PROVIDER REMINDERS & RESOURCES

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- Participating providers and select office staff complete your Cultural Competency Training: **Click Here!**
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healthfirst®
Health Insurance for New Yorkers

New York Provider Manual

Rev: 4/1/2024

Healthfirst®

Established in 1993, Healthfirst® is a not-for-profit managed care organization that provides high-quality healthcare coverage to low-income individuals and families living in New York. Our mission is to improve the health and well-being of underserved populations by providing effective managed care services through comprehensive provider partnerships and reinvesting in our hospitals.

By working in partnership with our participating hospitals throughout the five boroughs of New York City, and in Long Island and Westchester, Healthfirst has developed a solid and effective approach to meeting the diverse needs of New York residents.

Sponsor Hospitals/Health Systems

NYC Health + Hospitals	BronxCare Health System	SUNY Downstate
Stony Brook Medicine	Montefiore Health System	Medisys
St John's Episcopal Hospital	Interfaith Medical Center	Northwell Health
NuHealth – Nassau University Medical Center	Maimonides Medical Center	Mount Sinai Health System
The Brooklyn Hospital Center	St Barnabas Health System	NYU Langone Health

Healthfirst, Inc. is part of the Healthfirst family of companies, which includes HF Management Services, LLC, a hospital-owned company that provides comprehensive management services to healthcare organizations in New York, New Jersey, Pennsylvania, and Florida.

Healthfirst in New York (Healthfirst HFHP and Healthfirst PHSP, Inc.) Members must see providers in their health plan's network for services to be considered in-network. Services rendered without prior authorization by providers or facilities outside of the network designated by the member's health plan are considered out-of- network and shall be the member's financial responsibility (excludes emergent care).

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1 Introduction

Healthfirst is committed to ensuring that its members receive easily accessible, high-quality, comprehensive healthcare services. The Healthfirst provider network is a key partner in achieving this goal. The Provider Manual has been developed to assist our participating providers in understanding the administrative policies and procedures that govern the management of Healthfirst. It is designed to provide you with easy access to information that will enable you and your office staff to care for Healthfirst members within administrative guidelines. All the information in this manual applies to all Healthfirst members, unless specifically indicated.

Updates to the Manual

Healthfirst will update the Provider Manual and Appendices periodically and will make available electronic versions which can be downloaded from our website at hfproviders.org. Information related to these updates may appear on the Healthfirst website and in other mailings. These media provide the most current information on the Healthfirst programs and your responsibilities under these programs.

Keep Us Informed

Please take the time to read through the Provider Manual and let us know if there are any sections that are unclear or if there are other topics about which you would like more information. Our goal is to provide you with material that is timely, accurate, and easy to understand. We welcome your comments.

1.1 About Healthfirst, Inc

Healthfirst, Inc.

Healthfirst was founded in the early 1990's by a consortium of hospitals under the auspices of the Greater New York Hospital Association. An independent not-for-profit corporation since 1993, it has from its inception operated pursuant to a unique model that relies on population health management efforts on the part of its hospital sponsors and provider network supported by the infrastructure of an established and regulated health plan. Funds saved through higher quality and better care management are returned to the provider delivery system. Healthfirst has steadily expanded its product offerings from its start in Medicaid managed care to Medicare Advantage Prescription Drug (MAPD) plans, long term care, and commercial products offered on the New York State of Health (commonly known as the Exchange) branded at Healthfirst Leaf and Leaf Premier Plans. With more than a million members and top quality and member satisfaction rankings, Healthfirst's business model relies on empowering and partnering with the provider system and the community to achieve the superior outcomes and culturally competent healthcare for its customers.

Healthfirst PHSP, Inc.

Since 1994, Healthfirst has operated a Prepaid Health Services Plan (PHSP) serving Medicaid members in New York City under a certificate of authority granted by the State of New York. In 1995, the Healthfirst operating area was expanded to include Long Island. Healthfirst PHSP was developed to meet the objectives of New York State's Managed Care Act, which changed the way healthcare was delivered for Medicaid recipients. In 1999, Healthfirst implemented its Child Health Plus (CHPlus) program to expand its ability to provide healthcare services to eligible children through participation in the state's CHPlus Program. This offers reasonably priced healthcare coverage for the children of working parents who do not qualify for Medicaid and cannot afford unsubsidized health insurance.

Healthfirst Health Plan, Inc.

Healthfirst Health Plan, Inc. (HFHP) is the licensed HMO doing business as Healthfirst Medicare Plan and Healthfirst New York (commercial). Formerly known as Managed Health, Inc., HFHP was first managed by Healthfirst in July 1997 and then became a subsidiary of Healthfirst in August 1998. The service areas for the Healthfirst Medicare Plan include the Bronx, Brooklyn, Manhattan, Queens, Staten Island, Nassau and Westchester counties (not all plans are

available in all counties). The service areas for Healthfirst New York include the Bronx, Kings, Manhattan, Queens, Richmond, Nassau and Suffolk counties.

Provider Participation

Healthfirst hospitals and their affiliated providers may be contracted to participate in one Healthfirst program or in a combination of programs (see Section 2). Because contracting differs among the programs, it is important to note that a provider who is contracted to provide services for one program is considered out-of-network for all of the other programs. Additionally, participation is office-site specific. While a contract may cover multiple locations, if an application has not been submitted or approved for a particular office, services rendered there are considered out-of-network. To confirm the programs that you participate in, contact Provider Services.

Each of the Healthfirst companies, Healthfirst, Inc., Healthfirst PHSP, Inc. and Healthfirst Health Plan, Inc. do business under the “Healthfirst” name. Throughout this provider manual the term “Healthfirst” refers to all three companies collectively. When referring to a specific company or a specific line of business, the specific company name is used, i.e., “Healthfirst Health Plan, Inc.” or “Healthfirst PHSP, Inc.”, and the specific product name if a specific product is used, i.e., “Medicare” or “Medicaid.”

1.2 Network Management and Provider Services

Network Management

All participating hospitals, their affiliated providers, and individual participating providers have a designated Healthfirst representative who serves as the liaison between the facility, its affiliated providers, participating providers, and Healthfirst. These representatives provide information, problem-solve, and respond as needed to provider concerns.

Provider Services

Healthfirst also has a dedicated phone unit available to assist providers with questions regarding Healthfirst policies and procedures, member care, reimbursement, claim information or general information about Healthfirst and its products. If you have any questions or need more information about Healthfirst and its products, please contact Provider Services at 1-888-801-1660, Monday to Friday, 8:30am–5:30pm. After normal business hours you may leave a message and we will respond no later than the next business day.

Healthfirst Secure Provider Portal

Hospitals, providers, and their office staff can access information 24 hours a day, 7 days a week on the Healthfirst secure Provider Portal at hfproviders.org. Quick and easy online registration to the Provider Portal provides access to tools that let you:

- Verify member eligibility
- Submit appeals and view claim status
- View the status of authorizations
- Submit questions to Healthfirst
- Request access to online reports and member enrollment rosters
- Submit files/documents to Healthfirst
- Request demographic information update
- Access Healthfirst policies and procedures
- Review the latest clinical guidelines, newsletters, reference materials, and more

For more information about our website, send an email to webmaster@healthfirst.org, and to register for access, visit hfproviders.org and click “New User – Sign Up Here.”

Other Healthfirst Departments

In addition to Provider Services, there are other departments at Healthfirst that you may contact or work with on a regular basis. The following table highlights these areas and outlines their key functions. Healthfirst staff members from these departments are available to assist you in providing care to Healthfirst members.

Department Key Functions & Responsibilities	Contact Information	
Provider Services • Provider Services Inquiries	**Phone:** 1 (888) 801-1660 Monday to Friday 8:30am-5:30pm	**Mailing Address:** P.O. Box 5168 New York, NY 10274-5168
Provider Claim Appeals • Member Appeals and Grievances • Claims Appeals and Grievances	**Phone:** 1 (888) 801-1660 Monday to Friday 8:30am-5:30pm	**Mailing Address** P.O. Box 958438 Lake Mary, FL 32795-8438
Claims • Claims Payment and Status Inquiries • Claim Review and Reconsideration	**Phone:** 1 (888) 801-1660 Monday to Friday 8:30am-5:30pm **Email:** eclaims@healthfirst.org	**Mailing Address:** P.O. Box 958438 Lake Mary, FL 32795-8438
Clinical Performance Management • Quality of Care Investigations • HEDIS and QARR • Quality Incentive Programs • Quality Improvement Committees & Studies • Member Satisfaction Surveys • Public Health Reporting • Preventive Health and Clinical Practice Guidelines • Medical Record Documentation Audits • Risk Adjustment and Payment System • Credentialing	**Mailing Address:** P.O. Box 5163 New York, NY 10274-5163	
Confidential Compliance Contact To anonymously report compliance concerns in addition to suspected fraud, waste, and abuse	**Phone:** 1 (877) 879-9137 **Website:** http://hfcompliance.ethicspoint.com/	
Medical Management & Behavioral Health Unit • Transitional Care • Care Management and Disease Management • Assistance in Finding Appropriate Specialists • Utilization Review • Authorizations for Initial and Continuing Care	**Phone:** 1 (888) 394-4327 Monday to Friday 8:30am–5:30pm **Fax:** 1 (646) 313-4603	**Mailing Address:** P.O. Box 5166 New York, NY 10274-5166
Member Services • Eligibility Verification • Member Benefits • Distribution of Provider Directories to Members	**Medicaid / CHPlus / FHP:** 1-866-463-6743 Monday to Friday 8:00am–6:00pm	**Mailing Address:** P.O. Box 5165 New York, NY 10274-5166

Department Key Functions & Responsibilities	Contact Information	
• New Member Orientations PCP Selection	English, Spanish, Mandarin, Cantonese, Russian **Medicare/Commercial:** 1-888-260-1010 **Signature (PPO):** 1-833-350-2910 **Signature (HMO):** 1-855-771-1081 TTY 1-888-542-3821 (for the hearing/speech impaired) Monday to Friday 8:00am–8:00pm **Healthfirst Leaf Plans:** 1-888-250-2220 English TTY: 1-888-542-3821 Spanish TTY: 1-888-867-4132 Monday to Friday 8:00am–8:00pm **Small Group and Healthy NY:** 1-888-260-1010 Monday to Friday 8:00am–8:00pm English, Spanish, Mandarin, Cantonese	

2 Healthfirst Programs and Benefits

2.1 Healthfirst PHSP Programs

Healthfirst Personal Wellness Plan (HARP)

The Healthfirst Personal Wellness Plan also known as the Health and Recovery Plan (HARP), which isa NY State managed care plan created to better assist adults diagnosed with serious mental illness (SMI) and substance use disorders (SUD) in their recovery. This plan is offered in the 5 boroughs of New York City, Nassau, Suffolk, Westchester, Sullivan, Orange and Rockland counties.

The Personal Wellness Plan is for Medicaid eligible consumers who may benefit from extra behavioral health or substance abuse services. Enrolled members will have access to specialized care management teams with experience in Behavioral Health who understands the member's unique needs. It offers all the same coverage and benefits of Medicaid Managed Care, plus extra services like community support programs, mental health treatment, substance abuse programs, and other behavioral health services to help the member live life to the fullest.

Healthfirst Essential Plan

The Healthfirst Essential Plan provides health coverage for individuals between 19 – 64 years of age whose income is slightly higher than the Medicaid income limit or who are lawfully present in the United States but do not qualify for Medicaid due to immigration status. Healthfirst offers the Essential Plan in the 5 boroughs of New York City, Nassau, Suffolk, Westchester, Sullivan, Orange, and Rockland counties.

Essential Plan eligibility is determined by income and household size, and there are five variations - Essential Plan 200-250, Essential Plan 1, Essential Plan 2, Essential Plan 3, and Essential Plan 4. All five plans provide the same essential health benefits including inpatient and outpatient care, physician services, diagnostic services, prescription drugs, adult dental and vision benefits along with other benefits. All Essential Plans have no annual deductible, which means members only pay for services via copay or co-insurance.

Healthfirst Medicaid Managed Care Plan

Since 1994, Healthfirst has delivered managed healthcare services to the Medicaid-eligible population living in the 5 boroughs of New York City, Nassau, Suffolk, Westchester, Sullivan, Orange and Rockland counties. Healthfirst Medicaid offers the full range of New York State Medicaid benefits to individuals and families eligible to receive services under the following government programs: Temporary Assistance to Needy Families (TANF), Safety Net Assistance (SNA), Medicaid Only (MA-HR and MA-ADC) and Supplemental Security Income (SSI). The Healthfirst Medicaid Managed Care Plan is designed for low-income families and individuals under 65 who qualify for Medicaid in New York State. This high-quality plan offers benefits that include maternity coverage, PCP and specialist visits, prescription drug coverage and health and wellness programs, and more.

Healthfirst Child Health Plus (CHPlus)

Since 1999, Healthfirst has offered the Healthfirst Child Health Plus (CHPlus) Program to provide quality healthcare coverage for the children of uninsured and underinsured children. Healthfirst offers children access to a wide range of care and services in the 5 boroughs of New York City, Nassau, Suffolk, Westchester, Sullivan, Orange and Rockland counties. The CHPlus Program is for uninsured or underinsured children who do not qualify for Medicaid. This CHPlus plan offers no cost or low-cost coverage for qualified children under age 19, regardless of family income or immigration status.

CHPlus provides children with a comprehensive benefit package. The parent/guardian may be responsible for contributing to a premium based on their household income level. Children can enroll and renew their CHPlus coverage through the New York State of Health Marketplace (NYSOH).

2.2 Healthfirst Medicare Advantage Plans

Healthfirst offers several Medicare Advantage Plans (MA Plans) under contract with the Centers for Medicare & Medicaid Services (CMS). Some of these MA Plans also include Medicaid benefits offered through a State Medicaid Agency Contract (SMAC) with the New York State Department of Health.

To meet the eligibility requirements for Healthfirst MA Plans, beneficiaries must have Medicare Part A and Part B and have a permanent address within the specific plan's service area. Generally, the benefits for MA Plans change yearly, and providers are informed of these changes through the Quick Reference Guide in the Plans & Benefits section at **https://HFProviders.org.**

Healthfirst MA Plans provide all the benefits and services that Original Medicare does, plus supplemental benefits and prescription drug coverage (Part D).

Healthfirst Medicare Advantage plans currently include the following:

Healthfirst Signature (PPO)

Healthfirst Signature (PPO) is a plan that gives members the flexibility to go out of network and visit any doctor or hospital in the U.S. that accepts Medicare. This plan offers the benefits of Original Medicare, plus much more, for a $0 monthly premium. This plan includes Part D coverage, as well as supplemental coverage for prescription vitamins and erectile dysfunction drugs.

This plan is designed for people who do not qualify for programs like Extra Help (also known as Low Income Subsidy), Medicare Savings Programs (MSP), or Medicaid.

Healthfirst Signature (HMO)

Healthfirst Signature (HMO) is a plan that gives members the flexibility to pick benefits that best suit their needs. This plan offers the benefits of Original Medicare, plus much more, for a $0 monthly premium. This plan includes Part D coverage, as well as coverage for prescription vitamins and erectile dysfunction drugs.

This plan is designed for people who do not qualify for programs like Extra Help (also known as Low Income Subsidy), Medicare Savings Programs (MSP), or Medicaid.

Healthfirst 65 Plus Plan (HMO)

Healthfirst 65 Plus Plan offers a comprehensive benefit package, including additional benefits not covered by Original Medicare, for a $0 monthly premium, making it a high-value yet affordable choice. This plan includes Part D coverage, as well as coverage for prescription vitamins.

This plan is designed for those who do not qualify for programs like Extra Help (also known as Low Income Subsidy), Medicare Savings Programs (MSP), or Medicaid.

Healthfirst Increased Benefits Plan (HMO)

Healthfirst Increased Benefits Plan offers the benefits of Original Medicare plus additional benefits not covered by Medicare. This plan includes Part D coverage, as well as coverage for prescription vitamins. Those who qualify for full Extra Help will be eligible for a $0 monthly plan premium, no drug deductible, and lower copays for prescription drugs.

This plan is designed for those who qualify for some level of Extra Help (also known as Low Income Subsidy) and/or Medicare Savings Programs (MSP) but are not fully dual eligible.

Healthfirst Life Improvement Plan (HMO D-SNP)

Healthfirst Life Improvement Plan is a Medicare Advantage Dual-Eligible Special Needs Plan (D-SNP) that offers the benefits of Original Medicare plus additional benefits not covered by Medicare, such as supplemental benefits and Part D coverage, as well as coverage for prescription vitamins. This plan is designed specifically for those who are

eligible for both Medicare and full Medicaid. Healthfirst has a Coordination of Benefits Agreement (COBA) with New York State Department of Health (NYSDOH) that provides wraparound Fee-For-Service (FFS) Medicaid benefits and covers member cost-sharing. NYSDOH is financially responsible for cost-sharing obligations and Medicaid benefits for our dual-eligible beneficiaries.

Healthfirst Connection Plan (HMO D-SNP)

The Healthfirst Connection Plan is a Medicare Advantage Dual-Eligible Special Needs Plan (D-SNP) that coordinates coverage for those who are newly Medicare-eligible and enrolled in our Medicaid managed care plan pursuant to the CMS default enrollment process. Healthfirst Connection Plan members who do not opt out of the default enrollment receive their Medicare coverage from Healthfirst Connection Plan, which is coordinated with their Healthfirst Medicaid coverage. Healthfirst Connection Plan has a Coordination of Benefits Agreement (COBA) with New York State Department of Health (NYSDOH) that defines the Medicaid benefits and cost-sharing obligations of the plan.

Healthfirst CompleteCare (HMO D-SNP/MAP)

Healthfirst CompleteCare is a Fully Integrated Dual-Eligible (FIDE) Special Needs Plan (SNP) designed for Medicare and Medicaid dual-eligible beneficiaries who are (1) eligible for nursing home level of care using the Uniform Assessment System (UAS) and (2) expected to need at least one of the Community Based Long Term Care Services (CBLTCS) for 120 days or longer. CompleteCare offers the benefits of Original Medicare, Medicaid, Long Term Care, Medicare Prescription Drug coverage, and supplemental benefits.

As a FIDE SNP, CompleteCare provides primary, specialty, and long-term care services to those who need assistance with activities of daily living. The plan coordinates these services to address medical needs and manage chronic conditions while allowing members to remain safe and secure in their own homes and communities.

Plan Name	Counties of Service
Signature (PPO)	Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, Rockland, Suffolk
Signature (HMO)	Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, Orange, Sullivan, Rockland
65 Plus Plan	Bronx, Kings, New York, Queens, Richmond, Nassau
Increased Benefits Plan	Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, Orange, Sullivan, Rockland, Suffolk
Life Improvement Plan	Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, Orange, Sullivan, Rockland
Connection Plan	Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, Orange, Sullivan, Rockland, Suffolk
CompleteCare	Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, Orange, Sullivan, Rockland

2.3 Healthfirst Commercial Programs

Healthfirst offers a range of commercial products. Qualified Health Plans (QHP) are offered via the NY State of Health (New York State's health benefit exchange) and are marketed as Healthfirst Leaf Plans. These plans are available for eligible individuals and families. Healthfirst also offers individual and family health plans off the NY State of Health.

The benefits and cost-sharing of these off-Exchange plans mirror those of the on-Exchange Leaf Plans, but are marketed as Healthfirst HMO A, B, C, and D plans ("HMO Plans").

Healthfirst Leaf and HMO Plans are comprehensive health insurance plans that meet all state and federal QHP requirements. These plans are offered at a range of premium and coverage levels to meet the needs of a wide variety of consumers:

- **Healthfirst Platinum Leaf Plan/Healthfirst Premier Platinum Leaf Plan/HMO A:** Highest premiums, with $0 annual deductible, low copays, and an annual out-of-pocket limit of $2,000. Adult dental and vision coverage is available with Platinum Leaf Premier plans.
- **Healthfirst Gold Leaf Plan/ Healthfirst Premier Gold Leaf Plan/HMO B**: $600 annual deductible, modest copays, and an annual out-of-pocket limit of $4,000. Adult dental and vision coverage is available with Gold Leaf Premier plans.
- **Healthfirst Silver Leaf Plans/Healthfirst Premier Silver Leaf Plans/HMO C:** Modest premiums, with $2,000 annual deductible, modest copays, and an annual out-of-pocket limit of $5,500. Subsidies are available that can help reduce the Silver Leaf copays and deductibles. Adult dental and vision coverage is available with Healthfirst Leaf Premier plans.
- **Healthfirst Bronze Leaf Plan/Healthfirst Premier Bronze Leaf Plan/HMO D:** Lowest premiums, with $3,500 annual deductible, 50% coinsurance, and an annual out-of-pocket limit of $6,850. Adult dental and vision coverage is available with Healthfirst Leaf Premier plans.
- **Healthfirst Green Leaf Plan/HMO E:** Catastrophic coverage for individuals under 30 years of age

These plans offer the following essential health benefits:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness and chronic-disease management
- Pediatric services, including oral and vision care

Healthfirst's Healthy NY program plan is offered by Healthfirst Health Plan, Inc., a subsidiary company of Healthfirst, Inc. The Healthy NY program offers coverage to eligible small employer groups. This program was discontinued for individuals and sole proprietors on December 31, 2013.

2.4 Benefits/Covered Services

Members who participate under a government-sponsored program (Medicaid, Child Health Plus, and Medicare) are entitled to receive all services covered by that program. Benefits among the programs vary. For example, Medicaid members are entitled to receive all the services covered under the Medicaid program, but some services are covered directly by Medicaid Fee-for-Service. Medicare members are entitled to receive all the services under the Medicare program. Further, for Medicare members, the Healthfirst Medicare Plan offers a variety of products that not only cover the services available under Original Medicare, but also offer additional benefits such as dental and vision. Commercial health plan members are entitled to receive all services covered by their plan.

To view a detailed summary of the benefits offered by the Medicaid and CHPlus programs, please refer to the Healthfirst Provider Portal or to our member handbooks located on our website, **https://healthfirst.org**. For the Medicare programs, please refer to the applicable Summary of Benefits. Any changes to a particular benefit package will be noted through our mailings. Copies of these materials are located on our website at **https://hfproviders.org**.

To view a detailed summary of the benefits offered by the Healthfirst Leaf or HMO A–D plans, please refer to the Summary of Benefits available on our website at **https://healthfirst.org/leaf-plans/**.

