledged by Fidelis Care in writing. Complaints relative to the delivery of healthcare services will be referred to Fidelis Care’s QHCM Department for investigation.

A member or designee has no less than sixty (60) business days after receipt of the notice of the complaint determination to file a written Complaint Appeal. Complaint Appeals of clinical matters will be decided by personnel qualified to review the appeal, including licensed, certified or registered healthcare professionals who did not make the initial determination - at least one of whom must be a clinical peer reviewer.

Upon the member’s request, Fidelis Care will expedite the complaint process to accommodate the member's needs.

Member complaints involving providers that have been substantiated will be noted in the provider's credentials file and in the provider's Total Quality Profile on an annual basis.

NOTE: Members may always file a complaint with the New York State Department of Health and/or the City or respective County.

COMPLAINTS

If a member has a problem or dispute with care or services, the member may file a complaint with Fidelis Care. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to the following procedure. Fidelis Care is always available to assist a member in filing a compliant, complaint appeal, or action appeal. A Member Services Associate can assist the member or their designee with this.

A member may ask someone they trust (such as a legal representative, a family member, or friend) to file the complaint. If the member needs help from Fidelis Care because of a hearing or vision impairment, or if the member needs translation services, or help filing the forms, Fidelis Care can help with this.

A member has the right to contact the New York State Department of Health about their complaint at 1-800-206-8125 or may write to: NYSDOH Office of Managed Care, Bureau of Managed Care Certification and Surveillance, Room 1911 Corning Tower ESP, Albany, NY 12237. The member may also contact their local Department of Social Services with a complaint at any time. A member may call the New York State Insurance Department at (1-800-342-3736) if their complaint involves a billing problem.
Filing a Complaint with the Plan:

To file by phone, the member should call Member Services at 1-888-FIDELIS (1-888-343-3547) Monday-Friday from 8:30AM to 6:00PM. If the member contacts Fidelis Care after hours, they have the ability to leave a message. Fidelis Care will call the member back on the next working day. If Fidelis Care needs more information to make a decision, the member will be notified. The member can write Fidelis Care with his or her complaint or call the Member Services number and request a complaint form. It should be mailed to Attn: Member Services Department, Fidelis Care, 95-25 Queens Boulevard, Rego Park, NY 11374.

If Fidelis Care does not solve the problem right away over the phone or if Fidelis Care receives a written complaint, an acknowledgement letter will be sent within fifteen (15) business days.

Fidelis Care will let the member know the decision in forty-five (45) calendar days of when we have all the information needed to answer the complaint, but the member will hear from us no later than sixty (60) calendar days from the day we get the complaint. Fidelis Care will send the member a letter with the reasons for the decision. When a delay would risk a member’s health, Fidelis Care will make a decision within forty-eight (48) hours of when Fidelis Care has all the information needed to answer the complaint but no later than seven (7) calendar days from the day we get the complaint. Fidelis Care will call the member with our decision. The complaint decision will also inform the member of their appeal rights if the member is not satisfied and we will include any forms the member may need. If Fidelis Care is unable to make a decision about a complaint because we don’t have enough information, a letter will be sent to the member.

Complaint Appeals:

If a member disagrees with a decision, the member or their designee can file a complaint appeal with Fidelis Care. The member has at least sixty (60) business days after hearing from us to file an appeal. The appeal must be made in writing. If the member makes an appeal by phone it must be followed up in writing. If the member calls, Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member will sign and return the form to Fidelis Care. The member may make any needed changes before sending the form back to us.

Upon receipt of the appeal, an acknowledgment letter will be sent to the member within fifteen (15) business days. The complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about the complaint. If the complaint appeal involves clinical matters, the case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, who were not involved in making the first decision about the complaint.

If Fidelis Care has all the information needed, the member will be informed of the decision within thirty (30) business days. If a delay would risk the member’s health, a decision will be made in two (2) business days of when we have all the information we need to decide the appeal. The member will be given the reasons for our decision and our clinical rationale, if it applies. If the member is still not satisfied, the member or their designee can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

FAIR HEARINGS AND ACTION APPEALS

In some cases, a member may ask for a fair hearing from New York State. A member may request a Fair Hearing with regard to: enrollment/disenrollment decisions made by the Local Department of Social Services; the denial, suspension, termination, or reduction of a medical treatment or on services covered under the program benefits package. A member may also
request a Fair Hearing if they believe that Fidelis Care did not act in a timely manner with regard to services. A member may have any individual he/she selects or designates to represent them at a Fair Hearing.

