

## Table of Contents

Chapter 1: Introduction to the Designated Facility (DF) Program.....	4
Purpose of This Manual.....	4
Program Overview .....	4
Designated Facility’s Role & Responsibilities.....	4
Tufts Health Plan’s Role & Responsibilities.....	5
Designated Facility Network Meetings .....	5
Designated Facility Monthly Dashboards .....	5
Additional Program Information .....	5
Designated Facility Membership Assignments .....	5
Quality Incentive Program.....	5
Chronic Risk Pool.....	6
Chapter 2: Administrative Processes of Reporting Admissions and Discharges.....	7
Benefits and Eligibility .....	7
Registration of Inpatient Care.....	7
Capitated Members.....	7
Fee-for-Service Members.....	8
Registration of Intermediate Levels of Care (Acute Residential Treatment, Partial Hospital, and Intensive Outpatient Programs) .....	8
Capitated Members.....	8
Fee-for-Service Members.....	8
Reporting a Discharge from Inpatient or Intermediate Levels of Care .....	8
Chapter 3: Discharge Planning & Coordination of Care .....	9
Discharge Planning .....	9
Discharge Planning Standards.....	9
Coordination of Care Standards .....	11
Between the Designated Facility and a PCP.....	11
Between the Designated Facility and Non-physician Outpatient Treatment Provider(s) (e.g., social worker, psychologist).....	11
Between the Designated Facility and the Member’s Prescribing Provider .....	11

# Behavioral Health Designated Facility Manual

Between the Designated Facility and <i>other organizations</i> (Employee Assistance Programs, Schools, Courts, Department of Social Services, Department of Mental Health, or Other Social Service Agents).....	11
Chapter 4: Managing Requests for Out-of-Designated Facility Services.....	12
Out-of-Designated Facility Request .....	12
Authorizing Care .....	12
Transfers.....	12
Financial Responsibility for Capitated Membership.....	13
Cost-Share Process for Specialty Services.....	13
Initial Determinations.....	13
Unique Circumstances.....	14
Court-Ordered Treatment.....	14
Emergency Out-of-Area Admissions.....	14
Change of PCP and Its Impact on DF Assignment.....	14
Chapter 5: Utilization Management.....	15
Authorization Decisions: Initial and Concurrent Review.....	15
Medical Necessity.....	15
Utilization Management for Capitated Members.....	15
Tufts Health Plan Oversight of Designated Facility Utilization Management.....	16
Outlier Management.....	16
Utilization Management for Fee-For-Service Admissions.....	16
Chapter 6: Case Management Programs.....	17
Behavioral Health Case Management.....	17
Transition to Home Program (For Psychiatric Admissions).....	17
Substance Use Disorder (SUD) Program.....	17
Emergency Department (ED) Program.....	18
Chapter 7: Quality Occurrence Reporting.....	19
Examples of Quality Occurrences The following are Quality Occurrences that must be reported to Tufts Health Plan within 24 hours from the time of occurrence: ....	19
Regulatory, Accreditation, or other Oversight Agency Actions.....	19
Chapter 8: Additional Resources.....	21

## Behavioral Health Designated Facility Manual

Behavioral Health Department Information.....	21
Outpatient Authorization Requirements.....	21
Interactive Voice Response (IVR) Guide.....	21
Pharmacy Program .....	21
Utilization Review Time Frame Requirements.....	22
Provider Manuals .....	22
Appeals.....	22
Tufts Health Plan Medicare Preferred HMO Appeals and Grievances.....	22

# Chapter 1: Introduction to the Designated Facility (DF) Program

## Purpose of This Manual

The Tufts Health Plan Behavioral Health Department developed this manual to supply our DFs and their staff with details on the DF operating guidelines of Tufts Health Plan. Tufts Health Plan recommends that facilities and their staff read this manual and reference it as necessary.

## Program Overview

Tufts Health Plan uses a network of DFs for behavioral health and substance use disorder (BH/SUD) services. This DF network is a subset of Tufts Health Plan contracting facilities that are chosen for their ability to provide quality care, to manage clinical services across levels of care, and to serve the geographic needs of an assigned Tufts Health Plan membership.

## Designated Facility's Role & Responsibilities

Each DF is contractually responsible to provide the following clinical functions:

- BH/SUD emergency department
- Triage, assessment
- Crisis stabilization
- Level-of-care determination
- Intermediate BH/SUD levels of care (including acute residential treatment, partial hospital services, and intensive outpatient treatment)
- Acute inpatient BH/SUD treatment
- Family stabilization team (FST)
- Observation services
- Discharge planning

All DFs have members assigned to them based on their selected primary care physician (PCP) and are expected to serve the clinical needs of these members for acute BH/SUD services. DFs may have additional responsibilities for clinical management and oversight of its assigned membership including providing or arranging all BH/SUD inpatient and/or intermediate levels of care along with concurrent clinical management for that episode of care. DFs can also provide services to other Tufts Health Plan members that are not part of their assigned membership.