Consent to Receive Noncovered Services

If you are unsure whether a requested service is covered by Healthfirst, you must do the following:

- Determine if the member has coverage through one of the Healthfirst Medicare programs. If they do, refer to Section 15 for instructions.
- For non-Medicare programs, inform the member that their Healthfirst program may not cover the service.
- You should contact Member Services directly to confirm whether the service is covered. You should explain to the member that they may also contact Member Services.
- If Member Services confirms that the service is not covered, advise the member that, they may file a grievance if they disagree with Healthfirst's interpretation. Information on the process for filing grievances may be obtained by calling Member Services.
- If Member Services confirms that the service is not covered and the member asks that you provide the noncovered service anyway, you must tell the member the cost of the noncovered service. You must also explain that the member will be billed directly for, and must pay for, the noncovered service, and that Healthfirst will not be financially responsible for the cost of any noncovered service.
- You must obtain the member's written consent, acknowledging that they were advised of the cost of the noncovered service and agreeing to be financially responsible for it. A general consent signed by the member accepting financial responsibility for any services not paid for by Healthfirst is insufficient. The written consent must indicate the specific services and costs for the noncovered service that will be provided.

3 Healthfirst Provider Networks

3.1 Description of the Networks

Healthfirst serves the healthcare needs of its members through comprehensive provider networks for each of its various programs (Healthfirst Medicaid, Child Health Plus, Medicare, Healthfirst Leaf Plans, and Healthy New York). While each network is separate and unique, most Healthfirst providers participate in one or more of these networks. Each network includes the clinical practitioners necessary to offer the full spectrum of covered healthcare services.

The networks are organized around each Healthfirst hospital or designated group of hospitals. This includes all inpatient and outpatient facilities, primary care and specialty care providers, and other healthcare personnel affiliated with the hospital's delivery system, so that providers can refer members and coordinate treatment according to their normal practices and referral patterns. Medical services are generally rendered by hospital- and community-based providers within each hospital system. Additional services such as behavioral health, home care, dental, and other ancillary services are provided and managed by either Healthfirst, selected hospitals, or other organizations specializing in these areas.

While our network is organized around the Healthfirst hospitals so that existing referral and practice patterns among providers are maintained, members may see any participating provider within the network for a given Healthfirst program.

Hospital Responsibilities

Healthfirst was started by its member hospitals seeking to provide high-quality, comprehensive, managed healthcare services to members covered under government-sponsored and other health benefit programs. Healthfirst has contracted with these and other hospitals to provide inpatient care, outpatient services, and diagnostic testing to its member population. The hospitals and their associated delivery system of providers, allied and ancillary health personnel, therapists, and other affiliated providers comprise the core of the Healthfirst provider network. A listing of participating Healthfirst hospitals can be found in the Provider Directories.

The following is an overview of responsibilities for hospitals participating with Healthfirst:

- Provide all contracted services within the scope of the hospital's operating certificate
- Verify member eligibility for all services
- Get from Healthfirst's Medical Management department prior authorization for all elective admissions
- Report all obstetrical admissions for delivery to Healthfirst at the time of the delivery or on the next business day
- Provide Healthfirst with Client Identification Numbers (CIN) for all newborns delivered to Healthfirst members
- Refer members back to their primary care providers (PCPs) for coordination of specialty care following an emergency room visit
- Use the appropriate referral request form to refer all Healthfirst Leaf Plan members to in-network specialists before rendering the specialist service
- Ensure continuity of care by coordinating discharge arrangements with the member's PCP, specialty care provider (as appropriate), and other post-discharge providers, such as certified home health agencies and Healthfirst's Medical Management department
- Ascertain whether the member has executed an Advance Directive, include an executed Advance Directive in the member's medical record, and honor the member's wishes as documented in the Advance Directive
- Notify Healthfirst Medicare members receiving inpatient hospital care (or their representative) when services will be discontinued and/or their original Medicare or Medicare Advantage Plan will no longer pay for their benefits (see Section 15 for more information)
- Adhere to provider **Appointment Availability and 24-Hour Access Standards** as specified by the New York State Department of Health
- Implement operating procedures required to comply with Healthfirst's policies and procedures

Primary Care

Healthfirst primary and specialty care providers practice in a variety of settings, including hospital outpatient departments, hospital-sponsored independent community-based practices, and private provider offices located either on member hospital campuses or within the community.

Primary care providers (PCPs) are providers or nurse practitioners who specialize in family practice, internal medicine, geriatrics, or pediatrics. All members enrolling in Healthfirst select a participating PCP. Generally, members choose geographically convenient providers and hospitals. Members may change their PCP at any time and select a new provider from the Healthfirst network.

PCPs are responsible for coordinating all the care a member receives and are expected to refer members to specialists in the Healthfirst network for care that is outside of the scope of primary care. Written referrals are not required for Healthfirst members to receive care from in-network specialists. However, PCPs are responsible for monitoring all member care and promoting the return of the member for services and management. PCPs are also responsible for requesting authorizations from Medical Management.

Authorizations, when required, are essential for prompt claims payment. Please refer to Section 12 for more details on authorization processes.

Because the PCP is the member's first contact with Healthfirst, the PCP is responsible for identifying members with complex or serious medical conditions, assessing those conditions using appropriate diagnostic procedures, and recommending them to Care Management for intensive review and follow-up. If the case meets Care Management selection criteria, the PCP, along with Care Management, formulates and implements a time-specific treatment plan, taking into consideration the member's input. The PCP may need to request authorizations for certain services to accommodate the treatment plan. Please refer to Section 13 of this manual for more information.

Primary Care for HIV Positive Members

All HIV specialist PCPs must meet additional credentialing requirements to serve this population. (See Appendix II-A.) These multidisciplinary providers coordinate care throughout the service delivery system.

Treatment Adherence

At every visit, the HIV specialist PCP should discuss and document in the medical record the member's adherence to their treatment plan. For members who do not adhere to their treatment plan, the provider should either provide directly or ensure access to additional treatment adherence support services. To arrange for community-based treatment adherence support services, contact Healthfirst's Care Management department at **1 (888) 394-4327**.

Co-Management with an HIV Specialist

If a member has a life-threatening or degenerative and disabling condition or disease (other than HIV), either of which requires specialized medical care, the member may request a specialist to act as the PCP. A co- management model will be used in this circumstance. In these situations, an HIV specialist assists the PCP in an ongoing consultative relationship as part of routine care and continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the other specialist. Providers are expected to cooperate in the process.

Harm Reduction Services

Providers must ensure harm reduction services are provided to HIV-positive members. These services include:

- Education and counseling regarding reduction of perinatal transmission
- Individual and group HIV prevention and risk reduction education and counseling
- Harm reduction education
- Counseling and supportive services for partner/spousal notification

If you are not sure where to refer a member, Healthfirst's Care Management department can assist you in securing these services. Call **1 (888) 394-4327** for more information.

Specialist Providers (excluding Behavioral Health Providers)

Healthfirst has contracted with specialist providers and other specialty healthcare professionals to provide care and services to its members whose treatment falls outside the scope of the PCP's training. For all Healthfirst products, members can access these specialty services without a referral from their PCP or authorization by Healthfirst.

Specialist providers also have the responsibility of identifying individuals with complex or serious medical conditions. Once identified, the condition should be assessed and monitored using appropriate diagnostic procedures. These cases should be referred to Care Management for intensive review and follow-up. The specialist, along with Care Management, should establish and implement a time-specific treatment plan, taking into consideration the member's input and coordinating with the PCP.

Specialty care services are provided by clinicians practicing within the Healthfirst network. Healthfirst may make special arrangements to accommodate requests to see specialists affiliated with non-network institutions when appropriate.

Tertiary Care

Healthfirst negotiates system-wide arrangements for the provision of selected tertiary care services.

Behavioral Healthcare

Healthfirst has contracted with providers, community agencies, and other licensed professionals to provide Behavioral Healthcare services, including mental health and chemical dependency (addiction) treatment, outside the scope of the PCP's training. Special delegated arrangements for management of behavioral healthcare services apply to members affiliated with certain hospitals. See Section 9 for more information.

Ancillary Services

Healthfirst has established both network-wide and hospital-specific arrangements to provide ancillary services such as vision care, home healthcare, and dental services, as well as other services, to its members. Healthfirst provides specialized healthcare services, diagnostic testing, therapies and medical items, supplies, devices, DME, and chiropractic services through contracted ancillary providers. Members can access ancillary services via a written prescription or a direct call from the PCP or specialist provider. Please refer to Section 10 for a detailed description of all Ancillary Services policies and procedures.

Levels of Participation

The relationship between Healthfirst and its participating providers is characterized by three levels (e.g., employed, community-based, etc.). In some cases, the participation level of the provider determines which ancillary service vendors may be used. The levels are as follows:

- **Level I** providers are employees of participating hospitals. They are credentialed by the hospital with delegated oversight by Healthfirst, and are bound by the terms of the agreement executed by the participating hospital which employs that provider. Payment for services rendered by these providers is made to the hospital, not to the individual provider.
- **Level II** providers are contracted with Healthfirst directly on an individual basis or as members of a professional corporation or diagnostic and treatment center. These providers are credentialed by the Healthfirst hospital(s) with which they are affiliated, with delegated oversight by Healthfirst. Payment for services is made directly to the provider or designated contracting entity.
- **Level III** providers are PCPs based in the community who do not have admitting privileges at a Healthfirst participating hospital. These providers hold individual contracts with Healthfirst and are credentialed by Healthfirst. Providers are compensated directly for services rendered.

Partnering with Healthfirst — Mutual Expectations

Healthfirst is committed to working with its participating providers to ensure that high-quality services are provided in an atmosphere of collaboration and respect. Mutual expectations are as follows:

From Healthfirst

- Open, respectful, and receptive communication

- Knowledgeable and helpful staff
- Timely response to questions and concerns
- Timely communication of policy changes
- Timely, comprehensive orientation, training, and educational programs
- Timely processing of provider applications
- Timely payment for covered services rendered
- Responsive appeals and grievance processes
- Assistance with complex member issues
- Feedback on performance and utilization

From Participating Providers

- Professional, respectful, and responsible healthcare for members
- Timely response to inquiries
- Assistance with problem-solving and other issues
- Maintenance of all contractual credentialing standards and licensing obligations
- Adherence to access and scheduling standards
- Compliance with medical management protocols
- Timely and accurate claims submission
- Compliance with quality improvement protocols and requests
- Cooperative office and administrative staff

Quality Improvement and Commitment to Providers

Healthfirst has implemented a uniform Integrated Quality Plan and Quality Improvement Program throughout the network with oversight maintained by the Healthfirst Chief Medical Officer and Healthfirst Clinical Performance Management staff. This program supports processes designed to improve the quality and safety of clinical care and the quality of service provided to members to ensure members receive the highest quality of care. This includes clinical and service quality indicators, public health reporting, quality investigations, focused clinical studies, quality programs, and member satisfaction surveys. All Healthfirst providers are required to participate in quality improvement efforts.

In addition, any Quality Improvement plans developed by participating providers must adhere to the Healthfirst program standards. Healthfirst offers provider education and training programs regarding quality improvement initiatives conducted by the Clinical Performance Management and Network Management departments.

Healthfirst works closely with participating facilities to build consensus and support critical network policies and procedures and to find solutions to operational issues.

3.2 Provider Rights and Responsibilities

Provider Rights:

Healthfirst will not discriminate against any healthcare professional acting within the scope of his/her license or certification under state law regarding participation in the network, reimbursement, or indemnification, solely on the basis of the practitioner's license or certification. Nor will Healthfirst discriminate against healthcare professionals who serve high-risk members or who specialize in the treatment of costly conditions. Consistent with this policy, Healthfirst may differentiate among providers based on the following:

- Healthfirst may refuse to grant participation status to healthcare professionals whom Healthfirst, at its sole discretion, deems not necessary or appropriate for its provider network
- Healthfirst may use different reimbursement methodologies for different clinical specialties or for different hospital affiliations
- Healthfirst may implement measures designed to maintain quality and control costs consistent with its responsibilities
- Healthfirst providers will be given written notice of material changes in participation rules and requirements in this Provider Manual at least 30 days before the changes are implemented. These communications will generally be circulated in newsletters or special mailings.
- Healthfirst will not prohibit or otherwise restrict a healthcare professional acting within the lawful scope of practice from advising or advocating on behalf of a Healthfirst member regarding the following:
- The member's health status, medical care, or treatment options, as well as any alternative treatments that may be self-administered (This includes providing sufficient information to the individual so that there is an opportunity to decide among all relevant treatment options.)
- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Provider Responsibilities

Healthfirst maintains provider agreements that incorporate provider and health plan responsibilities consistent with industry standards in compliance with New York State Managed Care Legislation and requirements for individuals and organizations receiving federal funds. The following requirements are applicable to Healthfirst participating providers.

3.2.A Effective Compliance Program

Purpose

Although all New York State Medicaid providers should prioritize compliance, certain providers, defined further below, are required to establish, integrate, and demonstrate the effectiveness of their compliance programs to OMIG. It is the purpose of such compliance programs to detect and prevent fraud, waste, and abuse in the Medicaid program as well as organize provider resources to address compliance issues as quickly and efficiently as possible, and to impose systemic checks and balances to prevent future recurrence of such issues.

Healthfirst requires all of its contracted providers to comply with the OMIG requirements as established in the guidelines referenced below and also published by OMIG at https://omig.ny.gov/compliance/compliance-library

Healthfirst requires all contracted providers to establish their own Effective Compliance Program

An "effective compliance program" is a compliance program that is adopted and implemented by the provider that, at a minimum, satisfies the compliance program requirements, and that is designed to be compatible with the provider's characteristics. Being compatible with the provider's characteristics means that the compliance program:

1. is well-integrated into the company's operations and supported by the highest levels of the organization, including the chief executive, senior management, and the governing body;

2. promotes adherence to the provider's legal and ethical obligations; and
3. is reasonably designed and implemented to prevent, detect, and correct non-compliance with Medicaid program requirements, including fraud, waste, and abuse most likely to occur for the provider's risk areas and organizational experience.

Healthfirst may audit a provider to ensure compliance with these requirements, and all providers must timely comply with such audits, including provision of data and responses within timeframes communicated as part of an audit request.

Failure to comply with an audit, and/or failure to maintain an effective compliance program in Healthfirst's discretion, may result in penalties, including, without limitation: issuance of a corrective action plan, restrictions on ability to see members and/or termination of provider agreement for cause.

Consequences of not having an Effective Compliance Program

A provider that is not effectively monitoring its compliance with state and federal Medicaid requirements is potentially exposed to increased operational, reputational, service, and audit risks, as well as sanctions and the repayment of identified Medicaid overpayments. OMIG may impose penalties, including:

1. Monetary penalties up to $5,000 for each month that a provider fails to adopt, implement, and maintain an effective compliance program. For a second violation, this amount may increase to $10,000 per month
2. Recoupment of monies paid to the provider during the period in which it did not have a compliance program
3. Termination of the provider's enrollment in the Medicaid program
4. Sanctions, up to and including exclusion from participation in the Medicaid program

Elements of an Effective Compliance Program

Effective Compliance Programs are comprised of seven elements. OMIG includes general recommendations regarding the implementation of these elements which are noted in detail within their guidance. It is a provider's obligation to maintain documentation demonstrating that it has adopted and implemented an effective compliance program. Included with the elements noted in OMIG's guidance are examples of documentation providers may produce for compliance program reviews as evidence they met the specified requirements during a Review Period. The identified types of documentation are not meant to be all inclusive. OMIG recognizes that providers may have other types of documentation to evidence meeting the requirements. So long as the documentation demonstrates that the Medicaid compliance program requirements were met, that documentation will be accepted.

Please refer directly to OMIG's guidance for Effective Compliance Programs as referenced by the link noted above for additional clarity on these requirements.

Web-based Attestation

Contracted providers shall provide a copy of their Certification Statement for Provider Billing Medicaid (ETIN) form to Healthfirst upon signing their provider agreement or amendment with Healthfirst, and annually thereafter. The following language will be included in that attestation:

> I (or the entity) have adopted and implemented, where applicable, an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York State Codes, Rules and Regulations Part 521

The public awareness program is focused on the cost and frequency of Medicare Advantage (MA) program fraud, and the methods by which Healthfirst's enrollees, providers, and other contractors, agents, subcontractors, or independent contractors can prevent it. Providers are required to certify upon enrollment and annually thereafter that they have met the requirements of 18 NYCRR Part 521 regulation. Providers are required to attest on an annual basis via the following weblink: https://hfomig.org/.

Self-Disclosure Guidance

Providers are required to report, return, and explain any overpayments they have received to the New York State Office of the Medicaid Inspector General (OMIG) Self-Disclosure Program within sixty (60) days of identification, or by the date any corresponding cost report was due, whichever is later. See Social Services Law (SOS) § 363-d(6).

OMIG has enacted a Self-Disclosure process to allow providers a mechanism to report, return, and explain overpayments from the Medicaid program. The process covers all Medicaid program providers. See SOS § 363-d(7).

Additionally, the Self-Disclosure Program accepts provider reports of damaged, lost, or destroyed records. Pursuant to Title 18 of the New York Codes, Rules and Regulations, Section 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. If a provider becomes aware that their records have been damaged, lost or destroyed, they are required to report that information as soon as practicable, but no later than thirty (30) calendar days after discovery.

Provider Identified Overpayments

If a provider determines that it has been overpaid by Healthfirst, the provider shall send a refund check to Healthfirst PHSP, Inc. at the address below within 60 days of identification. The provider shall also include with the refund check a cover letter explaining the reasons for the overpayment, identifying the specific Healthfirst claim numbers (including member name, ID and dates of service) or invoices which were the source of the overpayment, providing contact information for someone who can speak on the overpayment should Healthfirst have any questions regarding the repayment, and any supporting documentation or additional information which may explain the overpayment.

Overpayment refund checks should be mailed to:

Healthfirst PHSP Inc., LB#8115,
PO Box 95000
Philadelphia, PA 19195-0001

Overpayment Identification

Pursuant to SOS § 363-d (6)(b), an overpayment has been identified when a provider has, or should have, through the exercise of reasonable diligence, determined that the provider received a Medicaid fund overpayment and they have quantified the amount of the overpayment.

Providers who have a compliance program should be utilizing routine internal audits to review compliance with Medicaid requirements and identify any Medicaid fund overpayments that may have been received. Additionally, if a provider is the subject of a government audit, part of that provider's due diligence is to review the results of the audit and look at past and future periods not covered in the audit scope to identify overpayments resulting from similar issues. If overpayments exist, providers are obligated to take corrective action, which includes reporting and returning any Medicaid overpayment identified to OMIG's Self-Disclosure Program.

3.2.B Nondiscrimination

Providers must provide care to all Healthfirst members and must not discriminate on the basis of the following:

- Age
- National Origin
- Race
- Disability
- Sex
- Economic, Social, or Religious Background
- Sexual Orientation
- Health Status
- Claims Experience
- Source of Payment
- Legally Defined Handicap

- Veteran Status
- Marital Status

In addition, providers are required to maintain compliance with Title VI of the Civil Rights Act of 1975, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA), and other laws applicable to recipients of federal funds. The New York State Department of Health (NYSDOH) has adopted specific guidelines for ADA compliance by managed care organizations, including their affiliated provider networks. Healthfirst has developed a plan for achieving full compliance with these regulations and may request information from your practice as part of this program. The scope of the guidelines includes ensuring appropriate access to services through physical access to the site of care (wheelchair accessibility), access within the site (exam rooms, tables, and medical equipment), and access to appropriate assessment and communication tools that enable disabled individuals to receive needed services and to understand and participate in their care. For more information on compliance and guidelines of the Americans with Disabilities Act, click here and read through some answers to Commonly Asked Questions on the ADA.

3.2.C Cultural Competence

Providers must ensure that services and information about treatment are provided in a manner consistent with the member's ability to understand what is being communicated. Members of different racial, ethnic, and religious backgrounds, as well as individuals with disabilities, should receive information in a comprehensive manner that is responsive to their specific needs. If language barriers exist, a family member, friend, or healthcare professional who speaks the same language as the member may be used (at the member's discretion) as a translator. In addition, the Healthfirst Member Services and Medical Management departments can provide assistance for members who do not speak English, either through their multilingual staff or by facilitating a connection with a telephone-based language interpretation service. It is essential that all efforts be made to ensure that the member understands diagnostic information and treatment options, and that language, cultural differences, or disabilities do not pose a barrier to communication.

The Mainstream Medicaid Managed Care, HIV Special Needs Plans, and Health and Recovery Plans Model Contract Section 15.10(c) requires that the MMCP "…ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees."

Attest Here: https://hfprovidercct.org/

Complete Training below: https://thinkculturalhealth.hhs.gov/education

BH providers can complete training at the above or below link:
https://omh.ny.gov/omhweb/bho/docs/cultural_competency_curriculum.pdf

3.2.D Additional Provider Responsibilities

Program Participation and Compliance

Healthfirst has developed Quality Improvement, Medical Management, and other programs to identify opportunities for improving the delivery of health services and their related outcomes. In addition, Healthfirst has operating agreements with Federal, State, and County governments that govern the terms of its participation in the Medicaid managed care, CHPlus, Healthfirst Leaf Plan, Leaf Premier Plan, and Medicare programs. Regulatory authorities periodically review Healthfirst operations and data reporting (i.e., complaints, enrollment, and financial information). Pursuant to their provider agreements with Healthfirst, participating providers are required to cooperate with Healthfirst to meet its regulatory responsibilities as well as comply with its internal programs to ensure compliance with contractual obligations. This applies to the policies set forth in this Provider Manual as well as to any new programs Healthfirst develops.

Healthfirst invites its providers to participate on committees that address medical management and quality improvement issues. Providers may sit on the Health Care Quality Council and its subcommittees, or they may

provide expertise as provider consultants for peer review and specialty utilization management review. You may contact the Clinical Performance Management department to inquire about participation and refer to Section 14 of this Provider Manual for more information.

In addition, Healthfirst providers are responsible for supporting the member care components of the Member Rights and Responsibilities document found in Section 4 of this Provider Manual. It outlines member rights related to access to care, complete treatment information, privacy and confidentiality, non- discrimination, refusal of medical treatment, and other fundamental elements of the member's relationship with Healthfirst. It is expected that providers will inform members under their care about specific healthcare needs requiring follow-up, and will teach members appropriate self-care and other measures to promote their own health. Further, providers must discuss potential treatment options, side effects, and management of symptoms (without regard to plan coverage).

Please note: The member has the final say in the course of action they will take about their health.

Release of Member Information

Medical information about Healthfirst members must be released to Healthfirst upon request and in compliance with the Confidentiality Policy detailed in Section 5.3 of this Provider Manual. Healthfirst will only release medical information to persons authorized by Healthfirst to receive such information for medical management, claims processing, or quality and regulatory reviews. Providers must also adhere to the appeals and expedited appeals procedures for Medicare members, including gathering and forwarding information on appeals to Healthfirst as necessary.