A member may request a Fair Hearing in the following ways:

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
4. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, Office of Administrative Hearings Managed Care Unit P.O. Box 22023, Albany, NY 12201-2023

If the services the member is receiving are scheduled to end, the member may choose to ask to continue the services a provider has ordered while the Fair Hearing case is pending. However, if the member asks for services to be continued, and the fair hearing is decided against the member, the member may have to pay the cost for the services received while waiting for a decision. The decision from the fair hearing officer will be final. A member always has the right to file a complaint anytime with the New York State Department of Health by calling 1-800-206-8125.

**ACTION APPEALS**

If a member disagrees with Fidelis Care's decision with a Service Authorization Request, a payment denial, or timeliness of an action taken by Fidelis Care, the member or their designee can file an action appeal. The member has sixty (60) business days after hearing from Fidelis Care to file an appeal. The action appeal must be in writing. If the appeal is by telephone, it must also be made in writing. Fidelis Care will send a form that is a summary of the phone appeal. If the member agrees with the summary, the member must sign and return the form to Fidelis Care. The member may make any changes to the form before sending it back to us. After receipt of the action appeal, an acknowledgement letter will be sent within fifteen (15) calendar days.

If Fidelis Care has all the information needed, the member will know our decision within thirty (30) calendar days. If a delay would significantly increase the risk to the member's health, the member or their designee can request an expedited review of the action appeal, which will be decided within two (2) business days. The timeframe for deciding an action appeal can be extended for up to fourteen (14) calendar days if the member or his/her designee requests one or if Fidelis Care determines that the extension is in the best interest of the member and additional information is needed. The member will be notified if this extension happens.

The member will be given the reasons for Fidelis Care's decision and clinical rationale. Fidelis Care will attempt to reach the member with the action appeal decision by phone. If the member is still not satisfied with Fidelis Care's decision, the member or someone on his or her behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125. Filing an action appeal is the member's right, and the Fidelis Care will not retaliate or take any discriminatory action against the member because they filed an action appeal.

An action appeal should be made in writing within sixty (60) business days of receipt of the letter to:

Attn: Quality Health Care Management
Fidelis Care
480 CrossPoint Parkway
Getzville, NY 14068
Phone#: 1-888-FIDELIS – (1-888-343-3547)
Fax#: 1-800-374-9808
EXTERNAL APPEALS

If the plan decides to deny coverage for a medical service the member or the provider asked for because:

It is not medically necessary; the service is experimental or investigational; the out-of-network service requested is not different from a service that is available in our network. The member can ask New York State for an independent External Appeal. It is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. For Medicaid and CHP members, the fee is waived for an external appeal. Only HBX has a $25 fee for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. Fidelis Care will waive the fee if we determine that paying the fee would be a hardship to the member. If the External Appeal Agent overturns our decision, the fee will be refunded to the member.

Members have four (4) months after receiving the Plan’s final adverse determination (notice of appeal denial) to ask for an external appeal. The member will lose their right to an external appeal for failure to file an application on time. If the member and the plan agreed to skip the plan’s appeal process, the member must ask for the external appeal within four (4) months of when the agreement was made. The member must fill out an application and submit it to the New York State Department of Financial Services. The member and their doctors will have to give information about their medical problem. The external appeal application will list what information will be needed.

The member’s standard external appeal will be decided in thirty (30) days. More time (up to five (5) work days) may be needed if the external appeal reviewer asks for more information. The member and the plan will be notified in writing of the final decision within two (2) work days after the decision is made. The reviewer will decide an expedited appeal in seventy-two (72) hours or less. The member and the plan will be notified immediately by phone or fax. Later, the member will receive written notification of decision made.

A member may request an External Appeal:

1. Call the Department of Financial Services at 1-800-400-8882
2. Go to the Department of Financial Services’ website at www.dfs.ny.gov
3. Contact Fidelis at 1-888-FIDELIS. Member Services will mail or fax the application to the member.