If you have additional questions about the services included under the DF's roles and responsibilities, contact the contract manager at your facility.

DFs are not able to deny services. A member who disagrees with any coverage being offered by the DF should be referred back to the Tufts Health Plan Utilization Manager (UM) for that facility. The DF UM can help with the next steps in the review process; refer to additional information in Chapter 5, Utilization Management.

## **Tufts Health Plan's Role & Responsibilities**

A key component of the DF Program is the close working relationship between Tufts Health Plan, the Tufts Health Plan UM, and the DF. Each DF is assigned a Tufts Health Plan DF UM, whose role is to communicate with DF representatives on a routine basis. In addition, Tufts Health Plan Behavioral Health Services seats a Facility Steering Committee whose role is to manage the overall participation in the program. Communication from the UM and/or the Steering Committee includes reviewing and evaluating DF utilization, quality of care performance metrics, and compliance with Tufts Health Plan policies and procedures. The UM can provide member benefit clarification, case consultation, and aid to the DF in meeting its responsibilities to assigned membership.

A Tufts Health Plan Behavioral Health Medical Director (a board-certified psychiatrist) may work directly with the Designated Facility Program to assist with quality assurance, utilization review, problem resolution, and to consult with the DF UMs and DF medical leadership as needed.

## **Designated Facility Network Meetings**

The Director of Behavioral Health Services, or his/her designee, chairs meetings for representatives of the DF network. Representatives from the DFs attend these meetings with representatives from Tufts Health Plan's Behavioral Health Department.

The DF network meetings provide a forum to share utilization and quality improvement (QI) performance data, network policy, and procedure changes. All the DFs are expected to participate in these meetings.

## **Designated Facility Monthly Dashboards**

Tufts Health Plan will periodically provide the DFs with informatics intended to enable the DF to evaluate and manage their performance. This information may include DF and network utilization statistics. They will also include the performance results for any quality incentives offered, and a comparison between the established goal and network average.

## **Additional Program Information**

### **Designated Facility Membership Assignments**

The member's age and PCP's provider organization determine the member's DF assignment. Child DFs serve members under the age of 16 while adult DFs serve members 16 and older.

Some IPAs do not affiliate with a Designated Facility. Instead, their PCPs may direct members to any one of the DFs or to any Tufts Health Plan contracted facility. Members, PCPs, or providers may also call Tufts Health Plan directly for assistance locating a contracted facility if needed. Tufts Medicare Preferred HMO members not assigned to a DF would be directed to a Medicare-certified hospital with BH/SUD services or the PCP's home hospital if it can meet the member's clinical and access needs.

### **Quality Incentive Program**

All DFs are expected to provide high quality care to Tufts Health Plan members. The DF program is designed to support this continued level of commitment through the quality incentives that are established for each contract year. DFs are required to participate in Tufts Health Plan's quality initiatives.

### **Chronic Risk Pool**

A catastrophic relief pool is a part of the DF Program and is funded in addition to the capitation payment. This pool is a protection for catastrophic cases that meet eligibility criteria for coverage. Settlement occurs annually and each capitated DF is provided a list of eligible members based on reported utilization for the calendar year.

Refer to the DF contract for more details about how eligibility for the funding is determined and how the reimbursement is calculated.

## Chapter 2: Administrative Processes of Reporting Admissions and Discharges

### Benefits and Eligibility

To verify a member's benefits and eligibility, log on to the secure website at [tuftshealthplan.com/providers](https://tuftshealthplan.com/providers) or use the Interactive Voice Response (IVR) at 800.208.9565. These systems will indicate whether a member has a Designated Facility assignment, effective dates, and other important information about the member's coverage.

### Registration of Inpatient Care

Preregistration is a notification to Tufts Health Plan of utilization of inpatient services. Preregistration is required for all inpatient BH/SUD admissions within one business day of admission. For admissions occurring after Tufts Health Plan's business hours, on weekends, and on holidays, notification must occur on the next business day. It is the admitting facility's responsibility to preregister a member's admission, even if the member is not at their assigned Designated Facility.

Providers can report admissions:

- On the secure website at [tuftshealthplan.com/providers](https://tuftshealthplan.com/providers)
- By faxing this [form](#) to 800.843.3553 for Commercial and Tufts Medicare Preferred HMO members and 617.673.0705 for Tufts Health Plan Senior Care Options (SCO) members; preregistrations can be faxed 24 hours a day, 7 days a week.
- By using EDI electronic submission of a HIPAA 278 transaction

The Precertification Operations Department requires the following information for all preregistration requests:

- Member's name
- Member's identification number
- Member's date of birth
- Admission date
- Attending physician name and phone number
- Admitting hospital name
- Diagnosis
- Contact name and phone number

If a provider wants to obtain a preregistration number after submitting a preregistration request via fax, the provider can contact the Behavioral Health Department at 1.800.208.9565 (please allow for time for the notification to be processed). Business hours are from 8:30 AM to 5:00 PM, Monday through Friday.