Billing

Providers must submit claims for reimbursement of services provided. These claims also serve as encounter data for services rendered under a capitation arrangement. Claims must be accurate and submitted according to the guidelines described in Section 16. Failure to comply with Healthfirst policies in this regard may result in nonpayment for services or termination from the Healthfirst provider network. See Section 2 for information on non-covered services. Providers should never bill Healthfirst members for covered services, except for any applicable deductible, coinsurance or copayment amount.

Provider Information

Providers are responsible for contacting Healthfirst to report any changes in their practice. It is essential that Healthfirst maintains an accurate provider database to ensure proper payment of claims and capitation, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members.

Any changes and updates to your provider record or participation with Healthfirst should be submitted at least 30 days before the effective date. When you submit your request to update your information, please include your full contact information and a comprehensive request on the provider or group letterhead that includes the applicable license number and identifies the practice record for update. Any supporting documentation (such as a W9 form or a Board Certificate) should be attached with these requests.

Providers should submit a request if any of the following categories are updated/changed:

Category	Documentation Required
Provider or Group Name	W9
Tax ID	W9
Billing Address	W9
Practice Address, Telephone, and/or Fax Number	Full Practice Information
Member Age Limits	None
NY License (i.e. new number, revocation, or suspension)	Certificate or information on action required
Provider Panel Closure	Reason for panel closure
Hospital Affiliation	Copy of current and active hospital privileges

Category	Documentation Required
Specialty changes or additions	Copy of Board Certification and/or appropriate education certificates
Practice Office Hours (*PCPs require at least 16 hours)	None
Board Eligibility/Board Certification Status	Copy of Board Certification and/or appropriate education certificates
Participation Status	NY Medicaid Number (if applicable) Medicare Certification (if applicable)
National Provider Identification (NPI) Number	NPI Number
Wheelchair accessibility	None
Covering Provider	None
Languages Spoken	None

Providers who fall under a delegated entity arrangement please contact your designated network account manager.

90 Day Demographic Verification:

To support the above requirements as well as to help ensure that Healthfirst members have the most accurate and up-to-date information to make decisions about their care, Healthfirst will validate your provider data every 90 days. You may be contacted by phone or letter to review your information. It's important that you respond to our request as soon as possible.

If any provider is not compliant with Healthfirst verification attempts, the provider will be suppressed from our directory. **Please note:** continued non-compliance with attempts to verify provider data could result in termination from our network.

3.3 Fraud, Waste & Abuse

It is the policy of Healthfirst to comply with all federal and state laws regarding fraud, waste, and abuse; to implement and enforce procedures to detect and prevent fraud, waste, and abuse regarding claims submitted to federal and state healthcare programs; and to provide protection for those who, in good faith, report actual or suspected wrongdoing.

Healthfirst is required to refer potential fraud or misconduct related to the Medicare program to the Health and Human Services Office of the Inspector General's Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Advantage and Prescription Drug programs. Potential fraud, waste, and abuse related to New York State–funded programs are reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).

The Compliance Policy

Healthfirst maintains a strict policy of zero tolerance toward fraud, abuse, and other inappropriate activities. Individuals who engage in any inappropriate activity—either alone or in collaboration with another employee, member, or provider—are subject to immediate disciplinary action up to and including termination.

As part of our commitment to zero tolerance, Healthfirst works with vendors to achieve the following goals:

- Demonstrate its commitment to responsible corporate conduct;
- Maintain an environment that encourages reporting of potential problems; and
- Ensure appropriate investigation of possible misconduct by the company.

Healthfirst has adopted various fraud prevention and detection programs to protect our members, the government, and/or Healthfirst from paying more for a service than it is obligated to pay. Therefore, Healthfirst has established a Special Investigations Unit (SIU) in compliance with all applicable state and federal regulations to identify, prevent, and detect fraud, abuse, waste, and other inappropriate conduct.

The SIU is responsible for accepting referrals of misconduct from inside and outside the company and for investigating such referrals to determine if fraud, waste, or abuse has occurred. All Healthfirst-contracted entities have a responsibility to report any inappropriate activities via email to SIU@healthfirst.org or to the confidential website at **https://hfcompliance.ethicspoint.com**.

For further information on our compliance program, please visit **https://healthfirst.org/fraud-and-compliance** and select *"A Guide to the Compliance Program."*

Definitions

Abuse: Consistent with the definition included in Healthfirst's contract(s) with the State of New York Department of Health or any contract with CMS and/or applicable Federal or State Law, abuse is defined as practices that are inconsistent with sound fiscal, business, medical or professional practices, and which result in unnecessary costs, payments for services that were not medically necessary, or payments for services which fail to meet recognized standards for health care. It also includes enrollee practices that result in unnecessary costs and conduct that causes harm to an enrollee. Fraud also includes enrollee practices that result in unnecessary cost.

Fraud: Consistent with the definition included in Healthfirst's contract(s) with the State of New York Department of Health or any contract with CMS and/or applicable Federal or State Law, fraud is defined as an intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person, provider, Plan, subcontractor, or another person. Fraud includes the acts prohibited by section 366-b of the Social Services Law and any other act that constitutes fraud under applicable Federal or State law. Fraud may be committed by Healthfirst employees, health care providers, contractors, enrollees, applicants for enrollment and others, and includes any act that constitutes fraud under applicable federal or state law.

Waste: Consistent with the definition included in Healthfirst's contract(s) with the State of New York Department of Health or any contract with CMS and/or applicable Federal or State Law, waste is defined as the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to any Federal or State benefit program. Waste is generally not caused by intentional action but rather the misuse or misappropriation of resources

Relevant Statutes and Regulations

Stark Law

42 U.S.C. § 1395nn

The Stark law, with several separate provisions, governs physician self-referral for Medicare and Medicaid patients. Physician self-referral is the practice of a physician referring a patient to a medical facility in which he/she has a financial interest, be it ownership, investment, or a structured compensation agreement.

The Omnibus Budget Reconciliation Act of 1989 also bars self-referrals for clinical laboratory services under the Medicare program. The law included a series of exceptions to the ban to accommodate legitimate business arrangements. The Omnibus Budget Reconciliation Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. The Social Security Act prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship - unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a health service furnished as a result of a prohibited referral.

Violations of Stark and Physician Self-Referral are to be reported to the Centers for Medicare and Medicaid Services through an established self-disclosure process.

Anti-Kickback Statute

42 U.S. Code § 1320a–7b and New York State Social Services Law § 366-d

Under both Federal and New York State law, criminal penalties are imposed for certain acts which impact Medicare, Medicaid or any other Federal or State funded program. If you solicit or receive any remuneration in return for referring an individual to a person (doctor, hospital and provider) for a service for which payment may be made, it can be seen as a potential kickback. Remuneration includes payment, monies, or any other goods or services from any healthcare facilities, programs, and providers.

False Claims Act

31 U.S.C. §§ 3729–3733 and New York State Finance Law, Art. 13, §§187-194

Under the Federal and New York False Claims Acts (FCA), private citizens (i.e., whistleblowers) can help reduce fraud against the government. The FCA allows everyday people to bring suits against groups or other individuals that defraud the government through programs, agencies, or contracts (the act does not cover tax fraud).

For the purposes of the FCA, "knowing and/or knowingly" means that a person has actual knowledge of the information; acts in a deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

Both Federal and State False Claims Acts (FCA) apply when a company or person:

- Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government
- Conspires with others to get a false or fraudulent claim paid by the federal government
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting premium claims to the Medicaid program for members not actually served by Healthfirst
- Knowingly failing to provide members with access to services for which Healthfirst has received premium payments
- Knowingly submitting inaccurate, misleading or incomplete Medicaid cost reports

Protections for Whistleblowers

Whistleblower protection is provided by federal acts and related State and federal laws, which shield employees from retaliation for reporting illegal acts of employers. An employer cannot rightfully retaliate in any way, such as discharging, demoting, suspending or harassing the whistleblower. If an employer retaliates in any way, whistleblower protection might entitle the employee to file a charge with a government agency, sue the employer, or both.

To report information about fraud, waste, or abuse involving Medicare or any other healthcare program involving only federal funds, call the toll-free hotline established by the federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number is **1-800-HHS-TIPS (1-800-447-8477)**. For more information about this hotline and about other ways to contact the Office of Inspector General, visit **https://oig.hhs.gov/fraud/report-fraud/index.asp.**

The following are the applicable False Claim Act statutes and regulations, for reference:

Federal False Claims Act Civil Remedies Act

31 U.S.C. 3801-3812

For a copy of this citation, visit **https://federalregister.gov/a/E9-12170**

This act provides federal administrative remedies for false claims and statements, including those made to federally funded health care programs. As of June 19, 2020, violations of the False Claims Act carry civil

penalties of between $11,665 and $23,331 per claim, plus three times the amount of damages that the federal government sustains because of the false claim, and the claimant's costs and attorneys' fees, as adjusted annually by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1). If the government takes on the case, the individual who brings the claim is usually entitled to receive 15% to 25% of the recovered funds. If the government decides not to intervene, the individual is entitled to 25% to 30% of the funds. It is important to note that when False Claims Act penalties increase, so do the financial rewards for whistleblowers, increasing their incentive to allege false or fraudulent claims. The amount of the false claims penalty is adjusted annually by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 1).

For a copy of the New York citations listed below, visit the Law of New York website at http://public.leginfo.state.ny.us/menugetf.CGI?COMMONQUERY=laws.

NY False Claims Act
State Finance Law, §§187-194

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including healthcare programs such as Medicaid. The penalty for filing a false claim is between $11,665 and $23,331 per claim as adjusted to be equal to the civil penalty allowed under the federal False Claims Act, 31 U.S.C. sec. 3729, and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have to pay the government’s legal fees.

The FCA allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25% to 30% of the proceeds if the government does not participate in the suit and 15% to 25% if the government participates in the suit.

Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment, or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within five (5) years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person’s family’s needs are not taken into account for six (6) months if a first offense, 12 (twelve) months if a second (or once if benefits received are over $3,900), and five (5) years for four (4) or more offenses.

Social Services Law §145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b, Penalties for Fraudulent Practices

Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits

false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor

Responsible Parties – Health Care Fraud:

Special Investigations Unit:

The purpose of the Special Investigations Unit is to coordinate and direct the activities of Healthfirst in regards to fraud, waste, and abuse awareness, detection, investigation, and reporting. The Special Investigations Unit will also ensure that Healthfirst is in compliance with state and federal regulations pertaining to fraud detection, investigation, prevention, and reporting.

Healthfirst-contracted Vendor:

Healthfirst contracts with a vendor to assist in the identification of potential fraud, waste, and abusive billing practices as mandated by federal and state regulations. Through state-of-the-art detection software, this vendor identifies billing patterns that are not within industry norms. Providers selected for review will be asked to submit medical records for examination. Please note that it is important to provide the Healthfirst-contracted vendor with all requested supporting documentation upon request. This will minimize any future disputes regarding any identified issues. Failure by a provider to provide the requested records within forty-five (45) calendar days of a request or to send the requested records to the address indicated in the record request letter will result in the denial of payment and/or recoupment of previously paid claims.

If, after a complete review of all documentation provided, it is believed that the services billed are unsupported, they will be denied and/or considered overpayments and Healthfirst may utilize an extrapolation methodology to determine the total overpayment and ask the selected provider to refund the monies paid. Appropriate education may also be provided to ensure further billings are submitted according to established guidelines. The results of these reviews may be presented to the Healthfirst Fraud, Waste and Abuse Committee.

Failure to cooperate in Pre-Pay or Post-Pay requests may result in the non-renewal or termination of your contract with Healthfirst and/or additional reporting to state and/or federal authorities. Pre-Pay reviews are reviews conducted on claim(s) prior to the claim's adjudication or payment. Post-Pay reviews are reviews conducted on claim(s) after a claim has been adjudicated or paid.

Fraud, Waste, and Abuse Committee:

The Fraud, Waste, and Abuse Review Committee (FWAC) is responsible for reviewing all allegations of improper billing and potential fraudulent and/or abusive activity committed by providers. The Committee has the authority to make determinations regarding allegations including, but not limited to, placement of a provider on pre-payment review, termination of the provider agreement according to the guidelines described in Section 3.8, referral of the provider to the applicable regulatory or law enforcement agencies, and recovery of overpayments.

The FWAC will render the final decision as to whether a provider should be terminated. Except in instances of immediate termination, when termination is recommended a Notice of Proposed Adverse Action will be issued to the provider and the provider shall have the opportunity to appeal the decision, as outlined in Section 3.8. Any allegations regarding imminent patient harm shall be referred to the Credentialing Subcommittee for final decision as to whether a provider should be terminated.

The FWAC meets approximately fifteen (15) times during the year and comprises the following Healthfirst staff members:

- Chief Legal Officer (or his/her representative)
- Vice President, Deputy General Counsel
- Chief Medical Officer (or his/her representative)
- Vice President Claims, Payment Integrity

- Vice President, Regulatory Affairs
- Vice President, Compliance and Audit
- Vice President, Network Management
- Assistant Vice President, Special Investigations Unit

Pre-Payment Review:

As part of its fraud, waste, and abuse prevention and detection program, Healthfirst maintains a pre-payment review program (PPR) in which providers must submit records to support the claims billed prior to payment being issued. After a provider is placed on PPR via the below detailed procedures, no claim will be paid unless medical records (1) are submitted timely; (2) are submitted to Healthfirst or our contracted fraud, waste, and abuse vendor (Vendor) at the address indicated in the record request letter; and (3) support the services billed, including, but not limited to, the medical necessity and the level of services billed.

The Vendor will continue to send requests for medical records to a provider on PPR for all subsequently submitted relevant claims while the provider remains on PPR to ensure that claims submitted for payment are supported by appropriate documentation meeting all applicable laws, rules and regulations, coding, and contractual

requirements. Providers will have a period of **45 calendar days** to submit requested records from the date of receipt of the request for such records. In the event records are not submitted within 45 days of the request, the claims at issue will be denied. All records must be sent to the address listed in the PPR medical record request letter from the Vendor.

The submitted medical records will be reviewed to determine if the claim lines billed by the provider are supported by appropriate documentation. If the records support the claim, the claim will be approved for payment. If the documents are not supportive of the services billed, the claim will be denied. Claim lines with no records—either because the provider failed to maintain such records or failed to provide such requested records—will be denied for payment. Providers will be timely informed of the PPR decisions through a detailed explanation of payment.

If providers disagree with the PPR claim determination, they may submit a Review and Reconsideration request to the Vendor within ninety (90) calendar days of the claim decision. Providers must submit additional supporting documentation directly to the Vendor for reconsideration and review in a timely manner. Thereafter, if a provider disagrees with the decision on Review and Reconsideration, a further appeal is available. All appeals from a PPR Review and Reconsideration must be submitted to the Vendor within 60 calendar days of the PPR Review and Reconsideration decision and include a cover letter noting that this is an appeal from a PPR Review and Reconsideration determination. No PPR Review and Reconsideration or appeal requests will be considered if submitted to the Vendor after the above-noted time frames. Please refer to relevant correspondence from the Vendor and Section 17.6 for additional details and information regarding the Review and Reconsideration and appeal processes, generally.

Post-Payment Review:

Periodically, the Vendor and the SIU conduct audits of claims that have previously been paid by Healthfirst. In such audits, the Vendor or the SIU will request documentation from providers which is required to be maintained in accordance with applicable laws, rules and regulations, coding requirements, and contractual requirements. The Vendor then presents the audit outcome to the provider in a Findings Letter. If the provider disagrees with the findings in the letter, the provider must follow the review and reconsideration and appeal processes noted in the above “Pre-Payment Review” Section. If a timely request for review and reconsideration or appeal is not initiated by the provider, the determination of the findings will be deemed final and sent for overpayment recovery in accordance with section 17.7 of this Provider Manual and any other available means of recovery (e.g., collections agency, litigation, etc.).

Requests for Review and Reconsideration of FWA Claims:

Healthfirst retains the right to contract with external vendors to evaluate the accuracy of claims payments, including for fraud, waste, and abuse. If a provider receives a letter co-branded between the Vendor and Healthfirst, be it on a pre- payment or post-payment review, please refer to letter for instructions on how to file a Review and Reconsideration of any denied claims.

Healthfirst mandates that all contracted vendors comply with the Healthfirst Review and Reconsideration process for first-level appeals of all denied or partially denied claims.

Prescription Fraud, Waste and Abuse (FWA) – Premier Audit Meetings:

In addition to the FWAC meetings discussed above, Healthfirst also conducts quarterly Premier Prescription FWA Audit meetings. This committee is concerned with fraud, waste, abuse, and potentially hazardous prescription use within the Prescription Drug Program. The committee meets to review reports prepared by CVS Caremark, the plan's contracted Pharmacy Benefit Manager. The committee is responsible for directing all further investigative activities and reporting of suspect questionable activities to the plan's Fraud, Waste, and Abuse Committee for further direction.

The committee is composed of the following Healthfirst staff members:

- Vice President Pharmacy
- Pharmacy Director or Pharmacist Alternate
- Assistant Vice President Special Investigations Unit
- Supervisor Special Investigations Unit
- CVS Caremark Representatives

Restricted Recipient Program:

Restricted Recipient Program (RRP) is a program whereby selected enrollees with a demonstrated pattern of abusing or misusing Benefit Package services may be restricted to one or more providers and/or pharmacies for receipt of medically necessary services.

Restricted Enrollee means an enrollee who has engaged in abusive practices or demonstrated a pattern of misuse of a category of Medicaid or FHP benefits and has been restricted by either the contractor or OMIG to receive certain services only from an assigned provider. The amount, duration, and scope of the Medicaid or FHP benefit are not otherwise reduced.

Member Review and Restriction Committee (MRRC):

The Member Review and Restriction Committee oversees the Restricted Recipient Program (RRP), which is intended to reduce the cost of inappropriate utilization of covered services by identifying and managing enrollees exhibiting abusive or fraudulent behavior. Through increased coordination of medical services, the number of providers that the enrollee may select for care and the referrals to services, medications, and equipment is controlled; enrollees targeted for the Restricted Recipient Program are ensured access to medically necessary quality healthcare, and unnecessary costs to the Medicaid program are prevented.

The MRRC is a professional team comprising, at a minimum, a physician, a registered professional nurse. and a pharmacist. The MRRC reviews and determines whether the enrollee has demonstrated a pattern of overuse, underuse, or misuse of services included in the Benefit Package and whether such behavior should be managed by the Restricted Recipient Program. The MRRC is also responsible for ensuring that the directives of the team regarding placing restriction of recipients are carried out. The MMRC consists of the following staff members:

- Vice President, Deputy General Counsel
- Chief Medical Officer (or his/her representative) Vice President Claims, Payment Integrity
- Vice President, Regulatory Affairs Vice President, Compliance and Audit Vice President, Network Management
- Pharmacy Director or Pharmacist Alternate

- Assistant Vice President, Special Investigations Unit

Common Methods of Fraud and Abuse

To assist you with understanding and/or identifying what may constitute fraud, waste, and/or abuse, we have provided some typical examples for your reference.

- **Fabrication of Claims:** In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate member names and insurance information either to concoct entirely fictitious claims or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed. Examples are as follows:
    - Submitting claims for services not rendered
    - A provider who, using existing information on his or her members, creates claims for office visits or services that never took place
    - A provider who, in the course of billing for actual member treatments, adds charges for X-rays or laboratory tests that were never performed
    - A durable medical equipment provider submitting claims for equipment and supplies never delivered, or continuing to submit claims for rented equipment after it has been picked up

- **Falsification of Claims**: In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim for the purpose of obtaining a payment to which he or she is not entitled. Examples are as follows:
    - A provider performs medically unnecessary services solely in order to bill and be paid for doing so
    - A provider falsifies symptoms or other diagnostic information in order to obtain payment for an uncovered service. This is somewhat more common in certain specialties, such as cosmetic surgery
    - A provider falsifies the dates on which services were provided, so that they fall within a given eligibility period of the member
    - A provider falsifies the identity of the provider of services so as to obtain payment for services rendered by a noncovered and/or non-licensed provider
        - For example, submitting claims for clinical social worker services as psychiatric treatment provided by a licensed psychiatrist, or billing fitness center massages as a licensed physical therapy
    - A provider upcodes the services rendered to obtain greater reimbursement
    - Upcoding of Evaluation and Management services to indicate a greater complexity of medical decision-making than was actually rendered; encounters that required straightforward decision-making are reported as having required highly complex decision-making
    - Reporting more intensive surgical procedures than were actually performed
    - Anesthesiologist bill for more intensive surgical procedures than reported by the surgeon

- **Unbundling**: Provider submits a claim reporting comprehensive procedure codes (e.g., resection of small intestine) along with multiple incidental procedure codes (e.g., exploration of abdominal and exploration of the abdomen) that are an inherent part of performing the comprehensive procedure.
Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

- **Fragmentation**: Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services (antepartum care, vaginal delivery, and obstetric care) which include the three components. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass fragmentation edits in the claims processing system.

- **Duplicate claim submissions:** Submitting claims under two Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

- **Fictitious Providers:** Perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims, usually on the CMS 1500 claim form.

Examples of FWA within the Prescription Drug Program	
Plan Sponsor	• Failure to provide medically necessary services • Marketing schemes offering beneficiaries inducement to enroll • Unsolicited marketing • Misrepresenting prescription drug products • Payment for excluded drugs • Multiple billing • Inaccurate data submission
Pharmacy Benefit Manager	• Prescription drug switching • Steering a beneficiary to a certain plan or drug • Inappropriate formulary decisions • Failure to offer negotiated prices
Pharmacy	• Inappropriate billing practices • Prescription drug shorting • Bait and switch pricing • Prescription drug forging or altering • Payment for excluded drugs • Dispensing expired or adulterated drugs • Prescription refill errors • Failure to offer negotiated prices
Prescriber	• Prescription drug switching • “Script” mills • Provision of false information • Theft of DEA number or prescription pad
Wholesaler	• Counterfeit or adulterated drugs through black markets • Drug diversions • Inappropriate/false documentation of pricing information
Manufacturer	• Lack of data integrity to establish payment or determine reimbursement • Kickbacks, inducement, or other illegal remuneration • Inappropriate relations with formulary committee members • Inappropriate relations with providers • Illegal “off-label” promotion • Illegal use of free samples
Beneficiary	• Misrepresentation of enrollment status • Identity theft • Prescription forging or altering • Drug diversion or inappropriate use • Prescription stockpiling • “Doctor shopping” for drugs

First Tier, Downstream, and Related Entities (FDR) and Affiliate Compliance Requirements

Healthfirst's commitment to compliance includes ensuring that our First Tier, Downstream, and Related Entities (FDRs) and Affiliates are in compliance with applicable state and federal regulations. Healthfirst contracts with these entities to provide administrative and healthcare services to our enrollees. Healthfirst is ultimately responsible for fulfilling the terms and conditions of our contract with the Center for Medicare and Medicaid Services (CMS) and

meeting the Medicare and Medicaid program requirements. Therefore, Healthfirst requires each FDR and Affiliate to comply with the compliance and fraud, waste, and abuse expectations.