### Capitated Members

The Designated Facility is responsible for pre-registering all admissions, conducting reviews and determining length of stay for their capitated members. When the treatment episode is completed and/or upon discharge, details of the inpatient level of care services should be reported on the secure website at [tuftshealthplan.com/providers](https://tuftshealthplan.com/providers).

## **Fee-for-Service Members**

The Designated Facility will also service Tufts Health Plan non-capitated members (Fee for Service). The Designated Facility, as with capitated members, is required to pre-register these admissions. Tufts Health Plan will conduct medical necessity reviews and determine coverage. Once the Designated Facility has obtained a preregistration number for inpatient treatment from the precertification department, they are required to:

- Review initial clinical information to review for medical necessity with a Utilization Manager
- Contact the Utilization Manager for continued authorization

## **Registration of Intermediate Levels of Care (Acute Residential Treatment, Partial Hospital, and Intensive Outpatient Programs)**

The reporting of intermediate levels of care is required for all members and must be done by the assigned Designated Facility. All intermediate levels of care must be reported through Tufts Health Plan's secure website at [tuftshealthplan.com/providers](http://tuftshealthplan.com/providers).

## **Capitated Members**

The Designated Facility is responsible for conducting reviews and determining length of stay for their capitated members.

## **Fee-for-Service Members**

Once the Designated Facility has obtained a registration number for any intermediate level of care through the secure website at [tuftshealthplan.com/providers](http://tuftshealthplan.com/providers) they are required to:

- Review initial clinical information within 1 business day of admission to review for medical necessity with a Utilization Manager
- Contact the Utilization Manager for continued authorization

## **Reporting a Discharge from Inpatient or Intermediate Levels of Care**

Whenever a Tufts Health Plan member is discharged from an inpatient or intermediate level of care, the Designated Facility is required to report the discharge information on the secure website at [tuftshealthplan.com/providers](http://tuftshealthplan.com/providers).

The Designated Facility is responsible for conducting medical necessity reviews and determining length of stay for their capitated members whether the member is at their assigned Designated Facility or if their Designated Facility has authorized the member's care at a different facility. As such, the assigned Designated Facility is responsible for ensuring that the discharge information is reported via the Tufts Health Plan secured provider website. The admission or referral will be closed appropriately.

## Chapter 3: Discharge Planning & Coordination of Care

### Discharge Planning

Discharge planning is a critical link between treatment received in the hospital by the member, and post-discharge care provided in the community.

Effective discharge planning and appropriate post-discharge support care are key elements in reducing avoidable hospital readmission. This includes an effective and timely discharge plan and a specific plan of care and medical documentation. The specific plan of care should include outpatient follow-up services and arrangements with treatment and other community resources for the provision of follow-up services, a crisis plan to support continued stabilization and medication reconciliation that addresses member knowledge and ability to follow medication regimen.

Effective discharge planning supports the continuity of care between the health care setting and the community, based on the individual needs of the member. Discharge planning should be initiated early in the treatment process based on requirements of the member's plan of care. The discharge planning process should address anticipated problems after discharge and suggested means for intervention, including:

- Accessibility and availability of community resources and support systems, including transportation
- Special needs related to the patient's functional ability to participate in aftercare planning

The DF should inform the Tufts Health Plan DF UM/Case Manager of any difficulties in developing a comprehensive discharge plan for both specific cases and any general trends or patterns of concern.

### Discharge Planning Standards

DFs are expected to maintain certain standards for arranging aftercare services prior to discharge from a hospital stay. The below expectations are not all-inclusive; all discharge planning is expected to incorporate the unique clinical and risk management needs of any given member.

- For all members (Commercial and Tufts Medicare Preferred HMO):
  - Benefit and eligibility verification for services being recommended
  - Aftercare review session forms
  - Medication reconciliation
  - Aligning pharmacotherapy treatment recommendations with Tufts Health Plan's formulary guidelines
  - Coordinating care with member's treatment team (Medical and Behavioral Health)
  - Arranging outpatient treatment and community supports
  - Copy of discharge summary to PCP
- Additional standards for Tufts Medicare Preferred HMO members:
  - Schedule a PCP follow-up appointment within 10 days of discharge

## Behavioral Health Designated Facility Manual

The DF discharge planners will verify the member's benefits and eligibility for all recommended aftercare services. This information can be found on the Tufts Health Plan website, by using the IVR, or via the Behavioral Health Department at 800.208.9565. This verification should include (but is not limited to):

- Coverage for intermediate levels of care
- Coverage for outpatient treatment
- Out-of-network coverage (if any)\*
- Notification and/or authorization requirements
  - Commercial members, based on their plan, may require a notification and/or authorization from the Tufts Health Plan Behavioral Health Department
  - Tufts Medicare Preferred HMO members require a referral from the PCP for outpatient behavioral health services including outpatient psychotherapy, psychopharmacology and ECT. The PCP also authorizes services for skilled nursing facilities and VNA services.

If the member is discharging to an intermediate level of care (acute residential treatment, partial hospital services, or intensive outpatient treatment), the DF must also:

- Check with Tufts Health Plan to see if the member's plan requires that he/she receive his/her intermediate level of care services from a DF. Tufts Health Plan Behavioral Health Department can be contacted for assistance with locating appropriate Tufts Health Plan programs at 800.208.9565.
- Register the intermediate level of care admission (see Chapter 2 for the administrative processes).
- Provide authorization to another facility if the DF is unable to meet the member's needs (refer to Chapter 4).
- Coordinate care with the treatment team.
- If member is also receiving outpatient treatment, the DF must also follow the process below.

If the member is discharging to outpatient treatment (individual therapy, couples therapy, group therapy, etc.), the DF must also:

- Use the Provider Search available on the Tufts Health Plan public [website](#) to find contracted providers. Tufts Health Plan Behavioral Health Department can also be contacted for assistance with locating appropriate Tufts Health Plan providers at 800.208.9565.
- Make every reasonable effort to ensure that the first outpatient appointment occurs within seven (7) days of discharge from an inpatient hospitalization.
- Must provide the member, family, and involved clinicians with all contact information, including the name of the person who is providing psychopharmacology coverage during the time prior to the first follow-up medication appointment.
- Obtain any required notification/authorization on behalf of the member or inform the member of any requirements.

**\*Note:** HMO/EPO members do not have out of network services and require notification/authorization from Tufts Health Plan for BH/SUD services. POS/PPO members may have out of network benefits. POS/PPO members with out-of-network benefits are not required to receive authorization to see a non-contracted provider.

## **Coordination of Care Standards**

Communication with the providers referenced below is recommended to occur during the course of the admission to inform the provider(s) of the admission, to review the course of inpatient treatment, and to assist with coordination of care and discharge planning.

### **Between the Designated Facility and a PCP**

All DFs must routinely document communication with the PCP for every member who has an assigned PCP. If there is a medical comorbid condition that requires medical intervention, the DF must communicate and document that communication with the PCP prior to the initiation of planned medical intervention, or immediately after the provision of emergency medical intervention. It is expected for all members that the discharge summary be provided to the PCP upon the member's discharge.

### **Between the Designated Facility and Non-physician Outpatient Treatment Provider(s) (e.g., social worker, psychologist)**

It is recommended that all DFs communicate and document that communication with the member's BH/SUD outpatient provider(s). It is recommended that a copy of the discharge summary be provided to the member's outpatient treaters.

### **Between the Designated Facility and the Member's Prescribing Provider**

All DFs must communicate and document that communication with the outpatient psychiatrist (or other physician or health care professional that will follow the member for outpatient medication management upon discharge). It is recommended that a copy of the discharge summary be provided to the member's outpatient treaters.

Clinical staff of the inpatient-contracted facility must inform the outpatient psychiatrist or other prescribing of any clinically significant abnormal laboratory or other medical findings or recommendations.

### **Between the Designated Facility and *other organizations* (Employee Assistance Programs, Schools, Courts, Department of Social Services, Department of Mental Health, or Other Social Service Agents)**

All DFs must communicate and document that communication when there is external agency involvement post discharge. It is recommended that a copy of the discharge summary be provided to the member's external resources with the member's consent.

## Chapter 4: Managing Requests for Out-of-Designated Facility Services

### Out-of-Designated Facility Request

In certain circumstances, a capitated member may request to have their BH treatment at a facility other than his/her DF, or it may be necessary for a DF to have a capitated member's care provided in another facility for one of several reasons such as:

- There are no beds available at the DF at the time the capitated member requires treatment.
- The member needs specialized care that the DF cannot adequately provide, e.g., eating disorders, substance use disorder, or needs related to the age of the member.
- For confidentiality reasons a capitated member cannot be adequately treated at his or her DF.
- Two capitated members of the same family require inpatient or intermediate level-of-care at the same time, and it is clinically contraindicated to provide for their care simultaneously at the same program.
- Treatment has reached a clinical impasse at the DF.

### Authorizing Care

When a DF authorizes care at another facility, the capitated member is not required to transfer to their DF during that episode of care. The DF remains clinically and financially responsible for managing the clinical care that the capitated member is receiving at the other facility. This responsibility also includes meeting all discharge planning standards.