Upon contract and on an annual basis thereafter, an authorized representative from each FDR and Affiliate is required to complete the Healthfirst FDR and Affiliate Compliance Attestation (on behalf of his or her organization) to attest to compliance with the standards of conduct; compliance policies; OIG, GSA (SAM), and OMIG exclusion screenings; and publication of FWA and compliance reporting mechanisms requirements.

Healthfirst is required to provide CMS with offshore subcontractor information and complete an attestation regarding protection of beneficiary Protected Health Information (PHI). Therefore, Healthfirst requires FDRs and Affiliates to indicate the name, address, and delegated function of any offshore subcontractors used for Healthfirst business.

If Healthfirst determines that an FDR or Affiliate is not in compliance with any of the requirements set forth in this policy, the FDR or Affiliate will be required to develop and submit a Corrective Action Plan (CAP). Healthfirst will assist the FDR or Affiliate in addressing the issues identified.

First Tier entities are responsible for ensuring that their downstream and related entities comply with Healthfirst's policies and applicable Federal and State statutes and regulations.

A copy of the Healthfirst compliance attestation and the FDR & Affiliate Compliance Guide can be found at **https://healthfirstfdr.org/**

Reporting of Fraudulent, Wasteful, and Abusive Activities

Healthfirst wants to make sure that our providers understand that we expect members, vendors, providers, interns (volunteers), consultants, Board members, and FDRs, as well as others associated with the business of Healthfirst, to bring any alleged inappropriate activity which involves Healthfirst to our attention. Providers may confidentially report a potential violation of our compliance policies or any applicable regulation by contacting the following individuals/departments:

Healthfirst Compliance Officer	Special Investigations Unit (SIU)
100 Church Street, New York, NY 10007 **Phone:** 1-212-453-4495 **Email**: compliance@healthfirst.org	100 Church Street, New York, NY 10007 **Phone:** 1-212-801-3292 **Email**: SIU@healthfirst.org

Providers may also report fraud, waste, and abuse anonymously to EthicsPoint, Inc., a contracted vendor, by using the Healthfirst Hotline at **1 (877) 879-9137** or online at **https://hfcompliance.ethicspoint.com**. These services are available 24/7.

3.4 Appointment Availability and 24-Hour Access Standards

Healthfirst maintains provider access, visit scheduling, and waiting time standards that comply with New York State requirements. Healthfirst and the NYSDOH actively monitor adherence to these standards (Appendix I). Healthfirst conducts audits of provider appointment availability, office waiting times, and 24-hour access and coverage. All participating providers are expected to provide care for their Healthfirst members within these access guidelines.

Office Hours

Each PCP that participates with Medicaid, Child Health Plus, HARP, and Essential Plans must practice at least two (2) days per week and maintain a minimum of 16 office hours per week at each primary care site. Providers credentialed as both an HIV PCP and specialist working at academic institutions may have some flexibility with this requirement. PCPs who participate with Medicare and commercial lines of business must maintain a minimum of ten (10) office hours per week at each primary care site. PCPs who have a participating location that services the homeless population are not required to maintain a minimum of 16 office hours per week at each primary care site.

24- Hour Coverage

Participating providers must be accessible 24 hours a day, 7 days a week throughout the year, either directly or through back-up coverage arrangements with other Healthfirst participating providers. Each provider must have an on-call coverage plan, acceptable to Healthfirst, that outlines the following information:

- Regular office hours, including days, times, and locations
- After-hours telephone number and type of service covering the telephone line (e.g., answering service)
- Providers who will be taking after-hours calls
- Facilities as well as individual practitioners must conform to the following requirements:
- Members will be provided with a telephone number to use for contacting providers after regular business hours.
- Telephone operators receiving after-hours calls will be familiar with Healthfirst and its emergency care policies and procedures, and will always have key Healthfirst telephone numbers available
- The Healthfirst provider will be contacted and patched directly through to the member, or the provider will be paged and will return the call to the member as soon as possible, but in no case to exceed 30 minutes
- It is expected that Healthfirst providers will be familiar with Healthfirst and will be able to act in accordance with Healthfirst emergency policies and procedures such as notifying Medical Management of emergency care or admissions. These policies are further discussed in Section 11. Please be aware that hospital-based providers may have their own on-call group relationships
- If the covering provider is not located at the usual site of care for the member, the covering provider must provide clinical information to the member's PCP by the close of business that day, or if on a weekend, by the next business day, so that it can be entered into the member's medical record
- Healthfirst members must be able to locate a Healthfirst participating provider or his/her designated covering provider. It is not acceptable to have an outgoing answering machine message that directs members to the emergency room in lieu of appropriate contact with the provider or covering provider. If an answering machine message refers a member to a second phone number, that phone line must be answered by a live voice.

Waiting Time Standards

In addition to access and scheduling standards, Healthfirst providers are expected to adhere to site-of-care waiting time standards. They are as follows:

- **Emergency Visits**: Members are to be seen immediately upon presentation at the service delivery site.
- **Urgent Care and Urgent Walk-in Visits:** Members should be seen within one (1) hour of arrival. Please note that prescription refill requests for medications to treat chronic conditions are considered urgent care. It is essential that these medications be dispensed to members promptly to avoid any lapse in treatment with prescribed pharmaceuticals.
- **Scheduled Appointments**: Members should not be kept waiting for longer than one (1) hour.
- **Non-urgent Walk-in Visits**: Members with non-urgent care needs should be seen within two (2) hours of arrival of an unscheduled appointment or scheduled for an appointment in a timeframe consistent with the Healthfirst scheduling guidelines. Providers must have policies and procedures which adequately address enrollees who present for unscheduled, non-urgent care, with the aim of promoting enrollee access to appropriate care.

Missed Appointments

Healthfirst expects providers to follow up with members who miss scheduled appointments. When there is a missed appointment, providers should follow these guidelines to ensure that members receive assistance and that compliance with scheduled visits and treatments is maintained.

At the time an appointment is scheduled, confirm a contact telephone number with the member. If the member does not keep the scheduled appointment, document the occurrence in the member's medical record and attempt to contact the member by telephone.

To encourage member compliance and minimize the occurrence of "no shows," provide a return appointment card to each member for the next scheduled appointment.

3.5 Provider Application Process

Participating hospitals, hospital-sponsored practices, treatment centers, community-based groups, and individual providers should call **1 (888) 801-1660** to notify Healthfirst about new providers joining an existing practice or to inquire about how to become a participating provider. If the provider is determined to be a desirable candidate, he or she will then be required to complete an application package and submit the appropriate credentialing information and required documentation based on their level of participation (e.g., Level III).

3.6 Credentialing, Recredentialing Requirements & Provisional Credentialing

Healthfirst is committed to providing healthcare services to its members through a high-quality provider network that meets the guidelines set by the NYSDOH. Providers are initially credentialed and biannually recredentialed through approved delegation agreements with participating hospitals, or every three (3) years through a rigorous credentialing review conducted by Healthfirst. Providers have the right to review their Healthfirst credentialing file (with the exception of peer review references or recommendations) and may contact Healthfirst if they wish to make arrangements to do so.

Healthfirst will notify providers as soon as possible within 60 days of receipt of a completed application as to whether the provider has been credentialed, whether the application has been denied, or whether additional information is needed to complete the credentialing process.

Provisional Credentialing

Physicians newly employed in Article 28 facilities*

Providers are eligible to apply for provisional credentialing if Healthfirst has received a completed application and Healthfirst has been notified in writing that the physician has been granted hospital privileges and meets the following requirements:

- Be a newly licensed physician in the state of New York,
- Be a physician relocating to New York from another state, or
- Be a physician who receives a new tax ID number based on a corporate change who is employed by a hospital or facility whose other physicians participate in the Healthfirst network.

Providers who, at the request of the Credentialing Committee, are required to submit additional documents or explanations of actions, sanctions, or malpractice history are not eligible for provisional credentialing until such time that the documents have been submitted and the Credentialing Committee takes action.

Providers who are provisionally credentialed are considered participating providers in the Healthfirst network with provisional participation status so that claims can be processed. These providers, however, cannot be assigned a panel. The provisional participation status for providers will continue until Healthfirstfully credentials the provider within 60 days or disapproves the provider for network participation.

**Article 28 facilities include hospitals, skilled nursing homes, diagnostic and treatment centers, freestanding ambulatory surgery centers, and acute care clinics.*

Other newly licensed providers and relocating providers

Newly licensed providers and providers relocating from other states can apply for provisional credentialing if Healthfirst is unable to credential providers within 60 days after the receipt of a completed application.

Providers are eligible to apply for provisional credentialing only after 60 days have passed since Healthfirst has received a completed application and the following two requirements are met:

- A provider must be newly licensed in the state of New York or be relocating from another state
- A provider group has notified Healthfirst that the group and the provider will comply with the statutory requirements concerning refunds and holding members harmless

Providers who are provisionally credentialed are allowed to participate in the Healthfirst network and given provisional participation status so that claims can be processed; however, they cannot be assigned a panel. The provisional participation status for providers will continue until Healthfirst fully credentials the provider or disapproves the provider for network participation.

The Credentialing Subcommittee

The Credentialing Subcommittee is a multidisciplinary committee of clinical practitioners from Healthfirst participating hospitals, as well as the Healthfirst Chief Clinical I Officer, Executive Medical Director, Sr. Medical Director, Medical Directors and Director of Credentialing (without vote). The subcommittee is charged with the credentialing and recredentialing function and, through the review of credentialing and recredentialing materials, has the authority to make recommendations and decisions regarding credentialing, recredentialing, and termination of providers. The subcommittee meets quarterly and is responsible, through a peer review process, for the following functions:

- Review and approve credentialing policies and procedures
- Review practitioner credentials and make recommendations with respect to provider applications for membership in the Healthfirst network
- Review practitioner recredentialing documents and make recommendations with respect to practitioner continuation in the Healthfirst network
- Review facility and vendor credentials and recredentials, and make recommendations with respect to participation and/or continuation in the Healthfirst network
- Review and approve the standards for delegated credentialing
- Review practitioner credentials and make recommendations with respect to provider applications for membership in the Healthfirst network
- Review practitioner recredentialing documents and make recommendations with respect to practitioner continuation in the Healthfirst network
- Review facility and vendor credentials and recredentials, and make recommendations with respect to participation and/or continuation in the Healthfirst network
- Review and approve the standards for delegated credentialing
- Review practitioner sanctions and make recommendations as to practitioners' ability to deliver care and remain in the Healthfirst network
- Review and approve the Delegated Credentialing File Audit Results of each member hospital's Level I and Level II practitioners credential files
- Review and approve Level I and Level II practitioners in the network on a quarterly basis
- Review Provider Quality of Care issues that meet Healthfirst's policy and threshold for Credentialing Subcommittee review
- Review and approve minutes of Credentialing Subcommittee meetings
- The Fraud, Waste and Abuse Committee will notify the Credentialing Committee of Provider fraud, waste, abuse, and improper billing Terminations and cases of imminent harm to members for awareness. The Fraud, Waste and Abuse Committee is responsible for making the termination decisions.
- Provide a summary report of findings and submit to Healthfirst Quality Improvement Committee (QIC) on a quarterly basis or more frequently as required

Please refer to Appendix II for a complete list of credentialing requirements.

3.7 Provider Profiling

Healthfirst monitors the performance of its provider network to ensure the quality and appropriate use of healthcare services and to identify opportunities for provider improvement and the management of medical costs. Healthfirst has developed criteria and methodologies to collect and analyze profiling data to evaluate a provider's practice patterns and performance. Areas evaluated include but are not limited to billing and coding patterns; inpatient, outpatient, ancillary, and pharmacy utilization trends; and specialty costs.

All providers are measured against an appropriate group of healthcare providers using similar treatment modalities and servicing a comparable member population. On a periodic basis and upon the request of a provider, Healthfirst

will provide a copy of the provider profile, data, and analysis used to evaluate the requesting provider's performance. Providers shall be afforded the opportunity to meet with Healthfirst to discuss the information reported in the provider profile and the unique nature of the provider's member population, which may have a bearing on the provider's profile. Providers will also be afforded the opportunity to work cooperatively with Healthfirst to improve performance.

All provider profiling evaluations comply with Section 4406 D(4) of the New York State Public Health Law.

3.8 Termination of Provider Agreements

Healthfirst or its participating providers may decide to terminate or elect not to renew a provider agreement. Termination procedures are subject to the provisions of the provider agreement. If there are conflicts between the provisions in this Provider Manual and any provider agreement, the terms of the provider agreement will apply.

Withdrawing from the Network

Providers who wish to withdraw from the Healthfirst network may request to do so by contacting their Healthfirst Network Management representative. Healthfirst will consider these requests on a case by case basis. Unless otherwise stated in the provider's contract with Healthfirst, Healthfirst must agree to allow the provider to withdraw from the Healthfirst network. If Healthfirst agrees, we will confirm our agreement in writing which will include the effect date that the provider will no longer participate in the Healthfirst network. Both Healthfirst and the provider must comply with the applicable transitional care requirements for members following the effective withdrawal date. If Healthfirst does not agree to the withdrawal, providers may non-renew their provider agreement as explained below.

Non-Renewals

Healthfirst or its participating providers may elect not to renew a provider agreement. Exercising the option of non-renewal is not considered a termination of a provider agreement under Public Health Law Section 4406-d. A non-renewal decision made by either Healthfirst or a participating provider requires at least 60 days written notice to the other party prior to the expiration date of the provider agreement or written notice as set forth in the provider's agreement with Healthfirst.

Immediate Termination

Consistent with Public Health Law Section 4406-d, Healthfirst reserves the right to terminate a provider contract immediately, based on the following:

- Final disciplinary action is taken by a state licensing board or governmental regulatory agency that impairs the provider's ability to practice
- There is a determination of fraud on the part of the provider made either by the Healthfirst Credentialing Subcommittee or another appropriate body
- Continuation of the provider's participation may cause imminent harm to members

Healthfirst may, at the sole discretion of the Healthfirst Medical Director, thereafter, afford the provider an opportunity for a hearing in accordance with the procedures outlined below in the Section entitled "Termination for Cause."

All provider requests for a discretionary appeal must be in writing, submitted no less than 30 days after the date of the termination notice, and sent to the Legal Department's attention who will then deliver the request to the Medical Director. Best efforts will be used by the Medical Director to decide and communicate this determination to the provider via letter within 30 days of receipt of the request.

In cases of immediate termination, Healthfirst will immediately close a provider's panel to new members. All Healthfirst members will be immediately reassigned from the Provider's panel. Termination notice, if applicable, will be sent by certified mail to the practitioner informing him/her of their proposed expedited termination and immediate suspension from the Healthfirst network. In addition, Healthfirst is not required to, and may not arrange for, post-termination continuation of care from any provider who is subject to immediate termination pending the outcome of a hearing if one is so afforded to the provider.

Termination for Cause

Healthfirst reserves the right to terminate a provider's contract for cause, for reasons other than those warranting immediate termination as described above, upon 60 days prior written notice to the provider, or upon notice as set forth in the provider's agreement with Healthfirst. The following are examples of circumstances that would be considered a basis for a "for cause" termination:

- Repeated failure to comply with quality assurance, peer review and utilization management procedures
- Unprofessional conduct as determined by the appropriate state professional licensing agency
- Failure to comply with Healthfirst credentialing standards and procedures
- Discrimination against Healthfirst members as outlined in the Provider Agreement
- Engaging in abusive or improper billing practices

The Healthfirst Credentialing Subcommittee shall review all proposed provider terminations for cause. If the Credentialing Subcommittee's recommendation is to terminate a Provider Agreement, the provider shall receive a written Notice of Proposed Adverse Action which shall include the following information:

- The reason for the proposed termination
- Information about the provider's right to request a hearing before a panel appointed by Healthfirst
- A statement that the provider has 30 days to request a hearing from the date that Healthfirst mailed the Notice of Proposed Adverse Action
- A statement that Healthfirst will schedule a hearing within 30 days from the receipt of a provider's request for a hearing
- A summary of the provider's hearing rights

All terminations for cause shall be done in accordance with Public Health Law Section 4406-d(2). Under no circumstances will Healthfirst initiate termination or non-renewal actions against a provider solely because he/she has:

- Advocated on behalf of a member
- Filed a complaint against Healthfirst with state or federal regulatory bodies
- Appealed a decision made by Healthfirst
- Provided information, filed a report or requested a hearing or review

Please note: At any point the contractor may receive notice from the New York State Department of Health to terminate a provider contract. The provider will be subjected to the provisions outlined above.

Provider Hearings

Providers who receive a Notice of Proposed Adverse Action from Healthfirst recommending contract termination have the right to appeal the decision and request a hearing. All requests for a hearing must be made in writing within thirty (30) days from the date the provider received the Notice of Proposed Adverse Action at the following address:

Healthfirst Medical Director
100 Church Street
New York, New York 10007

A provider's failure to submit a request for a hearing within thirty (30) days will be deemed a waiver of any appeal rights. The proposed termination will become final and the provider will not be afforded additional appeal rights.

Providers are encouraged to submit any additional documentation about his/her case together with the request for a hearing. If a hearing request is received, Healthfirst will schedule a hearing within thirty (30) days of the provider's written request for a hearing. The provider shall be further apprised, in writing, of the date, time and place of the hearing, and a list of witnesses, if applicable, that are expected to testify at the hearing on behalf of Healthfirst. Healthfirst will consider any reasonable requests to reschedule a hearing other than the date originally scheduled;

however, repeated requests to reschedule a hearing will lead to a waiver of appeal rights. In addition, Healthfirst reserves the right to be represented by outside counsel at the hearing.

The hearing panel shall consist of three (3) individuals appointed by Healthfirst. Specifically, the hearing panel shall include the Healthfirst Medical Director, a provider in the same or similar medical specialty as the provider under review ("clinical peer"), and a third individual selected by Healthfirst. If Healthfirst selects a hearing panel that is larger than three (3) individuals, at least one-third of the panel's membership will be clinical peers. In addition, if the provider participates in Healthfirst's Medicare Advantage programs, the majority of the hearing panel members shall be clinical peers.

At least ten (10) days prior to the scheduled hearing, a provider should submit to Healthfirst a written summary of his/her position and a copy of any exhibits or additional evidence that will be presented at the hearing.

At the hearing, a provider will be afforded the following rights:

- To be present at the hearing and represented by legal counsel
- To present any additional evidence that is relevant to the provider's case without regard to its admissibility in a court of law
- To call, examine, or cross-examine any witnesses, all of whom will testify under oath
- To submit a written statement at the close of the hearing
- To have a copy of the record of the proceedings (at the provider's expense)

The hearing panel shall render a final decision either on the day of the hearing or within ten (10) business days. The hearing panel may uphold or reverse the underlying determination made by the Healthfirst Credentialing Subcommittee or may conditionally reinstate the provider subject to certain conditions determined by the hearing panel. The provider shall be notified in writing of the hearing panel's decision within fifteen (15) business days from the date of the decision.

If termination is recommended, a provider's termination shall be effective no less than thirty (30) days after the provider's receipt of the hearing panel's decision. In no event shall termination be effective earlier than sixty (60) days from the provider's receipt of the initial notice of proposed termination.

Continuity of Care If a Provider Leaves the Healthfirst Network

Terminated or non-renewed providers are required under New York State law to continue a course of treatment until arrangements are made to transition the member's care to another provider. Specifically, providers are required to continue providing services to Healthfirst members for a period of ninety (90) days from the date of the contract termination or nonrenewal in accordance with Public Health Law Section 4403(6)(e). In the case of providers caring for pregnant members, the continuity of care/transition period extends through post-partum care directly related to the delivery. **Providers must continue to accept the Healthfirst reimbursement rates set forth in the provider agreement and to comply with Healthfirst policies and procedures during the continuity of care period.** Additional information on continuity of care is found in Section 12.

Notification to Members in Cases of Provider Termination

Healthfirst sends written notice to members of provider termination in accordance with applicable law. The notice will inform the member of the effective date of the provider's termination and advises members of procedures for selecting a new PCP within Healthfirst's network. When a PCP leaves the network, Healthfirst reassigns the provider's members to another PCP. Members have the option to change the new provider assignment by calling the Member Services Department and selecting a provider of their choice.

Healthfirst's Duty to Report

Healthfirst is legally obligated to report to the appropriate state professional disciplinary agencies as well as the National Practitioner Data Bank under the following circumstances:

- The termination of a provider's contract for reasons related to alleged mental or physical impairment, misconduct or impairment of a member's safety or welfare
- The voluntary or involuntary termination of a provider's contract or employment to avoid the imposition of disciplinary action or investigation by Healthfirst
- The termination of a provider's contract in the case of a determination of fraud or of imminent harm to a member's health
- Any disciplinary action based upon reasons related to professional competence or conduct that would adversely affect the clinical privileges of a provider for longer than thirty (30) days.

Reporting Suspected Fraudulent Conduct

Healthfirst is required by the New York State Department of Financial Services to report any suspected healthcare insurance fraud to the New York State Department of Financial Services Frauds Bureau whether or not Healthfirst elects to terminate a Provider Agreement.

To report suspected fraud or abuse an anonymous phone line is in place at **1 (877) 879-9137**.

4 Eligibility and Membership

4.1 Introduction

Healthfirst Medicaid Managed Care Plan

Members who are eligible for New York State Medicaid programs including TANF, SNA, Medicaid and SSI, and immigrants who are qualified aliens or fall under one of the permanent residence under color of law (PRUCOL) classifications, are also eligible for Healthfirst Medicaid. Coverage is available in Bronx, Kings, New York, Richmond, Queens, Nassau, Suffolk, Westchester, Orange, Rockland, and Sullivan counties.

To be eligible for the Medicaid program, a potential member must meet criteria which include household income, residency, citizenship, and alien status requirements.

Enrollment in a Medicaid Managed Care Plan is now mandatory for the Medicaid-eligible population living in New York City and in Nassau and Suffolk counties. Those individuals who do not voluntarily select a plan will be assigned to a participating managed care plan by the New York State enrollment broker, New York Medicaid CHOICE, which is responsible for managing the mandatory enrollment process. However, there are certain categories of Medicaid recipients who are either excluded from the Medicaid managed care program or are exempt from mandatory enrollment. If you are treating members who qualify for an exemption, you may be required to complete an exemption form. This form must be submitted to New York Medicaid CHOICE for State Department of Health approval of the exemption. Exempt individuals have the option of choosing to join a managed care plan.

Please contact Healthfirst if you have questions regarding managed care exemptions.

See Appendix III for a complete list of the Medicaid Managed Care excluded and exempt population groups. To obtain exemption forms, please call the New York Medicaid CHOICE helpline at **1 (800) 505-5678**.