**Note:** A DF does not have the ability to deny coverage for treatment to a member (refer to Chapter 5).

### Transfers

A recommendation to transfer a member from an inpatient setting to another facility may be made for reasons of medical necessity (e.g., necessary clinical services are not available at the hospital the member is to be transferred from that are available at the receiving hospital) or member health plan benefits and covered services (e.g., a member who presents for transfer from an out-of-plan to an in-plan hospital).

In the case of a recommendation for transfer, there must be physician-to-physician consultation between the sending and receiving facilities to evaluate the appropriateness of a transfer. The appropriateness of a transfer is based on a determination that the member's medical condition has stabilized. In general, the member is considered medically stable and is appropriate for transfer if there would be no significant deterioration of condition or danger to the member or others resulting from, or occurring during, the transfer.

For members with an assigned DF, the DF is responsible for efforts to coordinate care when a recommendation for a transfer is approved. The receiving hospital must have the capacity to provide medical treatment appropriate to the needs of the member, available space, and qualified personnel to treat the member. The transferring facility forwards relevant medical records and uses qualified personnel and transportation to affect the transfer. The attending physician informs the member or member's representative of the decision to transfer, including the reasons for the transfer.

If a transfer is not clinically appropriate, the assigned DF authorizes and funds the continued stay at the admitting facility until the capitated member can be discharged.

### **Financial Responsibility for Capitated Membership**

A DF is only financially responsible for a capitated member's treatment when that DF is providing the care, or has authorized care to another facility. When a capitated member is admitted to a facility other than their DF, and the DF agrees to authorize the care, the DF is financially responsible for the cost of the inpatient/intermediate BH treatment. When the DF is notified of the admission within one business day of the admission date, the DF is responsible to begin coverage from the date of admission.

If the DF declines to authorize care, it must arrange for appropriate transfer to the DF if inpatient treatment is warranted. If the member or admitting facility does not agree to the transfer then this request to remain at the admitting facility is processed as an initial determination.

The DF is not responsible for services provided outside of the service area. For capitated members, emergency services will be covered under Tufts Health Plan liability. Non-emergent or planned care outside of the service area is not a covered benefit.

### **Cost-Share Process for Specialty Services**

Tufts Health Plan recognizes that there are some specialty BH services that may be more expensive than network contract rates for the same levels of care, e.g., eating disorder services. In these situations, there is an available cost share option that can be accessed. Contact your DF Case Manager for further information.

### **Initial Determinations**

The DF serves as the authorizing agent for inpatient and intermediate levels of care for BH services. It does not have the authority to deny coverage without the review by Tufts Health Plan. All adverse determinations must be issued by Tufts Health Plan.

The DF must offer the member an initial determination and contact the Tufts Health Plan Behavioral Health Department at 800.208.9565 to initiate the process when

- The DF offers a treatment that a member or the member's authorized representative believes is not sufficient to meet the treatment needs of the member
- The member is requesting treatment at a facility other than their assigned DF and the DF believes they can adequately provide the care themselves
- There is a disagreement between the DF and admitting facility regarding medical transfer
- The DF believes that continued services at the admitting facility are no longer medically necessary

The focus of the initial determination is on coverage available under the plan, and the clinical needs of the member based on the:

- The member's benefit documents
- Evaluation of the services available by the DF to meet the needs of the patient
- Medical Necessity Guidelines
- CMS Guidelines (for Tufts Medicare Preferred HMO members only)

If the initial determination results in a denial, the member, or the member's representative may request an appeal. The appeals process is conducted by Tufts Health Plan.

### **Unique Circumstances**

#### **Court-Ordered Treatment**

Court-ordered treatment is only covered when the treatment is a covered benefit and is determined to meet the applicable medical necessity guidelines. The DF is not required to authorize services to the facility identified by the courts if the DF is able to provide the medically necessary care for the capitated member. The DF must initiate the initial determination with Tufts Health Plan if they do not want to cover treatment at the facility identified by the courts or the DF has assessed the treatment requested is not medical necessary.

#### **Emergency Out-of-Area Admissions**

When a member has an emergency admission that occurs outside of Massachusetts in a bordering state (e.g., Rhode Island or New Hampshire), it may not be possible for the member to transfer to his or her DF because of laws governing transporting members across state lines. If you are made aware of such an admission contact your DF Case Manager for help with determining coverage responsibility. The DF is not responsible for coverage for a capitated member's emergency admission to a facility outside of Tufts Health Plan's service area.

#### **Change of PCP and Its Impact on DF Assignment**

Any change of PCP, by a commercial HMO or Tufts Medicare Preferred HMO (member's PCPs do not update until beginning of month following change) member, that becomes effective while the capitated member is receiving inpatient or intermediate level-of-care treatment will not result in change of DF assignment until that capitated member has completed treatment at that level of care.