Individuals who have access to healthcare coverage through their own or a family member's employment with the federal, state, or county government, a municipality or a school district are not eligible to enroll in the Medicaid managed care program. Coverage for individuals meeting such criteria will end upon their next annual renewal date occurring after the effective date of implementation.

Medicaid Recertification

Medicaid members must recertify their eligibility for the program annually. Members will receive notice to recertify from their local district of Social Services or the New York State of Health (NYSOH). Notification will be received via mail reminding a member to renew their coverage. A member will be able to send their renewal form through the mail or to renew online (for NYC members only).

Child Health Plus (CHPlus)

CHPlus provides reasonably priced or no-cost healthcare coverage for children under the age of 19 for families who do not qualify for Medicaid and for whom the price of commercial health insurance is prohibitive. Those who qualify for Medicaid must pursue an application to participate in that program initially or upon recertification. The children are eligible for CHPlus regardless of immigration status, even if undocumented.

Their families must be income-eligible to qualify for coverage under the New York State-sponsored CHP initiative that provides varying levels of subsidization for the insurance premium, depending on the family's income level. Coverage is available in Bronx, Kings, New York, Richmond, Queens, Nassau, Suffolk, Westchester, Orange, Rockland, and Sullivan counties.

The application for CHPlus requires supporting documentation for income, identity/date of birth, and residency (must reside in New York State). CHPlus members who are pregnant should be referred to Medicaid. They will remain in CHPlus until their Medicaid eligibility determination is made. Prospective members' eligibility will be determined by NYSOH upon receipt of the application and required supporting documentation. If all requirements are not met, there

is potential for a prospect to become a member with the plan and receive 60days of temporary coverage—this is referred to as presumptive eligibility.

CHPlus Recertification

CHPlus members must recertify their eligibility for the program annually through the NYSOH. The form is sent to a CHPlus member 90 days before the member's anniversary date. It must be completed and submitted no later than 30 days before the anniversary date to ensure continuation of benefits.

Medicare

Our Medicare programs are offered by Managed Health, Inc./Healthfirst Medicare Plan. There are a variety of HMO products available to individual members who are eligible for Medicare Parts A and B and who will continue to pay their Medicare Part B premium. Some plans have additional eligibility criteria. Our 65+ plan is available in Bronx, Kings, New York, Queens, Richmond, and Nassau counties. Signature (HMO), LIP, and CC plans are available in Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, Rockland, Orange, and Sullivan counties. Signature (PPO) is available in Bronx, Kings, New York, Nassau, Queens, Richmond, Rockland, Suffolk, Westchester counties. IBP and Connection are available in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Sullivan, and Orange counties.

Commercial/QHP

Healthfirst offers commercial health plans through NY State of Health (NYSOH) as well as directly to consumers and employers outside of NYSOH. Our commercial programs are called Healthfirst Leaf Plans, Healthfirst HMO A–D plans, and Healthfirst EPO Pro/Pro Plus small group plans. Healthfirst Leaf Plans, Healthfirst Leaf Premier Plans, and Healthfirst HMO A–D plans for individuals and families are available in Bronx, Kings, New York, Richmond, Queens, Suffolk, Nassau, and Westchester counties. Healthfirst EPO Pro/Pro Plus plans are available in these same counties plus Rockland County.

4.2 Marketing, Advertising, Outreach and Enrollment

Healthfirst has implemented advertising, enrollment, and outreach/education guidelines and policies to govern healthcare providers' outreach/education of Healthfirst's government-sponsored programs such as Medicare, Medicaid, CHPlus, Essential Plans (EP), and Qualified Health Plans (QHP). These guidelines and policies are based on requirements set by the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (including the NY State of Health Marketplace). These guidelines are meant to ensure that advertising, enrollment, and outreach/education activities by all parties involved in Healthfirst programs are conducted in a responsible manner so that potential members receive the most accurate and complete information possible. Providers may advise their members of managed care plans with which they participate, but they must list all such plans and cannot promote one plan over another.

Under its contracts with CMS and the New York State Department of Health, Healthfirst is responsible for advertising, enrollment, and outreach/education activities undertaken by any individual or entity involved in advertising, enrollment, and outreach for, or on behalf of, Healthfirst. This applies regardless of whether Healthfirst directly employs the involved party or whether that party is affiliated with Healthfirst by subcontractor through a participating provider agreement. Hospitals, clinics, physicians, and other providers that participate in the provider network are considered subcontractors and are subject to the marketing guidelines. Violation of the marketing guidelines may lead to a suspension of marketing activities at Healthfirst facilities or regulatory sanctions affecting the provider or Healthfirst. All Healthfirst marketing activities are conducted in strict compliance with CMS and/or NYSDOH guidelines (see Appendix IV). These policies are followed throughout the Healthfirst service area.

Healthfirst does not discriminate against prospective members based on age, gender, race, national origin, sexual orientation, or medical/mental condition. Written advertising, enrollment, and outreach/education materials developed by Healthfirst, as well as those produced independently by Healthfirst providers, must be preapproved by Healthfirst, and by regulatory agencies, as applicable. Healthfirst providers who wish to contact their members to apprise them of managed care plan affiliations have the option of using a model letter approved by Healthfirst. This letter is available from Healthfirst upon request. Any modifications to this letter, and newly developed materials prepared by Healthfirst providers that advertise Healthfirst, must be submitted to Healthfirst for approval.

Please note: Marketing correspondence should not be sent to members who are in an exclusion category for Medicaid and cannot join a managed care plan (see Appendix III).

If you have members in your practice who express interest in one of the Healthfirst programs, you may refer them to Healthfirst Member Services. Healthfirst representatives will assist these individuals with the applicable enrollment or application process and will function as the liaison with the appropriate regulatory agency.

For providers interested in on-site marketing, Healthfirst will schedule time for a representative to be available in a common area at your office or facility for the convenience of your members. Please call **1 (888) 801-1660** for more information.

All providers participating in Healthfirst's Medicaid, CHPlus, EP, QHP, Commercial, or Medicare managed care plans are bound by the requirements of Healthfirst contracts with CMS and/or the New York State Department of Health, which include the MCO Advertising and Outreach Guidelines prepared by the New York State Department of Health (see Appendix IV), as applicable.

4.3 Eligibility Verification

You may verify a member's eligibility as described below. Note that member eligibility may change from time to time, including retroactively in certain circumstances. Verification of eligibility therefore does not ensure subsequent claims payment. To ensure coverage is renewed, please remind your Healthfirst members to call us 60 days before their coverage expiration date so we can assist them with their renewal. Providers must use one of the following steps to verify a member's eligibility before or at the time of service.

Note that verification of eligibility at the time of service does not guarantee payment by Healthfirst. Claims must still be submitted in a timely manner with all required information. In addition, members may lose eligibility after services are provided and claims are submitted. What's more, the loss of eligibility may be retroactive to the date of service.

View the Member ID Card

Each Healthfirst member is issued an identification card that includes the member's PCP, affiliated hospital, and mental health and substance abuse benefits manager, as well as other identification and informational items. If a Healthfirst member is eligible for dental coverage, the dental phone number will be printed on the Member ID card. Medicaid members should keep their Healthfirst Medicaid, Managed Care, and Medicaid identification cards together, since some benefits can be accessed only through the Medicaid card. Go to **https://healthfirst.org/** to view a sample of Member ID cards for all Healthfirst products.

Healthfirst Leaf Plan and Leaf Premier Plan Member ID cards will indicate the member's plan deductible limit and their cost sharing/copayment responsibilities. Leaf and Leaf Premier Plan Member ID cards will also have the member portal site listed, **https://member.healthfirst.org/login**, Leaf and Leaf Premier Plan members can be referred to the portal to pay their plan premium, find a doctor, access more information on their plan benefits, and more.

Verify Online at https://hfproviders.org

Providers can access eligibility information on our website using the member's Healthfirst ID number. Providers can verify eligibility for up to ten members at one time or view individual information and demographics.

Call Provider Services (1 (888) 801-1660)

Check the Member Enrollment Roster

Members are enrolled monthly into the Healthfirst programs. Members select a PCP at the time of enrollment. Healthfirst provides PCPs a monthly enrollment roster that identifies new members in the provider's panel as well as those members who have left the practice. The enrollment roster contains demographic information for each member by Healthfirst program. Providers may use these rosters to verify eligibility. However, if a member is not listed on the roster and says that he/she belongs to the provider's panel, the provider should verify eligibility through the Member

Eligibility section of our website or by calling Member Services. Member enrollment rosters are available on the Healthfirst provider portal.

Check eMedNY

Codes:

- Code SF to verify enrollment in the Healthfirst Medicaid plan
- Code MH to verify enrollment in the Healthfirst Medicare/Medicaid with Long-Term Care benefits for the CompleteCare (CC) plan

In some cases, a member may be added to a provider's panel after the creation of the monthly enrollment roster. If there is a discrepancy between the roster, the member's identification card, and the eMedNY system, or if there are questions about a member's eligibility, please call Member Services for the most current information.

Commercial Plans

Members in Healthfirst Leaf and Leaf Premier Plans or HMO A–D plans may have monthly premium responsibilities. Members with premium obligations will have to pay their premiums on time to maintain their insurance coverage. Members who receive no federal subsidies will have a 30-day grace period in which to pay their premiums. Members who receive federal subsidies will have a 90-day grace period to pay their premium. If members fail to pay their premium at the end of their grace period, they will be disenrolled. Claims incurred by members in the first 30 days of a 90-day grace period will be paid; those incurred in days 31–90 will not be paid unless the member pays their premium before the end of their grace period. To verify a member's eligibility in the commercial plan, providers can:

- Call Provider Services at 1 (888) 801-1660
- Log in to the provider portal: **https://hfproviderportal.org/**

4.4 Member Rights and Responsibilities

A member's relationship with Healthfirst guarantees a number of basic rights, including entitlement to high- quality, accessible, responsive and responsible healthcare; respectful and confidential treatment; and avenues to express dissatisfaction or receive assistance. In return, members are responsible for taking charge of their healthcare needs, using services appropriately, complying with member policies and procedures, and requesting assistance from Healthfirst to ensure that they are utilizing and receiving services appropriately.

Healthfirst member rights and responsibilities are outlined below. This information is provided to all new members as part of their orientation package. Providers participating with Healthfirst are expected to make every effort to support member rights.

Members Have the RIGHT to:

- High-quality healthcare services provided in a professional and responsible way
- Choose a PCP
- Complete and current information about available treatments, including diagnosis and prognosis as applicable, in terms the member can be expected to understand
- Have information provided to an appropriate person acting on the member's behalf when it is not appropriate to give such information directly to the enrollee
- Access to assistance for medical care through the PCP's office by telephone 24 hours a day, 7 days a week
- Privacy and confidentiality of their healthcare records, except as otherwise provided for by law
- Refuse treatment, as far as the law allows, and to understand the consequences of refusing treatment
- Receive information as necessary to give informed consent before the start of any procedure
- Express their concerns or complaints to Healthfirst and receive a timely response

- Receive considerate and respectful medical care and treatment from Healthfirst staff and providers without discrimination due to race, color, sex, age, national origin, sexual orientation, and/or physical or mental condition
- Accept or refuse medical treatment, including life-support treatment
- Information regarding advance directives

Members Have the RESPONSIBILITY to:

- Enter into this agreement with the intent to follow the rules and procedures outlined in the Member Handbook, Summary of Benefits, or Subscriber Contract
- Meet with their PCP and get a baseline physical exam
- Receive all covered healthcare services through the PCP, except in true emergencies; self-referral services, including OB/GYN, diagnosis, and treatment of TB by public health agency facilities, or as otherwise described in their Healthfirst Member Handbook, Subscriber Contract, or Evidence of Coverage (EOC); and to follow recommended treatments
- Use the emergency room only in the event of a true emergency
- Treat Healthfirst staff and providers with common courtesy and consideration
- Keep scheduled appointments or, if this is not possible, call in advance to cancel
- Call Member Services if they need information or have any questions about the benefits, rules, or procedures described in their Healthfirst Member Handbook, Subscriber Contract, or EOC

Commercial Members

In addition to the above rights and responsibilities, many members in Healthfirst Leaf Plans or HMO A–D plans will have monthly premium responsibilities. Members will have to pay their premiums on time to maintain their insurance coverage. Members who receive no federal subsidies will have a 30-day grace period in which to pay their premium. Members who receive federal subsidies will have a 90-day grace period to pay their premium. If members fail to pay their premium at the end of their grace period, they will be disenrolled.

4.5 Member Services and Education

The Member Services department provides members with an extensive array of customer service, outreach, orientation, and educational programs, including translation services to assist members who do not understand English.

New Member Outreach and Orientation

All new Healthfirst members are contacted and invited to attend monthly orientations, which are also open to existing members. These sessions are conducted at selected participating hospitals, at community-based organizations, and in Healthfirst's offices. They reinforce and supplement the information provided in Healthfirst marketing presentations. Orientations focus on explaining the enrollment process, benefits, and rights and responsibilities to new members. Member orientations include presentations on covered benefits and services, the role of the PCP, free access services, and access to "carved out" services.

All members receive a new member enrollment kit and Provider Directory that lists primary care, OB/GYN, specialists, and ancillary service providers. The new member enrollment kit contains a member handbook and subscriber contract or EOC, depending on which product the member enrolls in. Members also receive copies of our member newsletter and health education materials.

As part of the mandatory Medicaid managed care program, Maximus, the enrollment broker, issues health risk assessment questionnaires to newly enrolled individuals and families as part of the enrollment process. Healthfirst also sends health risk assessment forms to new members and once annually to all existing Medicare Special Needs Plan (SNP) members (e.g., members in Healthfirst's Maximum, CompleteCare, and Life Improvement Plans). Healthfirst uses these self-reported health assessment tools to better understand the member's health and lifestyle, their wellness, or specific service needs. Healthfirst encourages these members to visit their PCP as soon as

possible to obtain services. In addition, Healthfirst Case Managers call members with complex medical needs to ensure that they receive appropriate attention and care.

Special Outreach and Care Management

Healthfirst sponsors special outreach programs to encourage appropriate preventive care and to provide care management services for selected conditions. Outreach programs include Quality Improvement initiatives that remind members to seek preventive care services such as well-child care, immunizations, and screening tests such as mammograms and regular Pap smears.

Healthfirst's Care Management includes Asthma, Healthy Mom/Healthy Baby (for normal and high-risk pregnancies), Congestive Heart Failure, HIV, Behavioral Healthcare, Diabetes, Domestic Violence, Health Buddy (CHF and Diabetes), and the Coordinated Care Program.

Commercial Plans

Members new to Healthfirst Leaf, Healthfirst Leaf Premier, or HMO A-D plans will receive the following new member material:

- A letter with their assigned Primary Care Physician (or PCP) and their Healthfirst Member ID number
- A New Member Welcome Kit including the Healthfirst Member Handbook
- A member ID Card

These members will all receive a welcome call which will explain plan benefits, inform members of their PCP selection; offer members the opportunity to change their PCP; explain their financial responsibilities, such as deductibles, maximum-out-of-pocket, copay, and coinsurance; and cover the definition of emergency services. Additionally, these members will be asked to complete a health questionnaire to assess their baseline health status. The health questionnaire will be available on the member portal at **https://member.healthfirst.org/login**. Healthfirst will also follow up with members who do not fill out the health questionnaire to ask them to complete the questionnaire by phone.

5 Regulatory and Reporting Requirements

5.1 Reporting Requirements

Healthfirst is required to report to federal, New York City, and New York State regulatory authorities on a variety of data elements, including financial, clinical, and quality-related indicators. In order to maintain compliance with these requirements, Healthfirst relies upon its provider network to supply it with comprehensive, accurate, and timely information. Healthfirst expects its participating providers to follow all public health and regulatory guidelines related to the reporting of communicable diseases, the delivery of preventive care services, lead screening, procedure consents (e.g., sterilization/hysterectomy), child abuse and domestic violence, and any other required data sets. Please refer to Section 14 for more information.

Fraud, Waste & Abuse Hotline

If you suspect fraud, waste, or abuse by a Healthfirst member, another provider, or Healthfirst itself, **please call our Compliance Hotline at 1 (877) 879-9137**, which allows anonymous reporting and is staffed 24/7, **or visit** https://hfcompliance.ethicspoint.com. Fraud is broadly defined as intentional deception, or misrepresentation an individual knows to be false or does not believe to be true and makes regardless, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

Examples of fraud, waste, and abuse include:

- Submitting inaccurate claims
- Billing for services that were not provided
- Accepting inducements to utilize or refrain from utilizing a service
- Using another person's Healthfirst Member ID card
- Failing to comply with Healthfirst policies

5.2 Medical Record Reviews and Documentation Standards

Well-documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality care. In private-office or clinic settings, the medical record is an essential tool for communication between providers. Providers shall maintain a separate, individual medical record for each enrollee. Obstetricians and Ob/Gyns shall maintain a record for pregnant women that serves as a central repository for the provision of prenatal care and all other services. This will enable Healthfirst to provide, or to arrange the provision of, comprehensive prenatal care services in accordance with the standards and guidelines established by the Commissioner of Health pursuant to Section 365-k of the Social Services Law.

Providers should be in compliance with professional standards and should take steps to safeguard confidentiality when sharing medical-record information with other network providers.

Providers must include supporting documentation in a member's medical record for all diagnosis codes submitted to Healthfirst for payment, consistent with CMS guidelines. Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient, and physician diagnoses submitted to Healthfirst. In addition, coding guidelines require coding to the highest level of specificity which includes fully documenting the member's diagnosis. In all cases, the medical record documentation must support the ICD-10 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the provider.

Periodically, Healthfirst requests medical records and conducts reviews to evaluate practice patterns, to identify opportunities for improvement, and to ensure compliance with quality standards. In many instances such reviews are required under the Medicaid, CHPlus, or Medicare Advantage programs. Clinical professionals conduct all Healthfirst medical-record reviews, and all information in the records is kept strictly confidential. Providers must make medical records available upon request by Healthfirst or by CMS, NYSDOH, or any other regulatory agency with jurisdiction over Medicaid, CHPlus, or Medicare Advantage programs.

The provision of enrollee personal health information and records for the purposes listed below constitute healthcare operations pursuant to 45 CFR 501, and therefore the member's explicit consent is not required for the release of such records and information to Healthfirst. In addition, at enrollment Healthfirst obtains the member's authorization to review records.

Healthfirst reviews medical records as part of the following activities:

- Credentialing and recredentialing
- Clinical quality of care investigations
- Monitoring utilization to validate prospective and concurrent review processes, identify trends, assess level-of-care determinations, and review billing issues
- Monitoring for accuracy and completeness of coding, including RADV audits
- Monitoring for compliance with approved Practice Guidelines and Standards of Care
- Reporting for Quality Improvement and Peer Review Organization studies and HEDIS®/QARR measure compliance
- Monitoring of provider compliance with public-health regulations on reporting requirements
- Monitoring for compliance with Healthfirst Medical Record Documentation Standards

In addition, NYSDOH and Peer Review Organizations audit medical records as part of their respective quality review processes. If deficiencies are found after an internal medical-record review or a review conducted by regulatory agencies, providers will be required to participate in a corrective action plan, as necessary.

Medical records must be maintained by practitioners who provide primary care and referral services. They must be maintained for a period of 10 (ten) years after the last visit date, or, in the case of minor children, for 10 (ten) years from the age of majority.

There is no official regulation about timeliness in signing electronic records, but to comply with HIPAA and security standards many organizations have created policies designed to have electronic charts signed and locked within 48–72 hours but no longer than 30 days from the DOS. This prevents alteration to the original note, whether intentional or accidental, without an amendment being noted by the software. We present our message as both signing and locking because you cannot lock a record without signing but you can sign without locking. The signing itself creates a date/time stamp that is useful in verifying the authenticity of the.

Transfer of Medical Records

When transferring medical records from one participating PCP to another, a release of information form is not required. However, a release form must be signed when the member requests records to be sent to other entities outside of Healthfirst, such as other insurance companies. When a member transfers PCPs, providers must facilitate the transfer of medical records in a timely manner.

5.3 Confidentiality

A member's protected health information (PHI) is protected under the contractual relationships between Healthfirst and the member and between Healthfirst and the provider. PHI is found in Healthfirst enrollment data, medical records, treatment documentation and information, and/or claims data, Explanation of Benefits (EOBs) and Explanation of Payment (EOPs) for the provision of health services. Such PHI must be safeguarded and held in strict confidence in order to comply with applicable privacy provisions of state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), specifically, 45 C.F.R. parts 160 and 164, Subpart E (the "Privacy Rule"), and Subpart C (the "Security Rule"), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH") (collectively hereinafter referred to as "HIPAA Rules").

Upon enrollment, Healthfirst members authorize Healthfirst to review, release, and use their respective PHI.A member's written acknowledgment—to be maintained in the provider's records and subject to periodic audit by Healthfirst—is required upon receipt of the Privacy Notice. Providers should take all reasonable measures to protect

the privacy and confidentiality of members' nonpublic personally identifiable information and PHI at all times and to prevent unauthorized use or disclosure to any unaffiliated third party.

The release of a member's protected health information and records for quality assurance/utilization review and encounter data is for healthcare operations pursuant to the definitions in 45 C.F.R §164.501, and therefore the enrollee's consent is not required for the release of such records and information to Healthfirst.

All providers should remain aware that PHI related to behavioral health and/or substance use disorder and PHI that identifies the presence of behavioral health, substance use disorders, and/or HIV-related illness are governed by a special set of confidentiality rules. Without specific authorization, these records and data should not be released to anyone but the member, except under certain circumstances. If you have any questions regarding the disclosure of a Healthfirst member's information, please call Provider Services, 1- 888-801-1660.

All Medicaid providers are required to develop policies and procedures to assure the confidentiality of behavioral health, substance use, and HIV-related information, including the following information:

- Initial and annual in-service education of staff, contractors
- Identification of staff allowed access, and limits of access
- Procedure to limit access to trained staff (including contractors)
- Protocol for secure storage (including electronic storage)
- Procedures for handling requests for behavioral health, substance abuse, and HIV-related information
- Protocols to protect from discrimination of members with, or suspected of having, behavioral health, substance use disorders, and/or HIV infection

In the event a contracted provider is a Part 2 program, as that term is defined in 42 CFR Part 2, et seq., the provider must ensure that:

1. it obtains and maintains members' written consent authorizing the disclosure of substance abuse information covered by 42 CFR Part 2, et seq., ("Part 2 Data") for all such data disclosed to Healthfirst in a form that complies with the requirements of 42 CFR Part 2; and
2. all consent forms that are the basis of disclosures of Part 2 Data to Healthfirst permit Healthfirst to use such Part 2 Data for purposes of payment and healthcare operations.