## Chapter 5: Utilization Management

The function of UM is to facilitate the provision of quality, cost effective and efficient BH services for Tufts Health Plan members. The clinical review guidelines utilized by Tufts Health Plan are based on national standards for BH professional practice and define the general criteria used to determine the level of care and type of treatment needed for each member. The guidelines include medical necessity, impairment of functioning, degree of risk factors, and level of care required to safely and effectively treat the member's symptoms. Authorization decisions are also influenced by the unique characteristics of each individual benefit plan (which determine the coverage that is available), and the specific limitations of each plan.

Implicit in these guidelines is Tufts Health Plan's goal of providing the most effective level of care in the least restrictive (intensive) environment, and within the benefit coverage available to the member. Also implicit is that all members have ready access to the covered services they need and that they receive quality treatment.

### Authorization Decisions: Initial and Concurrent Review

An inpatient admission does not require prior authorization, however it does require notification (see the Tufts Health Plan Provider Manuals for further information).

Member treatment progress and requests for continuing treatment authorizations are reviewed concurrently. Authorization decisions are made by UMs who are independently licensed BH clinicians. Providers are verbally notified at the completion of the review about the continued stay disposition. Continued stay requests are reviewed for the member's response to treatment, appropriateness of care coordination and involvement of the member's psychosocial support system, and the early, proactive, integrated development of effective discharge, aftercare, and crisis plans.

### Medical Necessity

The central consideration in all Tufts Health Plan clinical review activity is the determination of the most appropriate and medically necessary level of care. All clinical information gathered by the Tufts Health Plan UM is aimed at satisfying this consideration.

### Utilization Management for Capitated Members

The DF is responsible for the clinical management of capitated members consistent with NCQA guidelines, *Designated Facility Operating Guidelines*, and all other applicable standards. For all DF admissions, the DF is responsible for managing the member's care and ensuring that treatment is provided in the most medically necessary level of acute or intermediate care. These levels of care include inpatient, acute residential, crisis stabilization, partial hospitalization, intensive outpatient, and family stabilization services.

In the case that the DF authorizes a capitated member to another facility for inpatient or intermediate levels of care, the DF is responsible for managing these admissions and for ensuring that treatment is provided in the most clinically appropriate setting.

While the DF can authorize care for their capitated members, they cannot deny care that is being requested by a member or by another facility. In the event that a DF believes that a member no longer meets guidelines for a requested level of care, and there is a

disagreement by the member, the member's authorized representative, or the requesting facility, the DF should contact their Tufts Health Plan BH UM immediately to review the case and discuss options including the Initial Determination process if applicable.

### **Tufts Health Plan Oversight of Designated Facility Utilization Management**

Tufts Health Plan is responsible for providing oversight of the DF to ensure that utilization of services is appropriate. The DF can also contact their Tufts Health Plan BH UM at any time for case consultations to address treatment issues, aftercare needs or barriers to discharge.

### **Outlier Management**

Outlier management for assigned commercial and Tufts Medicare Preferred HMO members may occur at any time, and typically begins at day 14 of an admission, and periodically thereafter until discharge. The goal of Tufts Health Plan's outlier management reviews is to collaborate on complex cases, ensure a shared understanding of the difficulties in treatment and discharge planning for a given case, and provide assistance or resources when available. The Tufts Health Plan UM will contact the DF to request clinical updates on these identified cases. Through this contact the UM will collaborate with the DF on treatment and aftercare planning, and helping to identify and resolve barriers to discharge.

### **Utilization Management for Fee-For-Service Admissions**

DFs are also able to provide services to members who are not assigned to a DF. These members can receive their care at the authorized level of benefit.

The Tufts Health Plan assigned DF UM reviews all fee-for-service members who are receiving inpatient or intermediate levels of care. Tufts Health Plan UMs gather clinical information relevant to determining medical necessity for fee-for-service members. Tufts Health Plan determines benefit coverage by using clinical criteria to determine the medical necessity and appropriateness of behavioral health services under the terms of the applicable health plan benefit. These criteria may include guidelines created by Tufts Health Plan and/or commercially purchased criteria.

As a contracted provider and DF, it is expected that there will be collaboration and cooperation between the admitting facility and Tufts Health Plan for utilization management, regardless of member capitation status. In some cases a review of care may result in some services not being covered, at the DF's expense. Refer to the Tufts Health Plan website for further information regarding relevant provider payment policies.

## **Chapter 6: Case Management Programs**

### **Behavioral Health Case Management**

All program referrals will be evaluated for eligibility for case management services.

#### **Transition to Home Program (For Psychiatric Admissions)**

Tufts Health Plan Behavioral Health Transition to Home Program supports members who have been psychiatrically hospitalized and who are at risk for readmission. Case managers follow eligible members, or work with the parents/guardians of members through the 60 day post-hospitalization period to provide support to attend aftercare appointments and to follow through with their provider's recommendations for care. The program is provided at no cost to the member.

Factors associated with increased risk of readmission include:

- A history of noncompliance with outpatient services or with taking medication as prescribed
- Lack of or limited social supports
- Ineffective condition self-management
- Co-occurring conditions that can make self-management more challenging

Telephonic case management provides the following support services to the member or their parent or guardian:

- Support to attend aftercare appointments
- Support to fill and take medications as prescribed by their provider
- Coordination of care with providers as necessary
- Education regarding the member's condition and medications
- Identification of barriers to following the treatment plan, with workable solutions

Referrals to the program can come from:

- Tufts Health Plan contracting and noncontracting facilities with psychiatric inpatient services
- Tufts Health Plan Commercial case managers working with members who have both psychiatric and medical issues for which noncompliance with psychiatric care can impact compliance with medical care
- Providers who are currently working with members diagnosed with a psychiatric disorder and who have assessed their patient to be at risk for an inpatient hospitalization

#### **Substance Use Disorder (SUD) Program**

The SUD Case Management Program is a program to assist members in recovery with the first 60 days being the most intensive case management.

**The program focuses on:**

- Commercial, Tufts Medicare Preferred HMO, and Tufts Health Plan Senior Care Options

- Members who have recently entered or completed acute treatment of SUD
- Members who have recently needed medical care (including detoxification on a medical unit, hospitalization due to a medical condition in which substance use problems were identified, or medical problems caused or worsened by substance use) whose Tufts Health Plan Nurse Case Manager or utilization reviewer has determined the member could benefit from specialized assistance formulating and executing a plan of care that addresses the SUD

The program assesses:

- Current physical and emotional health
- Aftercare plan including crisis plan and engagement into evidence-based treatment
- Medication knowledge and adherence
- Condition knowledge
- Treatment history (member history, SUD history and current treatment)
- Member motivation
- Relapse prevention through condition self-management, motivation, understanding triggers, healthy coping skills and stress management

### **Emergency Department (ED) Program**

The Tufts Health Plan ED Program is designed to assist members in accessing the care that they need in the appropriate setting. Some members utilize the ED as the setting for care when in some cases the more appropriate setting could have been in a provider's office or an urgent care setting.

The goals of the ED Program are to:

- Ensure members are able to follow through on ED discharge instructions
  - Members are able to visit the provider as determined by ED discharge instructions
  - Members understand and can follow medication/treatment instructions
  - Provide needed reinforcement/education regarding ED discharge instructions
  - Refer member to appropriate community resources as needed
- Refer member to appropriate Tufts Health Plan BH Case Management program
- Educate member on accessibility and value of Urgent Care Centers when appropriate

If you think a member would benefit from BH case management assistance, for more information about any of the BH case management programs or to make a referral to one of the programs, call Tufts Health Plan's Behavioral Health Department at 800.208.9565.

**Tufts Health plan also has a variety of case management programs assisting members with medical conditions. For more information on these programs follow the links below.**

**Medical Case Management:** [Commercial Products](#)

**Disease Management:** [Disease Management](#)

## Chapter 7: Quality Occurrence Reporting

In an effort to ensure quality of care for Tufts Health Plan members receiving services at a designated or contracting facility, Tufts Health Plan requires that all designated and contracted facilities complete the “Tufts Health Plan Quality Improvement Occurrence Report Form” for the quality occurrences outlined below. All quality occurrences will be reviewed by a Clinical Quality Improvement (CQI) Coordinator within the CQI department and scored to determine if the occurrence merits further investigation or a corrective action plan.

The CQI Coordinator may seek input or further clinical review by a Tufts Health Plan Medical Reviewer for Behavioral Health. In addition, Tufts Health Plan may request additional information from the reporting facility, including a copy of the medical record or submission of a written report of the event by the Medical Director at the facility.

### Examples of Quality Occurrences

The following are Quality Occurrences that must be reported to Tufts Health Plan within 24 hours from the time of occurrence:

- Coordination of care concerns and/or inadequate discharge planning
- Unexpected deaths, excluding those related to end-stage/terminal illnesses (e.g., metastatic cancer, end-stage chronic obstructive pulmonary disease). This includes any death subsequent to a case transfer from the facility psychiatric or SUD treatment unit to a medical unit
- A patient who causes harm to self or others during an inpatient behavioral health/substance use disorder stay, intermediate level of care or during an ED evaluation
- An adverse medical outcome secondary to care or lack thereof. Examples include all falls, injury related to restraint and/or seclusion, complications from ECT and medication errors
- Breach of patient confidentiality while in the provider’s care
- Suspected, alleged, or proven abuse of a patient while in the provider’s care
- Patient elopement while in the provider’s care
- Sexual activity on inpatient unit
- Drug use / drug dealing while on an inpatient unit or on the grounds of a treatment program
- Failure of staff to find potentially harmful objects on patients prior to admission

Refer to the [Tufts Health Plan Quality Improvement Occurrence Report Form](#) located on the Provider public website.