All contracted providers are bound by 42 CFR Part 2 with respect to any Part 2 Data they receive from Healthfirst and must ensure that such Part 2 Data is used only for purposes of payment or healthcare operations, as such terms are defined in 42 CFR 2.33, on behalf of Healthfirst, absent notice from Healthfirst that the applicable members have consented to allow their Part 2 Data to be used for other purposes.

Providers are bound to comply with any future changes to applicable law and regulations relating to the confidentiality of member information.

5.4 Advance Directives/Health Care Proxy

All members, including Healthfirst members, have the right to make decisions about the amount and type of care that they will receive, including care if they are terminally ill. A terminal illness is defined as any illness that is likely to result in the death of a person within six months. Through advance written Advance Directives, a Healthfirst member can ensure their wishes are known and followed if they cannot make decisions for themselves.

Healthfirst members have the right to appoint a healthcare agent through a Health Care Proxy (Appendix VI). A Health Care Proxy is a formal document enabling a member to designate a trusted individual to make healthcare decisions on his/her behalf if the member is unable to make decisions themselves. All competent adults can appoint a healthcare agent by signing a Health Care Proxy form. A lawyer is not required, but two witnesses must be present and must also sign the form. Members who have questions or would like additional information on these issues should be directed to the Member Services department.

A Living Will allows the member to define his/her wishes about the type and amount of care that will be provided or withheld at the end of life. Examples of the types of care that may be addressed in a Living Will include the use of ventilators, intubations, and other life-saving procedures, as well as the areas of nutrition and hydration therapy.

Inpatient facilities must determine if a member has executed an Advance Directive or that the member is aware of the possibility of doing so. If the member has completed a Health Care Proxy, a copy should be kept in the member's inpatient chart or medical record, or the name, address, and phone number of the healthcare agent should be documented in the member's inpatient medical records. It must be clearly documented in the inpatient medical record that the member has executed an Advance Directive.

Copies of both forms can be found in the Member Handbook. Providers must document in all Healthfirst Medicare member medical records that there was a discussion about Advance Directives and a Health Care Proxy, and the documentation must be updated annually. If the member is hospitalized at the time, the documentation can include that the member was given the information about Advance Directives in the hospital.

If the facility feels that it is unable to adhere to the member's wishes, the hospital should notify the member of this fact and recommend that he/she contact the Member Services department. Otherwise, Healthfirst expects the facility to adhere to the member's wishes as determined by the chosen healthcare agent.

5.5 Disclosure Restrictions for Services Paid Out-of-Pocket

If a Healthfirst member (or their representative) pays the full cost of services out of pocket at the time that those services are rendered and requests a restriction of the disclosure of their PHI to Healthfirst, the participating provider must comply with this request, unless the disclosure is required by law or if the restricted PHI is needed to provide emergency treatment (45 CFR § 164.522). The participating provider should employ a method to flag or notate the participating provider record with respect to the PHI that has been restricted. This will ensure that the PHI is not inadvertently sent to or made accessible to Healthfirst for payment or healthcare operations purposes, such as audits conducted by Healthfirst.

5.6 Critical Incident Reporting

Effective Date: November 1, 2012

Pursuant to Special Terms & Conditions, #28, c) ii), the State, through its contracts with MCOs, shall ensure that a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This includes critical incident monitoring and reporting to the State and investigations of incidents.

General Definition: A "Critical Incident" is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a Nursing Home, LTSS, Home Health, Adult Home, and Home- and Community-Based Service participant.

Reportable Critical Incidents Defined:

- Abuse
- Neglect
- Mistreatment
- Injuries of unknown origin
- Sexual abuse
- Verbal abuse
- Misappropriation of resident property has occurred
- Medication error/drug diversion
- Burns
- Attempted suicide or death related to suicide, restraints, equipment
- CPR concerns
- Accidents related to choking or equipment hazard; resident found in nonresident area

- Elopement from building
- Physical environment

Critical Incident Management and Reporting: Provider Responsibilities

As a participating Healthfirst provider, you will be required to report all allegations of abuse, neglect, and exploitation of a member, as defined in the Critical Incident Manual. Take immediate action to assure the member is protected from further harm and respond to emergency needs of the member.

Who is supposed to report a critical incident? Facility/staff member who becomes aware of a critical incident as defined on this form. Qualified Service Providers that are enrolled with the Department of Human Services, Transition Coordinators, and Case Managers are required to report incidents.

Incident Reporting Procedure

How do you report a critical incident? Complete the Critical Incident Report form on the HCS Internet Portal **https://commerce.health.state.ny.us** within 24 hours of knowledge of the incident, any day of the week or time of day.

Using your username and password, log on to the HCS Internet Portal and proceed to the Nursing Home Surveillance and Reporting System to enter information on the electronic Incident Form. Instructions for the Incident Form can be found either by clicking on the Instruction link found on the left-hand side of the form, or through the Instruction link found within the Dear Administrator Letter section.

The Incident Reporting Line phone number, 1 (888) 201-4563, may be used in case of an emergency such as loss of Internet or computer service. If circumstances dictate reporting via the hotline, that contact will be sufficient and there will be no need to report online. If a provider continues to report via the hotline, they will be redirected to the website.

PLEASE NOTE:

For purposes of facility reported incidents, long-term care facilities must report abuse, neglect, and misappropriation within 24 hours after the reasonable cause threshold is concluded. All other reportable incidents are to be communicated to the NYSDOH by the next business day.

Detailed information and general Q&A on critical incident reporting can be found in the New York State Department of Health Nursing Home Incident Reporting Manual (**http://www.health.ny.gov/professionals/nursing_home_administrator/docs/11-12_incident_manual.pdf**)

6 Primary Care

6.1 Responsibilities of a Primary Care Provider (PCP)

Most Healthfirst members select a PCP at the time of enrollment. The PCP is responsible for managing and coordinating healthcare services provided to members, including primary and specialty care, hospital care, diagnostic testing, and therapeutic care. Healthfirst defines the following clinical specialty areas and practitioners as primary care providers.

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

Healthfirst PCPs are evaluated annually in areas of quality and satisfaction such as:

- Wellness and Preventive Care
- Chronic-Care Management
- Enrollee Experience and Satisfaction with Care
- Medication Adherence and High-Risk Medications

The ratings for each measure are combined to generate an overall quality rating for the provider. More information on this can be found in Section 14.6 of our Provider Manual.

PCPs are the first points of entry into the Healthfirst delivery system. PCPs also play essential clinical and oversight roles in managing the care of Healthfirst members. Healthfirst has identified the following scope of activities and responsibilities as key expectations for participating PCPs.

Access

For participation in the Medicaid, Child Health Plus, HARP, and Essential Plan programs, the PCP must practice at least two (2) days per week and maintain a minimum of 16 office hours per week at each primary care office site.

For participation in the Medicare, Qualified Health Plan and Commercial programs, the PCP must maintain a minimum of 10 (ten) office hours per week at each primary care office site.

Maintain access 24 hours a day, 7 days a week either directly or through arrangements with other Healthfirst providers for back-up coverage. See Section 3 for additional information on access and coverage requirements.

Clinical Care

Provide first-line primary, preventive, inpatient, and urgent care, or arrange for care, as appropriate, to manage conditions outside of the scope of primary care.

Identify Healthfirst members with complex or serious medical conditions—assessing those conditions through appropriate diagnostic procedures—and contact the Healthfirst Care Management staff to collaborate on treatment plans and follow-up.

Provide Healthfirst members with education on the appropriate use of healthcare services, personal health behavior, health risks, preventing STDs, preventing HIV/AIDS, and achieving and maintaining optimal physical and mental health.

Preventive Care

Provide or arrange for all appropriate screenings and preventive care, including immunizations and well-child visits; tuberculosis screening, diagnosis, and treatment; lead screening for children and appropriate dental care; HIV testing and counseling; mammography screening, colorectal cancer screening, cervical cancer screening, and HbA1c testing (Appendix VII).

Maintain compliance with established preventive care standards (Appendix VII-A) and clinical practice guidelines (Appendix XIII) adopted by Healthfirst.

Adhere to the New York State C/THP Guidelines (Appendix VII-B) and Guidelines for Adolescent Preventive Services (GAPS) (Appendix VII-C).

Participate in the Healthfirst Clinical Quality programs designed to improve care for members.

Behavioral Health Screening

Healthfirst promotes the use of the Patient Health Questionnaire (PHQ-9) as a screening tool (Appendix VII-D) to assist its PCPs in identifying Healthfirst members with symptoms of depression who are appropriate candidates for referral to the Healthfirst Behavioral Health (BH) Care Management Unit or delegated organization. The PHQ-9 should be used at the baseline appointment, at the annual preventive care visit, and at any point where the member's condition indicates that a behavioral health issue may be present. A copy of the questionnaire should be kept in the member's medical record. This tool is not intended to replace a complete mental health evaluation and assessment.

Before asking a Healthfirst representative or a behavioral health provider to try contacting a member to arrange for an evaluation of the member's needs regarding mental health or alcohol/substance abuse services, a PCP must get the permission of the member in question to do so.

Healthfirst makes every effort to partner with providers to promote the integration of Behavioral Health and medical-service delivery to adults and children. To this end, primary care and other medical providers will be routinely engaged in dialogue with Healthfirst clinical management teams and are invited to participate in ongoing education, trainings and seminars, access to rapid consultation from child and adolescent psychiatrists, and referral and linkage to appropriate Behavioral Health providers for our most at-risk child, adolescent, and adult members.

Long-Term Services and Supports (LTSS)

PCPs may identify that their members require long-term services and support (LTSS). Some ways to identify this are:

- 1) if a member already receives home care, adult day care, or other home care services, and 2) if they already have both Medicaid and Medicare
- If a member requests a Home Health Aide, Personal Care Assistant Services, or non-skilled needs with a deficit in their Activities of Daily Living
- If a member needs Adult Day Health Care (ADHC) services
- If a SNF member is receiving short-term rehab or nursing care and is qualified to return to the community with home care
- If a member has dementia, confusion, Alzheimer's, psych conditions, and/or other cognitive deficits with a deficit in their Activities of Daily Living, with someone to direct their care in the community
- If a member requests a power wheelchair or a hospital bed with a deficit in their Activities of Daily LivingIf a member has a history of falling and a deficit in their Activities of Daily Living

Please note some programs require members to be over age 21

Any members that meet these needs and are identified as having a need for LTSS should be referred to the Healthfirst Care Management team or a participating LTSS provider as classified in the online Healthfirst Provider Directory.

Coordination of Care and Services

- Coordinate primary and specialty care, ancillary services, and other covered healthcare services and collaborate with Healthfirst case managers and other providers involved in the member's care.
- Arrange for behavioral health services through the Healthfirst Behavioral Health Care Management Unit or the member's designated behavioral health care management organization.
- Arrange for transportation services, as needed, to ensure that members are able to access healthcare services.
- PCPs, as well as all members of the Interdisciplinary Team (IDT) of Healthfirst special needs plans, coordinate primary and specialty care, ancillary services, long-term services and support (LTSS), and other covered healthcare services.
- PCPs, as well as all members of the care planning team (some Healthfirst plans call this the Interdisciplinary Team (IDT)), arrange for behavioral health services through the Healthfirst Behavioral Care Management Unit or the member's designated behavioral health care management organization.
- PCPs, as well as all members of the care planning team (some Healthfirst plans call this the Interdisciplinary Team (IDT)), arrange for transportation services, as needed, to ensure that members are able to access healthcare services.

Administrative Responsibilities

Verify member eligibility at every visit by logging in to the Healthfirst Provider Portal at **https://hfproviderportal.org** or by calling Member Services at 1 (866) 463-6743 to ensure that members are still active and enrolled in Healthfirst.

Provide comprehensive, accurate, and reliable encounter data with CMS HCFA 1500 or UB-04 claim forms sent to Healthfirst on a timely basis.

6.2 Primary Care Panels and Member Enrollment Rosters

Most Healthfirst members select a primary care provider (PCP) at the time of enrollment. PCPs can receive enrollment rosters indicating the Healthfirst members assigned to their panel each month by logging in to the Healthfirst Provider Portal at **https://hfproviderportal.org** and requesting access under the Healthfirst Reports section.

The enrollment roster contains demographic information for each member in the provider's panel and reflects the Healthfirst product the member is enrolled in. Each time a Healthfirst member visits their PCP, the eligibility verification steps outlined in Section 4 should be followed.

6.3 Preventive Care Standards

Healthfirst provides its members with access to routine and preventive healthcare services; these services are provided and/or coordinated by the member's PCP. Direct access to a women's health specialist is provided within the network for routine and preventive women's healthcare services. Adult routine physicals and screenings are recommended according to age and risk factors consistent with the AAP/Bright Futures Recommendations for Children and Adolescents, which is included in Appendix VI.

Please note: Healthfirst Medicare Plan members do not require a referral to obtain an influenza or pneumococcal vaccine. Additionally, there is no copayment for administering the influenza or pneumonia vaccine. Healthfirst expects participating PCPs to adhere to established preventive care standards and schedules in effect in New York State. These include New York State Vaccines for Children Program (VFC), which supplies selected vaccines to providers caring for Healthfirst PHSP members at no cost. In addition, providers may order vaccines for Medicaid and CHPlus members at no cost through the VFC program.

For additional information on the VFC or Immunization Program or to order vaccines for Healthfirst Medicaid CHPlus members, call:

- New York State Department of Health Bureau of Immunization: 1 (518) 473-4437
- New York City Department of Health and Mental Hygiene Immunization Hotline: 1 (347) 396-2400
- New York State Vaccines for Children Program: 1-800-KIDSHOT (1 (800) 543-7468)

To encourage compliance with timely and appropriate preventive care, Healthfirst has developed the Healthfirst Quality Incentive Program (HQIP) for (Section 16.3) Healthfirst participating providers. Under this program, eligible PCPs caring for Medicaid, HARP, EP, CHPlus, QHP, Medicare, CompleteCare, and Connection plan members can receive additional compensation for their efforts in promoting and documenting the provision of selected preventive care services.

Additionally, Healthfirst provides preventive care screenings and immunization guidelines (Appendix VI) for the pediatric population.

Depression

Prevention is a key in quality clinical care provided to our members. Mental health diagnoses have historically been and continue to be included in the Healthfirst top ten (10) inpatient and outpatient diagnoses. It is extremely important to ensure that our members receive evaluations and get help as soon as possible if they have any symptoms of depression. It is a requirement for Healthfirst providers to include this information in the member's chart and to refer the member to an appropriate mental health professional, if necessary.

If a member is given a prescription for any antidepressant medication, he/she should be given an appointment to return to their PCP every four (4) weeks for a minimum of three (3) visits within 84 days of receiving the prescription and then return for follow-up visits every three (3) months for at least one (1) year.

7 Obstetrics and Gynecology

7.1 Definition of Services

All female members have access to Obstetrician/Gynecologist (Ob/Gyn) care from any in-network provider without referral from their assigned PCP. An Ob/Gyn is responsible for providing and managing medical care for obstetrical and gynecological conditions. In addition, Medicaid members may choose to receive Family Planning and Reproductive Health services from a nonparticipating provider who accepts Medicaid for these services (also known as “Free Access Policy”). Family Planning and Reproductive Health services mean the offering, arranging, and furnishing of those health services that enable members, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. This does not include obstetrical care for pregnancy. All members, including Medicaid members, must use an in-network provider for obstetrical care for pregnancy.

The following medically necessary services are subject to “free access” for Medicaid female members and include related drugs and supplies that are furnished or administered under the supervision of a provider, licensed midwife, or certified nurse practitioner during a Family Planning and Reproductive Health visit:

- Family Planning and Reproductive Health services which include those education and counseling services necessary to effectively render the services
- Contraception, including all FDA-approved birth control methods and devices, including diaphragms, insertion/removal of an intrauterine device (IUD), or insertion/removal of contraceptive implants and injection procedures involving pharmaceuticals such as Depo-Provera
- Emergency contraception and follow-up
- Sterilization (requires sterilization consent and hysterectomy consent form as applicable) Screening, related diagnosis, and referral to a participating provider for pregnancy
- Medically necessary induced abortions, which are procedures—either medical or surgical—that result in the termination of pregnancy. The determination of medical necessity shall include positive evidence of pregnancy, with an estimate of its duration
- When clinically indicated, the following services may be provided as a part of a Family Planning and Reproductive Health visitScreening, related diagnosis, ambulatory treatment, and referral as needed for dysmenorrhea, cervical cancer, or other pelvic abnormality/pathology
- Screening, related diagnosis, and referral for anemia, cervical cancer, glycosuria, proteinuria, hypertension, and breast disease
- Screening and treatment for sexually transmissible disease: HIV testing and pre- and post-test counseling

Specialty Areas under Ob/Gyn

Healthfirst includes the following seven (7) specialty areas in its definition of obstetrics and gynecology. Practitioners in the specialties will be referred to as Ob/Gyn providers in this Provider Manual unless otherwise indicated:

- Gynecology
- Gynecology (Nurse Practitioner)
- Midwifery
- Obstetrics
- Obstetrics and Gynecology
- Obstetrics and Gynecology (Nurse Practitioner)
- Women’s Health (Nurse Practitioner)
- Maternal and Fetal Medicine
- Obstetrics and Gynecology – High-Risk

PCP and Ob/Gyn Care

In certain circumstances, a member may choose the same provider to serve as both her PCP and Ob/Gyn. This might occur if a member selects a family practitioner as her PCP or HIV Specialist PCP who also provides routine Ob/Gyn services.

Healthfirst members may access Ob/Gyn services directly, without a referral from a PCP, for routine care. The PCP, however, may refer a member to an Ob/Gyn for consultation. Reports of all diagnostic tests must be forwarded to the PCP for inclusion in the member's medical record. See Section 7.2 for additional details.

7.2 Perinatal Services

In accordance with NYS perinatal standards, Healthfirst provides comprehensive perinatal care services to its members, including, but not limited to, prenatal risk assessment, health education, mental-health and related social services, labor and delivery, postpartum care, and breastfeeding support. Healthfirst does not require female members to obtain referrals before accessing routine obstetric care.

All pregnancy-related clinical care and services must be delivered in a high-quality, person-centered, cohesive, and comprehensive manner across all provider types. To accomplish this goal, Healthfirst requires all providers who deliver care to pregnant/postpartum persons follow the care guidelines outlined in the NYS Medicaid Perinatal Care Standards.

During pregnancy, the primary maternity provider assumes the responsibility for coordinating and managing the member's care. They may treat and/or make specialty referrals for any medical conditions that may arise during pregnancy without referring the member back to her PCP, though they are required to communicate care and findings to the member's other care providers. If illness or injury occurs that is unrelated to the pregnancy, the maternity provider should refer the member to her PCP for further evaluation and treatment. In addition, when caring for a high-risk pregnant member, if the provider needs assistance with care coordination for the member then contact our Maternity Complex Care Program by calling Healthfirst's member services phone number located on the back of the insurance cards.

Please see following link to review the current New York State Medicaid Perinatal Care Standards
https://www.health.ny.gov/health_care/medicaid/standards/perinatal_care/

7.3 Consent Requirements for Hysterectomy – Medicaid, CHPlus, FHPlus and Leaf Plans

Hysterectomy and other sterilization procedures are subject to special informed consent guidelines for members receiving Medicaid benefits as well as for members covered under the CHPlus, FHPlus, and LeafPlan programs. Medical necessity and informed consent for hysterectomy are discussed in this section; information on family planning and sterilization procedures follows.

Before a hysterectomy is performed on a Healthfirst member, an adequately documented informed consent procedure must be completed. In addition, the hysterectomy will only be authorized if it is not being performed solely for the purpose of rendering the member incapable of reproduction and there are clinical indications for performing the hysterectomy—these cannot include rendering the individual permanently incapable of reproducing.

Informed consent policies and procedures for hysterectomy are strictly regulated. Providers must ensure that they are in full compliance with appropriate documentation standards to be reimbursed for performing these procedures. Providers must comply with the Informed Consent Procedures for Hysterectomy and Sterilization specified in 42 CFR, Part 441, sub-part F, and 18 NYCRR 505.13, and with applicable EPSDT requirements specified in 42 CFR part 441, sub-part B, 18 NYCRR 508, the NYSDOH C/THP Manual and all applicable public health laws.

All women undergoing hysterectomies must be informed, verbally and in writing, prior to surgery, that the procedure will render them permanently incapable of reproducing. Members or authorized representatives must sign Part 1 of the DSS-3113 Acknowledgment of Receipt of Hysterectomy Information Form. This documents that the member received all pertinent information or certifies that there are reasons to waive the receipt of information. It also contains the surgeon's statement that the hysterectomy is not being performed for the purpose of sterilization.

Copies of the DSS-3113 and associated instructions may be obtained by contacting:

New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243
Re: Hysterectomy Information Forms

The requirement that the member sign Part 1 of the form may be waived under certain circumstances, such as evidence that the woman was sterile prior to the hysterectomy and the hysterectomy was performed in a life-threatening emergency in which prior receipt of hysterectomy information was not possible.

In either of these situations, the surgeon performing the hysterectomy must certify in writing on a DSS-3113 form that one (1) of these two (2) conditions existed. He/she must attest to the reason for the member's sterility or indicate the nature of the emergency that precluded transmittal of the Receipt of Hysterectomy Information Form. For example, the member may already be post-menopausal at the time of the hysterectomy, or she may have been admitted to the hospital via the emergency room requiring immediate surgery.

In certain situations, a member may not have been a Medicaid recipient at the time of her hysterectomy, but if she subsequently applied for Medicaid and was determined to qualify for retroactive eligibility, the surgeon might receive payment from Medicaid for this procedure. He/she must certify in writing that the woman received information prior to surgery indicating that the hysterectomy would make her permanently incapable of reproducing, or that one (1) of the extenuating circumstances existed allowing waiver of Part 1 of DSS- 3113. **Providers must submit the DSS-3113 form to Medical Management before prior authorization for the procedure that will be provided.**

7.4 Family Planning and Reproductive Health

Scope of Services

Family planning and reproductive health services comprise diagnostic, educational, counseling, and medically necessary treatments, medication, and supplies furnished or prescribed by, or under the supervision of, a provider or nurse practitioner for the purposes of:

- Contraception, including insertion or removal of an IUD, insertion or removal of Norplant, and injection procedures involving pharmaceuticals such as Depo-Provera
- Screening and treatment for STDs
- Screening for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease, pregnancy, and pelvic abnormality/pathology
- Termination of pregnancy services (provider must document the duration of the pregnancy)

HIV testing and pre- and post- test counseling (when performed within the context of a family planning encounter) is considered a free access service. HIV blood testing and counseling may also be obtained from Healthfirst PCPs, by referral from a PCP to a participating specialist, or by anonymous counseling and testing programs operated by New York State and New York City. Providers of family planning and reproductive healthcare services shall comply with all of the requirements set forth in Section 7 of the NYS Public Health Law, and 20 NYCRR, Section 751.9 and Part 753 relating to informed consent and confidentiality.