### Regulatory, Accreditation, or other Oversight Agency Actions

Designated and contracted facilities must report any significant action by a regulatory, accreditation, or other oversight agency that is initiated by a major quality of care concern for a Tufts Health Plan member, or that is taken by the hospital against a staff member or program due to a general patient quality of care issue.

Examples of agencies and actions include:

- Department of Public Health
- Department of Mental Health

## Behavioral Health Designated Facility Manual

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) sentinel event
- Board of Registration of medicine reportable event
- Decredentialing termination, or other adverse action for cause taken by the hospital against a hospital provider

The Tufts Health Plan Case Manager may observe, over time, events that occur frequently at a specific facility that may indicate an evolving pattern of care, or a clinical practice that is inconsistent with Tufts Health Plan quality of care standards. The Case Manager may discuss issues of concern with the Tufts Health Plan Behavioral Health Management Team and/or report concerns to the CQI Department. The Case Manager may also discuss concerns with the clinical contacts at the facility. The Case Manager may convey his or her findings in a written report. The Tufts Health Plan Medical Reviewer for Behavioral Health, Case Manager, and the Manager of Behavioral Health Clinical Programs, in coordination with the CQI Department will determine the appropriate action to be taken.

## Chapter 8: Additional Resources

### Behavioral Health Department Information

- [Behavioral Health and Substance Use Disorder Resources](#) – BH/SUD services offered by Tufts Health Plan
- [List of Designated Facilities](#)
- [Find an Outpatient Provider](#) – Provider search option for finding providers and facilities offering mental health services
- [Inpatient and Intermediate Behavioral Health/Substance Use Disorder Facility Payment Policy](#) – Policy outlining the requirements for payment of inpatient and intermediate level of care services.
- [Registration for Online Trainings and Education](#) – Office manager guides and resources, webcasts and webinars to assist provider staff in learning about web tools, policies and procedures and administrative updates
- [Instructions for Reporting a Discharge](#) – Form provides information on how to report a discharge as well as the data elements needed
- [Transition to Home Referral Request Information](#) – Document details how to initiate a request for transition to home services as well as the information needed

### Outpatient Authorization Requirements

- [Commercial and Senior Products](#) – List of services requiring authorizations

### Interactive Voice Response (IVR) Guide

- [Overview of IVR System](#) – phone system option to obtain information about member eligibility/copays, DF assignments (if applicable); also provides option to submit notifications for outpatient counseling services

### Pharmacy Program

- [General Pharmacy Web](#) – Pharmacy section of the Tufts Health Plan website
- [Pharmacy Program Overview](#) – High-level overview of pharmacy programs including tiered copays, new to market drug evaluations, prior authorization, step therapy, quantity limits, specialty drugs, and non-covered drugs
- [Medicare Preferred Pharmacy Information](#) – Medicare formulary searchable lists.
- [Standard Formulary](#) – Online search of commercial drug formulary

## Utilization Review Time Frame Requirements

- [Utilization Review Determination Time Frames for Commercial Products](#) – Chart showing the decision time frames, extension rules time frames as well as notices of authorization or denials time frames for commercial products.
- [Utilization Review Determination Time Frames for Tufts Medicare Preferred HMO Members](#) - Chart showing the decision time frames, extension rules time frames as well as notices of authorization or denials time frames for Medicare Preferred products

## Provider Manuals

- [Commercial Provider Manual](#) – Covers a range of topics including but not limited to: member rights and responsibilities, claims requirements and disputes, financial programs, notifications and prior authorizations for Commercial members.
- [Tufts Medicare Preferred HMO Provider Manual](#) – Covers a range of topics including but not limited to: member rights and responsibilities, claims requirements and disputes, financial programs, notifications and prior authorizations for Tufts Medicare Preferred HMO members.
- [Tufts Health Plan Senior Care Options Provider Manual](#) – Covers a range of topics including but not limited to: member rights and responsibilities, claims requirements and disputes, financial programs, notifications and prior authorizations for Tufts Health Plan Senior Care Options members.

## Appeals

- [Provider Payment Dispute Policy](#) – Document details policies and procedures for filing a payment dispute
- [CareLinkSM Provider Payment Dispute Policy](#) – Document details the policies and procedures for filing a payment dispute where Cigna is the primary administrator or when the administration is shared with Tufts Health Plan, Cigna and Union or Trades

## Tufts Health Plan Medicare Preferred HMO Appeals and Grievances

- [Appeals and Grievances](#) - Document details the member process and procedure for filing an appeals or a grievance.