Consent Requirements for Sterilization – Medicaid, CHPlus, FHP, and Leaf Plans

Family planning and reproductive health services include sterilization. Sterilization is defined as any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing, or performed for other reasons, but which renders the individual permanently incapable of reproducing. Medicaid reimbursement is available for sterilization only if informed consent guidelines are met. The consent requirements for voluntary sterilization are described in this section. General requirements are summarized below, followed by specific disclosures that must be made to the member prior to the procedure.

General Requirements

Minimum Age: Members undergoing sterilization must be at least 21 years of age at the time of giving voluntary, informed consent to sterilization.

Restrictions:

- The member undergoing sterilization must not be a mentally incompetent individual. For the purpose of this restriction, the term “mentally incompetent individual” refers to an individual who has been declared mentally incompetent by a Federal, State or Local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization
- The member undergoing a sterilization procedure must not be an institutionalized person. For the purposes of this restriction, “institutionalized individual” refers to an individual who is (a) involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or (b) confined under a voluntary commitment, in a mental hospital or other facility for the cure and treatment of mental illness
- Informed consent to sterilization may not be obtained while the member is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the member’s state of awareness

Translation Services: An interpreter must be provided if the member to be sterilized does not understand the language used on the consent form or the language used by the person obtaining informed consent.

Disabled Persons: Suitable arrangements must be made to ensure that the sterilization consent information is effectively communicated to deaf, blind, or otherwise disabled individuals.

Presence of Witnesses: The presence of a witness is optional when informed consent is obtained, except in New York City, where the presence of a witness is mandated by New York City Local Law No. 37 of 1977.

Waiting Period: Voluntary informed consent to sterilization must be given not less than 30 days or not more than 180 days prior to the sterilization procedure. When computing the number of days in this waiting period, the day the recipient signs the form is not included.

Waiver of Waiting Period: Waiver of the thirty (30)-day waiting period may occur only in cases of premature delivery, when the sterilization was scheduled for the expected delivery date or when there is emergency abdominal surgery. Since premature deliveries and emergency abdominal surgeries are unexpected, medically necessary procedures may be performed during the same hospitalization, as long as seventy-two (72) hours have passed between the original signing of the informed consent document and the sterilization procedure.

Reaffirmation Statement: In New York City, a statement signed by the member upon admission for sterilization, acknowledging again an understanding of the consequences of sterilization and his or her desire to be sterilized, is mandatory. New York City Local Law No. 37 of 1977 establishes guidelines to ensure appropriate informed consent for sterilization procedures performed in New York City. Medicaid will not pay for services that are rendered illegally; therefore, conformance to the New York City Sterilization Guidelines is a prerequisite for payment of claims associated with sterilization procedures performed in New York City.

Consent Form:

- A copy of the New York State Sterilization Consent Form DSS-3134 must be given to the member undergoing the procedure. Completed copies of the form must be submitted to Medical Management before prior authorization for the procedure is provided.
- To obtain the New York State Sterilization Consent Form (DSS-3134) and the associated instructions in English and Spanish, contact: New York State Department of Social Services, 40 North Pearl Street, Albany, New York 12243, Re: Sterilization Consent Forms.

Specific Disclosures

The individual obtaining informed consent for a sterilization procedure must offer to answer any questions concerning the procedure, must provide a copy of the Medicaid Sterilization Consent Form (DSS-3134) for signature, and must verbally provide all of the following information or advice to the individual electing to undergo the procedure. In addition, the provider who performs the sterilization procedure must discuss the following points with the member at least thirty (30) days before the procedure, usually during the preparation examination:

Advise that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.

A description of available alternative methods of family planning and birth control. Advise that the sterilization procedure is considered irreversible.

A thorough explanation of the specific sterilization procedure to be performed.

A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.

A full description of the benefits or advantages that may be expected as a result of the sterilization.

Advice that the sterilization will not be performed for at least thirty (30) days except under the circumstances specified under the “Waiver of 30-Day Waiting Period.”

8 Specialty Care

8.1 Definition of Specialty Care

Healthfirst has contracted with specialist providers and other specialty care professionals to provide healthcare services beyond the scope of primary care. Healthfirst commercial plan members can access these services in accordance with Healthfirst's referral and prior authorization policies.

Specialty care practitioners provide medically necessary care within the scope of their practice. They are responsible for the following four (4) activities:

- Identifying individuals with complex or serious medical conditions, assessing and diagnosing those conditions, and working with the member, as well as with the PCP and Utilization Management team, to provide effective, coordinated medical care
- Collaborating with PCPs to provide coordinated clinical care and to enhance continuity of care for Healthfirst members. Specialists are responsible for contacting the PCP to request information where needed
- Following up with PCPs in writing to apprise them of consultation results, diagnostic testing results, and treatment plans
- Assisting members in accessing required services such as diagnostic tests, acute rehabilitation, home care, DME, and transportation

A complete listing of participating specialty providers can be found at **https://healthfirst.org/find-a-doctor/**. A directory can also be created and printed or emailed based on the search criteria entered, such as zip code and provider specialty.

Specialists as PCPs

Under certain circumstances, Healthfirst may authorize a specialist to serve as a member's PCP. This may occur when a member has a life-threatening, degenerative, or disabling condition, or a disease that requires prolonged specialized medical care through a specialty provider or at a specialty care center. In these situations, Healthfirst arranges for the specialist to take on primary care responsibilities in caring for the member. The member's PCP must be part of this decision process, and the Healthfirst Utilization Management department must authorize the transfer of primary care responsibilities to the specialist. The specialist will then be accountable for coordinating care, referring the member to sub-specialty providers as appropriate, managing health education and preventive care activities, and complying with all guidelines, reporting requirements, and medical and Care Management policies.

For HIV-positive members: If the PCP does not meet the qualifications of an HIV specialist, an HIV specialist will be assigned to assist the PCP in an ongoing consultative relationship as part of the member's routine care.

The following situations illustrate examples of cases when it would be acceptable and beneficial for a specialty care provider or specialty care center to take on the primary management of care for a Healthfirst member:

- HIV-positive members may select an HIV specialist to serve as their PCP
- Members with multiple traumas who require prolonged complex rehabilitative management
- Members with cancer who require a complex, ongoing course of treatment

The following procedures are applicable under these circumstances. Additional information on this subject also appears in Sections 3 and 12 of this Provider Manual.

If the PCP or specialist believes that it is in the member's best interest to assign primary care responsibilities to the specialist, or if the member requests this arrangement, the PCP will discuss this option with the member.

The PCP or specialist will contact Utilization Management with information about the member's condition, course of treatment, and the name of the treating specialist. If all parties agree, the PCP, the specialist, and Utilization Management will coordinate a plan to transfer care.

If a member has requested the transfer and the PCP or the specialist disagrees with the request, the member may contact Utilization Management directly. In these cases, the Medical Director will make a final determination.

Specialty Care Centers

In some situations, a member may be best served by receiving care for a complex condition through a team of providers affiliated with an accredited or designated Specialty Care Center with experience in treating the member's life-threatening or degenerative and disabling disease or condition. For example, an HIV-infected mother with an HIV-infected and/or HIV-exposed child may be appropriately served by a Maternal/Pediatric HIV Specialized Care Center. The member, their PCP, or a specialty provider may initiate a request for this service. When a member makes the request, the PCP and Utilization Management will evaluate the situation, and the following procedures will be followed:

- The member, or the PCP on behalf of the member, should contact Utilization Management to request care at a Specialty Care Center if he or she believes that this is the most appropriate resource.
- If there is a Specialty Care Center in the Healthfirst network that provides the same or substantially similar services to those requested, the member will be directed for in-network care.
- If it is determined that an out-of-network Specialty Care Center is the most appropriate provider of care for an individual member, Ancillary Services will contact the out-of-network Specialty Care Center to negotiate an arrangement. *(Healthfirst is financially responsible for all authorized out-of-network medical expenses.)*

9 Behavioral Health Services

9.1 Description of the Network

Healthfirst has participation agreements with a broad network of providers and other licensed professionals, community agencies, and inpatient and outpatient facilities that specialize in the treatment and management of mental health and substance use disorders (together referred to as "Behavioral Health") Healthfirst manages the Behavioral Health services for all of its members.

Providers may use the Provider Portal (**https://hfproviderportal.org/**) to request authorization via the Online Authorization tool or fax authorization requests to 1 (646) 313-4603 for services that require prior authorization.

Providers may contact Member Services at the oversight of listed in Section 1 to determine a member's hospital affiliation or to obtain information about participating behavioral health providers. Healthfirst retains programmatic and quality oversight of these delegated arrangements to ensure that members are being served appropriately.

Behavioral Health Provider Responsibilities

Healthfirst expects Mental Health, Substance Use, Adult and Children's Home and Community Based Service (HCBS) providers to assume the following set of responsibilities:

- Contact the Healthfirst Behavioral Health Department to verify member eligibility and to receive authorization for admissions and selected outpatient services as outlined in Appendix XI. The same authorization requirements will apply for all products. The authorization requirements are listed on the Healthfirst Provider Portal (**https://hfproviderportal.org/**)
- Maintain contact with the Healthfirst Behavioral Health Department as treatment progresses to receive continuing authorization for additional services.
- Comply with the established policies and procedures of the Healthfirst Behavioral Health and Quality Improvement Programs
- Adhere to recovery-oriented principles, including provision of person-centered services
- Coordinate with the Behavioral Health Department when necessary to ensure appropriate integration of services

Type of Services Covered (depending on plan and benefit):

- Applied Behavior Analysis (ABA)
- Inpatient – Substance Use Disorder and Mental Health
- Clinic – Substance Use Disorder and Mental Health
- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment (ACT), Young Adult ACT & Youth ACT
- Continuing Day Treatment (CDT)
- Partial Hospitalization Program (PHP)
- Comprehensive Psychiatric Emergency Program (CPEP)
- Intensive Outpatient Program (IOP)
- Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)
- Opioid Treatment Programs (OTP)
- Outpatient Chemical Dependence Rehabilitation
- Rehabilitation Services for Residential SUD Treatment Support
- Rehabilitation Supports for Community Residences
- Residential Rehabilitation Services for Youth (RRSY)
- Buprenorphine Prescribers

- Ambulatory Detox
- Inpatient and Outpatient Electroconvulsive Therapy (ECT)
- Mobile Crisis Intervention
- Crisis Residence Services
- Children and Family Treatment and Support Services (CFTSS)
- Adult Behavioral Health Home and Community Based Services (Adult BH HCBS)*
- Children's Home and Community Based Services (HCBS)*
- Community Oriented Recovery and Empowerment Services (CORE)

**Only HARP members (age 21 and over) and specially identified children (ages 0–20) will be eligible for HCBS pending an approved eligibility assessment.*

Mental Health and Substance Use billing guidelines are available on the Healthfirst secure Provider Portal and in Appendix XV-D of the Healthfirst Provider Manual. Providers should refer to Section 9.4, "Utilization and Medical Management Guidelines," for additional guidance on Level of Care screening tools such as MCG clinical care guidelines, and evidence based Healthfirst policies for Mental Health treatment and LOCADTR 3.0 for Substance Use Disorder treatment and LOCADTR for Gambling Disorder Treatment.

9.2 Benefits and Access to Care

Benefits Overview

All Healthfirst Medicaid members have access to Behavioral Health services, including mental health and substance use disorder treatment.

For a list of the Level of Care (LOC) covered for Medicaid Mainstream and Health and Recovery Plan (HARP), refer to Section 9.1.

As of January 1, 2016, and October 1, 2019, an additional array of Adult and Children's Home and Community Based Services (HCBS) became available to members who meet specific eligibility criteria, as defined by New York State. These services are designed to provide opportunities for Medicaid beneficiaries with serious mental illness and/or chronic substance use disorders to receive person-centered, recovery-oriented services in their own community.

Program	Services
Adult Behavioral Health Home and Community Based Services (BH HCBS)	• Habilitation • Education Support Services • Prevocational Services • Transitional Employment • Intensive Supported Employment (ISE)
Community Oriented Recovery and Empowerment (CORE) Services*	• Psychosocial Rehabilitation • Community Psychiatric Support and Treatment (CPST) • Psychosocial Rehabilitation (PSR) • Empowerment Services – Peer Support • Family Support & Training (FST)
Children's Home and Community Based Services (HCBS)	• Caregiver Family and Support Services • Community Habilitation • Community Self-Advocacy Training and Support • Day Habilitation • Environmental Modifications • Palliative Care – Pain and Symptom Management • Palliative Care – Bereavement • Palliative Care – Massage Therapy • Palliative Care – Expressive Therapy • Prevocational Services • Respite – Planned • Respite – Crisis

Program	Services
	• Supportive Employment • Adaptive and Assistive Equipment • Non-medical Transportation

**Processed through Fee For Service (FFS)*

Access to Care and Authorizations

Members in need of services, or providers wishing to arrange services on behalf of a Healthfirst member, may call Member Services for information about network providers.

Healthfirst offers Behavioral Health Care Management by telephone for at-risk or high-risk members at no additional cost. Members who are receiving intensive outpatient services and those who are transitioning to lower levels of care may benefit from this program. In addition, our Clinical Services department can provide referral or assignment to Health Home Care Management for those members who meet eligibility criteria. For further information, or to refer a member for Healthfirst Behavioral Health Care Management or Health Home Services, please contact our Clinical Services department at 1 (888) 394-4327, or the delegated Behavioral Health Care management organization (as noted in the chart in Section 9.1).

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

Authorization is required for admissions, all out-of-network care, and select outpatient services such as Electroconvulsive Therapy (ECT), Neuropsychological Testing, Partial Hospital program, Intensive Outpatient Treatment (IOP), Assertive Community Treatment (ACT)*, and Home and Community Based Services (HCBS). Members in need of care, or providers wishing to arrange these services for Healthfirst members, should call our Clinical Services department at 1 (888) 394-4327 for assistance.

Concurrent review may be required for Medicaid, PWP/HARP, and CompleteCare members who have been enrolled in ACT continuously for at least 36 months AND have not used any acute behavioral health services (CPEP, psychiatric ER, or psychiatric inpatient).

Commercial Plans

Healthfirst Leaf and HMO A–D plans include the following mental health and substance use disorder benefits:

Mental Health Care: Outpatient services relating to the diagnosis and treatment of mental health disorders are covered, including:

- Outpatient services relating to the diagnosis and treatment of mental health disorders
- Partial hospitalization program services
- Intensive outpatient program service
- Inpatient services relating to the diagnosis and treatment of mental health disorders

Substance Use Disorder Services: Inpatient services relating to the diagnosis and treatment of substance use disorders are covered. These include:

- Detoxification and/or rehabilitation services as a consequence of substance use and/or dependency
- Outpatient services relating to the diagnosis and treatment of a substance use disorder
- 20 outpatient visits for family counseling. A family member will be covered as long as that family member:
    1) identifies himself or herself as a family member of a person suffering from substance use and/or dependency, and
    2) is covered under the same family contract that covers the person receiving treatment for substance use and/or dependency

Depending on the Healthfirst plan, the member may have a copayment or coinsurance, which will be applied towards his/her deductible.

9.3 Program Overview

The Behavioral Health Care Management and Utilization Management program is designed to maximize quality of care while providing services in a cost-effective manner. The program focuses on assisting providers in planning for, organizing, and managing the behavioral health services provided to Healthfirst members. Behavioral Health Care Management and Utilization Management staff collaborate with network providers, community-based organizations and service agencies, contracted vendor organizations, and other Healthfirst staff to ensure that high-quality care is provided at the most appropriate level by the most qualified mix of providers.

The Healthfirst Behavioral Health department is responsible for the following areas:

- Notification process
- Authorization review
- Concurrent review
- Continuity of care
- Care coordination/care management

Healthfirst offers a transitional care management program to members returning to the community from inpatient behavioral health treatment settings. This program provides enhanced care coordination and community-based support at no cost to our members.

For additional information about Behavioral Health program components, please refer to Appendices 18.1 and 19.1, and manual subsections 12.3–12.6, and 13

9.4 Utilization and Medical Management Guidelines

Authorization of Services

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

Admissions and outpatient services like Electroconvulsive Therapy (ECT), Neuropsychological Testing, Partial Hospital program, Intensive Outpatient Treatment (IOP), Assertive Community Treatment (ACT), and Home and Community Based Services (HCBS) are subject to utilization and medical-necessity review to ensure that the most appropriate treatment and level of care are being provided. Authorization from the Healthfirst Behavioral Health department or the delegated Behavioral Health organization as outlined in Section 9.1 is required. Providers affiliated with the Behavioral Health organization operate under a delegated arrangement with Healthfirst and must comply with that organization’s authorization policies and procedures, as well as with those of Healthfirst.

General Requirements

Providers must get authorization for all admissions, selected outpatient services, and out-of-network care. The following information must be supplied when requesting authorization of services:

- Healthfirst Provider ID number
- Member’s name and Healthfirst ID number
- Attending/requesting provider’s name and telephone number
- PCP’s name (if not the attending/requesting provider)
- Diagnosis and ICD-10 Code
- Procedure(s) and CPT-4 Code(s) and procedure date(s)
- Services requested and proposed treatment plan

- Clinical documentation to demonstrate medical necessity
- For inpatient admissions: hospital/facility name, expected date of service, and expected length of stay
Please be sure that ALL the above information is available when calling in the request.

Authorization of Services When Healthfirst Manages Care

Providers must contact the Healthfirst Clinical Services department at 1 (888) 394-4327 to speak with a Clinical Intake Coordinator to ensure that all care is appropriately authorized. For ACT and Adult BH-HCBS, providers may also fax authorization requests to 1 (646) 313-4612.

Requests for authorization with the corresponding clinical information may also be submitted through the Provider Portal. Authorization status may be checked through this website as well. After requesting an authorization, providers are given a notification number that can be used to obtain authorization status. This notification number can be used within two (2) to three (3) business days after Healthfirst has received all the medical-necessity information.

Healthfirst Treatment Principles

Healthfirst has developed general treatment principles and guidelines for outpatient behavioral health services. They are consistent with established clinical practice and standards for behavioral health treatment. The principles are:

1. **Therapeutic Environment**: An appropriate therapeutic environment must include face-to-face, in-person contact between the therapist and the member.
2. **Duration of Therapy Sessions**: Individual therapy sessions should ordinarily be a minimum of 30 (thirty) minutes, customarily 45 (forty-five) minutes, unless they are only for medication management by a psychiatrist.
3. **Group/Family/Couple Therapy:** Sessions are usually required to run between 45 (forty-five) and 90 (ninety) minutes, unless they are for crisis intervention. Crisis intervention sessions ordinarily should not exceed two (2) hours per day for individual therapy or three (3) hours per day for family therapy.
4. **Individual Psychotherapy:** Only one (1) therapist may provide individual psychotherapy to a member; therefore, separate claims should not be submitted when two (2) or more therapists are treating the same member concurrently. Ordinarily, no more than two (2) family members should receive individual therapy from the same provider. When more than two (2) family members require treatment, the provider would be expected to use family therapy as the treatment of choice.
5. **Composition of Therapy Group**: Group therapy sessions usually consist of four (4) to 10 (ten) members, unless they are multifamily or multi-couple groups.
6. **Electroconvulsive Therapy (ECT):** Psychotherapy should not be rendered within 24 hours of ECT. Conventional practice does not recognize more than one (1) ECT treatment per day or more than 12 (twelve) ECT treatments in a 30 (thirty)-day period. Indications for a greater number of treatments should be discussed with a Healthfirst psychiatrist.
7. **Pharmaceuticals**: The use of prescription medications should follow national professional standards.
8. **Contraindications for Psychotherapy:** Psychodynamic psychotherapy is generally considered inappropriate for members with a sole diagnosis of organic brain syndrome, substance abuse or chemical dependence, or developmental disorders.
9. **Documentation:** Documentation regarding the member’s progress should reflect movement toward defined treatment goals with measurable objectives. When a member’s diagnosis or treatment plan is changed, the documentation should include clinical information substantiating the reasons for the change.

10 Ancillary and Other Special Services

10.1 Overview of Services and the Provider Network

Healthfirst has arrangements in place to provide a full range of ancillary and other special services to its members, depending on the program in which they are enrolled. These services include:

- Adult and Social Day Care
- Ambulatory Surgery Center
- Audiology and Hearing Services
- Cardiac Monitoring
- Community Care Management (AIDS Institute–defined)
- Chiropractic Services (Medicare and Commercial)
- Dental Care
- Diagnostic Imaging Services
- Dialysis
- Durable Medical Equipment (DME)
- Home Healthcare and Home Infusion Therapy
- Hospice
- Laboratory Services
- Mental Health
- Orthotics and Prosthetics
- Outpatient Rehabilitation
- Personal Care Services
- Physical/Occupational/Speech Therapy
- Routine Vision Care
- Nursing Home and Custodial Care
- Substance Use Disorders
- Transportation

This section of the Provider Manual describes the scope of services and network arrangements in place for selected ancillary and special services covered by Healthfirst. Please refer to Appendix XI for additional instructions on referral and prior authorization guidelines for Ancillary Services.

Ancillary Services Provider Responsibilities

Healthfirst expects participating ancillary service providers to adhere to the following service guidelines:

- When ordering services for a member, identify the member as a Healthfirst member and provide the member's Healthfirst ID number as well as his or her own Healthfirst provider ID number.
- Promptly report all findings, clinical reports, test results, and recommendations to the PCP and/or ordering provider in writing, by mail or fax.
- Consult the Healthfirst Medical Management staff to obtain required authorization for services.
- Collaborate with the member's PCP and Medical Management staff to ensure continuity of care and appropriate integration of services
- Ensure that all arranged services are provided by other Healthfirst participating providers, unless otherwise authorized in advance by Healthfirst. As an example, anesthesia services provided to Healthfirst members at Ambulatory Surgery Centers must be performed by in-network anesthesia providers.

10.2 Laboratory

Laboratory services are provided by Healthfirst Preferred Laboratory network of Clinical Diagnostic Laboratories including Healthfirst participating hospitals and several Specialty Laboratories in Genetics, Pathology, Dialysis Testing

and Toxicology. Providers must comply with service delivery system guidelines for referring members to laboratories. Please note that services sent to out-of-network laboratories will not be paid, and the members will be held harmless. Refer to the Provider Directory for a complete list of laboratories and drawing stations.

10.3 Pharmacy

Programs and Covered Services

Pharmacy services are covered for the Medicaid, Personal Wellness Plan (PWP), Child Health Plus, Essential Plan, Leaf Plans, Commercial and Medicare lines of business. To determine whether a member has pharmacy coverage for a specific product, please refer to the member's Healthfirst ID card for the line of business in which the member is enrolled.

Healthfirst members should present their Healthfirst identification cards to pharmacy staff when accessing pharmacy services.

Healthfirst Resources:

- A comprehensive formulary is available on the Healthfirst website at **https://healthfirst.org/formularies/**
- Pharmacy services are provided by the Healthfirst pharmacy benefit manager (PBM), CVS Caremark, and its network of participating pharmacy providers. If there are any questions, call Healthfirst Provider Services at 1 (888) 801-1660 for Medicaid, Personal Wellness Plan (PWP), Essential Plan, Child Health Plus, Commercial, and Leaf Plans, and 1 (888) 260-1010 for Medicare
- A list of participating pharmacies is available online (for all lines of business) at **https://healthfirst.org/find-a-doctor**

Please note that members who participate in the Restricted Recipient Program may be restricted to a pharmacy and/or provider chosen by Healthfirst.

All prescriptions must be filled at a Healthfirst participating pharmacy. Healthfirst may require prior authorization of certain items and medications filled via the pharmacy benefit. To help your members maximize their pharmacy benefit, consider the following:

Prescription Formulary	Healthfirst plans with drug coverage have a restricted formulary. Providers are encouraged to consider the comparative cost and efficacy of pharmaceutical alternatives when prescribing medication for Healthfirst members. As part of the Healthfirst prescription drug plan, pharmacists may contact providers to discuss whether an alternative drug might be appropriate for the member. A provider can help a member to file a request for an exception to cover a nonformulary prescription. All prescription coverage exception determinations are made by CVS Caremark, Healthfirst's pharmacy benefits manager (PBM). All of the formularies for Medicaid, Personal Wellness Plan (PWP), Essential Plan, Child Health Plus, Leaf Plans, and Medicare lines of businesses are available on our website at **https://healthfirst.org/formularies/**
Generic Medications	Healthfirst strongly encourages the use of generic drugs when clinically appropriate. The member's copayment will be less if a generic equivalent is prescribed. Eligible Medicare plan members can get over-the-counter (OTC) nonprescription medications and health-related items at participating locations. Some plans offer healthy foods and produce in addition to the OTC benefit. Upon enrollment, eligible members will receive a Healthfirst OTC or Healthfirst OTC/Healthy Foods and Produce card with a prefunded monthly benefit allowance. A member with an activated card is free to use the allowance to purchase eligible items (i.e., aspirin, cold & flu relief medications, adhesive bandages, healthy foods, and produce on select plans) at any participating OTC network location. To purchase items, members will take their eligible items to the front checkout lanes of a participating store and swipe the OTC card (not their Member ID card) at any register. Purchases for eligible items are automatically deducted from the member's card balance. Any remaining

	balance will carry over until the next purchase. Any unused balance automatically expires at the end of the month or upon disenrollment from the plan. If a member makes a purchase of an eligible item at a store without the necessary technology, he/she may submit an Over-The-Counter (OTC) Reimbursement Claim Form with proof of purchase. This form is available at https://healthfirst.org/OTC or by calling Member Services.
Specialty Medications	Specialty medications are available via CVS Caremark, Healthfirst's pharmacy benefits manager (PBM), specialty pharmacy network. **Items or Medications Excluded from Medicare Part D Coverage** • Needles or syringes (except for diabetes) • Appetite suppressants • Erectile dysfunction medication • Growth hormones are covered under a member's medical benefit when medically necessary • Prescription vitamins • Cosmetic drugs, Rogaine (Minoxidil) • Anabolic steroids • Fertility agents
Medical Pharmacy	Healthfirst requires prior authorization (PA) for select medications provided under the medical benefit that are administered on an outpatient basis by a provider. Healthfirst reviews medical pharmacy prior authorization requests. The complete list of medications requiring prior authorization is updated monthly via the document titled "Medications Requiring Prior Authorization Under the Medical Benefit" and can be found in the Provider Resource Center via Healthfirst's Provider Portal (https://hfproviderportal.org) Since the "Medications Requiring Prior Authorization Under the Medical Benefit" document is updated often, Healthfirst encourages reviewing the document regularly. Requests for medications requiring prior authorization under the medical benefit can be submitted: • **Online**: Log in to the Healthfirst Provider Portal at https://hfproviderportal.org, navigate to the "Online Authorization Request" tab, once a member is identified click "Begin", select Outpatient as Request Type, then select "Outpatient Pharmacy" as "Authorization Type" • **Phone:** Call Provider Services at 1 (888) 801-1660, Monday to Friday, 8:30am–5:30pm • **Fax:** 1-212-801-3223 (Note: DO NOT use for pharmacy benefit authorizations via CVS Caremark)

10.4 Durable Medical Equipment (DME), Orthotics and Prosthetics, and Medical Supplies

DME, along with orthotics and prosthetics, are covered benefits for Healthfirst members who require such services to aid in the treatment of illness or injury or to improve bodily function. The provider must document in the member's medical record that these items are medically necessary.

DME may be obtained through a participating DME provider with a provider's written order and the appropriate authorization from Healthfirst. Some DME are available through NYRx for Medicaid and PWP members. For information about NYRx DME coverage, contact 1 (800) 342-3005

If a member is receiving home healthcare services, DME is obtained from the home healthcare provider. This may be a hospital-owned or hospital-operated certified home health agency (CHHA) or another contracted home health agency or home infusion therapy provider. Members who are not receiving home healthcare services may be referred to, or may have their provider order directly from, DME and/or orthotic and prosthetic vendors that participate with Healthfirst. Healthfirst follows CMS guidelines as they relate to rental periods for all contracted providers.

DME and orthotic and prosthetic vendors must obtain prior authorization from Medical Management for all items. Diabetic test strips and glucometers are limited to Bayer (Contour Next products), Healthfirst's exclusive, preferred manufacturer. The specific covered diabetes products can be found on the Healthfirst comprehensive formularies' page: **https://healthfirst.org/formularies/**

When prescribing DME for Healthfirst members, please fax prescriptions and clinical notes to 1 (646) 313-4603. This provides the fastest turnaround time for patients on products like nebulizers, walkers, wheelchairs, etc. For questions on specific products or coverage, please call Provider Services at 1 (888) 801-1660.

10.5 Home Healthcare

Healthfirst members are eligible to receive medically necessary home healthcare services provided by a Certified Home Health Agency (CHHA). Some Healthfirst members may also be eligible to receive medically necessary Private Duty Nursing services provided by a Licensed Home Care Service Agency (LHCSA).

Home care providers participating with Healthfirst include CHHAs maintained by member hospitals, other contracted CHHAs, and for some products, contracted LHCSAs. For a listing of participating CHHAs and LHCSAs, see the Provider Directory.

Certified Home Health Agency Services and Eligibility

The services listed below comprise the scope of covered home healthcare benefits:

- Intermittent or part-time nursing visits rendered by a registered nurse
- Intravenous therapy as ordered by a provider
- Home health aide services provided under the direction and supervision of a registered nurse. Other services to be delivered in the home setting as requested by the PCP or attending specialist and approved by Medical Management
- DME, oxygen, respiratory devices, and other equipment and supplies required to care for the member in the home
- Treatment adherence home assessments for some members on Highly Active Anti-Retroviral Therapy (HAART)

In order to be eligible to receive home healthcare services, members must meet all of the following criteria:

- be confined to the home
- be under a plan of treatment established and periodically reviewed by a provider
- be in need of intermittent skilled nursing care, physical therapy, speech therapy, or, in certain situations, occupational therapy

Responsibilities of Certified Home Health Agencies

All participating CHHAs must complete the following steps when providing care for Healthfirst members.

- Verify member eligibility through eMedNY for Medicaid members or by calling Member Services at 1 (866) 463-6743
- Develop a treatment plan based on an assessment of the member's physical, psychological, and social needs
- Obtain the signature of the provider who initially recommended home healthcare services on the treatment plan
- Call Medical Management at 1-888-394-4327 for prior authorization of services

- If changes to the treatment plan are required within the period for which home health services have been approved, the CHHA will notify the PCP or specialist and will contact Utilization Management to obtain further authorization
- If the duration of the home healthcare service period needs to be extended, the CHHA shall notify the treating provider and shall obtain authorization from Healthfirst for the extension. Healthfirst will also notify the PCP or specialist of authorized changes
- If DME is required as part of the approved treatment plan, the CHHA shall request separate and simultaneous prior authorization of the home healthcare treatment plan and associated DME and/or home infusion therapy from Healthfirst
- Issue the Healthfirst Notice of Noncoverage to Medicare members two (2) days prior to end of services and retain a signed copy of the notice. CHHA must provide Healthfirst with notice by close of business when requested for QIO appeal. The provider shall be responsible for those services in which the Notice of Noncoverage is not issued to the member with the appropriate signatures within the required time frames.

Licensed Home Care Agency Services and Eligibility

The services listed below are covered LHCSA Home Care benefits:

- Private Duty Nursing services to be delivered in the home setting as requested by the PCP or attending specialist and approved by Medical Management
- 14 days Care Giver Respite per calendar year. Request should be made 6 weeks in advance.
- In order to be eligible to receive Private Duty Nursing home healthcare services, members must meet all of the following criteria:
    - be under a plan of treatment established and periodically reviewed by a provider
    - be in need of more individual and continuous skilled nursing care that exceed the amount and scope of nursing services that a CHHA may provide
    - requires nursing services that exceed the amount and scope of nursing services that a CHHA may provide
    - be in need of skilled services that are so inherently complex that they must be performed by a skilled or technical person and cannot be provided by an available non-skilled person/caregiver who has been trained

Responsibilities of Licensed Home Care Service Agencies:

- Verify member eligibility through eMedNY for Medicaid members or by calling Member Services at 1 (866) 463-6743
- Develop a treatment plan based on an assessment of the member's physical, psychological, and social needs
- Obtain the signature of a treating provider
- Call Medical Management at 1 (888) 394-4327 for prior authorization of services
- If changes to the treatment plan are required within the period for which home health services have been approved, the LHCSA will notify the PCP or specialist and will contact Utilization Management to obtain further authorization
- Notify Healthfirst when a member has had improvement and no longer requires the same level/frequency of nursing
- Send new orders reflecting these changes to the MD for signature
- LHCSA is expected to collaborate with Healthfirst to develop an appropriate Plan of Care
- Healthfirst requires an attestation signed by the treating provider with orders to accompany any request for Private Duty Nursing
- Healthfirst requires the LHCSA to inform us via fax or the provider portal when a member has refused nursing shift(s), or any adverse events, unsafe situations, or sentinel events. The reasons for refusal or any details regarding the event must be included with this notification.

Prior Authorization Process: General Guidelines

Home healthcare providers are responsible for obtaining authorization from Utilization Management before providing services. Home healthcare services must be coordinated with the member's PCP or attending specialist in accordance with the prescribed plan of care. It is expected that home care providers will inform members under their care about specific healthcare needs requiring follow-up and will teach members appropriate self-care and other measures to promote their own health. Medical necessity guidelines are used to determine the appropriateness of setting for home healthcare. Home healthcare services are not intended solely for convenience or for activities of daily living or other custodial needs. Please refer to Section 6.1 for an explanation regarding Long Term Services and Supports.

Please note: If the only service required is venipuncture, it will not qualify for the Healthfirst Medicare Plan home health benefit. Insulin shots for members who are incapable of self-administration are a covered benefit in the home.

Healthfirst members may be referred for home healthcare services by PCPs, specialists, or hospital discharge planners by one of the following methods:

Referrals to Hospital-Owned or Hospital-Operated Home Health Agencies

When a Healthfirst member is referred to a participating hospital-operated home health agency for home care services, the referral must be made by the member's PCP, the attending specialist, or a hospital discharge planner with approval from the appropriate provider. Referral policies and procedures are based on the current home healthcare referral process of the participating hospital. Home care services must be pre-authorized by Healthfirst.

Referrals to Other Contracted Certified Home Health Agencies

When a Healthfirst member in Nassau or Suffolk County is referred for home healthcare or home infusion services to a contracted CHHA other than a hospital-owned or operated agency, the referring provider must contact Medical Management at 1 (888) 394-4327 to pre-authorize services through a participating home health agency. Medical Management staff will work with the referring provider to confirm the agency's participation status with Healthfirst and to direct the referral to the appropriate individual responsible for developing a plan of care and initiating services.

10.6 Dental

Healthfirst provides dental benefits through a third-party benefits manager, DentaQuest. DentaQuest maintains a comprehensive network of dental providers and should be contacted to arrange treatment as indicated. To become part of the DentaQuest network, contact them directly at 1-800-233-1468 or go to their website at DentaQuest.com to complete a provider enrollment form.

To check eligibility for a Healthfirst member, providers can contact DentaQuest's Provider Services line at 1-888-308-2508. To assist Healthfirst members in obtaining dental services, please contact DentaQuest Member Services at 1-800-508-2047.

Note: HIV-positive members may select an HIV specialist dentist by contacting the DentaQuest Member Services department.

Specialty Dental Care

In addition to preventive dental services, the network includes specialty care dental providers such as endodontists and oral surgeons. These providers see Healthfirst members without a referral but with approvals obtained from the delegated vendor.

However, there are specific situations where providers may need to request prior authorization from Healthfirst:

- **Oral Surgery Requiring General Anesthesiology in a Hospital Setting:** In these situations, DentaQuest authorizes and reimburses *oral surgery services*. Healthfirst authorizes and reimburses *anesthesia services* delivered.

- **Oral Surgery Treating Head and Neck Cancers:** After receiving a referral from the member's PCP, the oral surgeon must submit a prior authorization request to Healthfirst's Medical Management department. All services are authorized and reimbursed by Healthfirst.

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10.7 Routine Vision

Healthfirst members are entitled to routine eye examinations and eyeglasses provided through EyeMed, a delegated vendor. Members may access these services without a referral from the PCP by making an appointment and presenting their Healthfirst identification card at the office of the appropriate vision care provider. Information on the vision care benefits and the vision care network is provided in the Member Handbook and in the Provider Directories.

Information on vision care benefits and the vision care network is provided in the Member Handbook and in the Provider Directories. Members may contact EyeMed at the following numbers:

Product	Contact
Medicare	Toll Free Number 1 (844) 844-0881
CompleteCare	Toll Free Number 1 (844) 844-0882
Senior Health Partners	Toll Free Number 1 (844) 844-0883
Signature HMO	Toll Free Number 1 (844) 844-0884
Signature PPO	Toll Free Number 1 (844) 844-0885
Medicaid *Including Medicaid Managed Care, Personal Wellness Plan (PWP/HARP) Child Health Plus (CHPlus)*	Toll Free Number 1 (844) 844-0886
Commercial *Including Essential Plans, Qualified Health Plans, Employer Groups*	Toll Free Number 1 (844) 844-0887

10.8 Hospice – Medicaid, Personal Wellness Plan, CHPlus, Leaf Plans, Commercial, and Medicare

Hospice is a coordinated program that is designed to provide comfort and alleviate the symptoms caused by a terminal illness. Under Medicare an individual is "terminally ill" when they have a medical prognosis of six months or less if the illness runs its normal course. The hospice benefit covers provider services; nursing care; pain and symptom management; physical, occupational, and/or speech therapy; home health aide services; homemaker services; counseling; short term inpatient care; and respite care.

Hospice care requires prior authorization and is covered by Healthfirst's Medicaid, Personal Wellness, Essential, CHPlus, Leaf, and Commercial plans.

For the CompleteCare and Senior Health Partners plans, coverage is limited to room and board only.

Hospice is not covered under our Medicare product offerings. However, the benefit is covered directly by Medicare Fee for Service (Original Medicare) and prior authorization is required. Note: Healthfirst Medicare will continue to cover treatment for conditions other than the terminal illness. For Medicare Fee for Service: the beneficiary (or his or her representative) must file and sign an election statement with the hospice provider. Additionally, the Social Security Act requires that the individual or representative electing hospice must acknowledge that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the individual's terminal prognosis; and must acknowledge that he/she waives the right to payment of standard Medicare benefits for treatment of the terminal illness and related conditions. If a Healthfirst Medicare member meets the following criteria, he or she should consider electing Medicare's hospice services:

- Member is entitled to Medicare Part A
- Member has a terminal illness as certified by their PCP
- Member has a life expectancy of less than six (6) months
- Member will waive the right to receive treatment for the terminal condition from any provider other than the hospice and attending providers

10.9 Transportation

Emergency Transportation

All Healthfirst members are eligible for emergency transportation benefits. To obtain emergency transportation to the nearest emergency facility when there is a life-threatening situation, dial 911.

Non Emergency Transportation (NEMT)

If a member has a non-emergent medical condition but requires an ambulance, ambulette, stretcher ambulette, or livery service to access medical care, the provider/member must notify the appropriate transportation service **72 hours** before the transportation is required.

See below for contact information based on a member's plan and/or location:

<table>
<tr><th>Member Plan</th><th>Location</th><th>Non Emergency Transportation Contact</th><th>Transportation Requiring Advanced Life Support (ALS)/Basic Life Support (BLS)</th></tr>
<tr><td rowspan="2">CompleteCare</td><td>NYC, Nassau, and Westchester Counties</td><td>Medical Answering Services (MAS)
Website: Medanswering.com
Downstate: 1-844-666-6270</td><td rowspan="2">Healthfirst Member Services
Phone: 1-888-260-1010.
English TTY: 1-888-542-3821
Spanish TTY: 1-888-867-4132

ModivCare TripCare Portal
www.modivcare.com</td></tr>
<tr><td>Orange, Rockland, and Sullivan Counties</td><td>Medical Answering Services (MAS)
Website: Medanswering.com
Upstate: 1-866-932-7740</td></tr>
<tr><td rowspan="2">Medicaid and Essential Plans 3&4</td><td>NYC, Nassau, and Westchester Counties</td><td colspan="2">Medical Answering Services (MAS)
Website: Medanswering.com
Downstate: 1-844-666-6270</td></tr>
<tr><td>Orange, Rockland, and Sullivan Counties</td><td colspan="2">Medical Answering Services (MAS)
Website: Medanswering.com
Upstate: 1-866-932-7740</td></tr>
<tr><td>Medicare Plans</td><td>All Counties</td><td colspan="2">Healthfirst Member Services
Phone: 1-888-260-1010.
English TTY: 1-888-542-3821
Spanish TTY: 1-888-867-4132

ModivCare TripCare Portal
www.modivcare.com</td></tr>
</table>

Member Plan	Location	Non Emergency Transportation Contact	Transportation Requiring Advanced Life Support (ALS)/Basic Life Support (BLS)
Senior Health Partners (SHP) See Section 3.3 in Healthfirst's SHP Manual	NYC, Nassau, and Westchester Counties	**Medical Answering Services (MAS)** **Website:** Medanswering.com **Downstate**: 1-844-666-6270	

For transportation requests managed by **Healthfirst**, providers/members will need to share the appointment date, time, address, and provider's name when calling member services or using the ModivCare TripCare Portal. A medical necessity form should be furnished for a member whose medical condition is such that other means of transportation are contraindicated. The member's condition requires both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

For transportation requests managed by **Medical Answering Services**, providers/members will need to use New York State Department of Health's Verification of Medicaid Transportation Abilities form: ***https://www.health.ny.gov/forms/doh-2015.pdf***

10.10 Custodial Long-Term Care Placement

If a Healthfirst member is enrolled with Community Medicaid and is being placed for custodial services, the Nursing Home must contact Healthfirst immediately to obtain an authorization. Healthfirst will provide a 90-day authorization for custodial care and the MAP 2159i form. For any issues regarding the MAP 2195i form, please contact Healthfirst at NursingHomeHF@Healthfirst.org.

Per DOH guidelines, the Nursing Home is responsible for compiling all required documentation for Long Term Care Placement (Custodial) approval from the State. The facility is responsible for compilation and submission of the below documentation:

- 2159i – Notice of Permanent Placement Medicaid Managed Care
- MAP 648P – Receipt for Submission of "Request" from Residential Health Care Facilities (RHCF); submit 2 copies – 1 copy will be returned to the RHCF as a receipt
- DOH 4220 – Access NY Health Care
- DOH 4495A – Supplement A
- MAP 2123 - Statement in support of claim
- MAP 3043 – Authorization to Apply for Medicaid on My Behalf
- MAP 3044 – Facility Submission of Application on Behalf of Consumer
- MAP 258M – Medicare Buy-In
- OCA-960 – Authorization for release of Health Information Pursuant to HIPAA
- Patient Review Instrument (PRI) – Pages 1–4
- Must submit a New Application for active in NYSOH (Health Benefits Exchange) clients If applicable:
- LDSS 486T – Medical Report Form
- LDSS 1151 – Disability Interview Form
- Signed HIPAA Releases (3 blank copies)
- MAP 252F – AIDS Medical Form
- MAP 259D – Discharge Alert & MAP 259H – Intent to Return Home

You may submit completed applications online through the Eligibility Data and Image Transfer System (EDITS) by registering with the MAP Authorized Resource Center (MARC).

If your facility is in New York City, you can also mail applications to:

Medical Assistance Program Nursing Home Eligibility Division
P.O. Box 24210
Brooklyn, New York 11202-9810

If your facility is in Westchester, Nassau, or Suffolk counties, you may mail applications to your Local Department of Social Services. For your Local Department of Social Services address, please visit www.health.ny.gov/health_care/medicaid/ldss.htm.

The LDSS/HRA has 45 days from the date of application to complete the eligibility determination, including a 60-month look-back period and transfer of asset review.

For SSI individuals, if a disability determination is required, the district has 90 days from the date of application or request for an increase in coverage to determine Medicaid eligibility. The district may exceed these time periods if it is documented that additional time is needed for a consumer to obtain and submit required documentation.

Proof Of Disposition Submission:

Facilities have 90 calendar days from the member's admission to the facility to provide Healthfirst with proof of application disposition status:

- **For approved status:** Healthfirst will extend the custodial authorization by 90 days
- **For denied status:** Healthfirst will issue a continued stay denial at day 75 for which the custodial authorization will term on day 90
    - **Note:** Failure to submit an application will result in a continued stay denial at day 75 for which the custodial authorization will term on day 90
- **For pending status**: Healthfirst will issue a one-time extension of the custodial authorization for 45 days to allow time for final disposition.

Healthfirst reserves the right to recoup all claims associated with dates of services for which no proof of State approval can be provided.

The only valid proof of State approval for purposes of claims reimbursement is a screenshot showing that the applicable N-code has been appended to the member's ePaces account retro to the dates of service at issue.

The initial authorization will be extended for a period of 180 days once the N code is noted in ePaces.

Net Available Monthly Income (NAMI):

NAMI is the amount of a nursing home resident's income that they are expected to contribute toward the cost of their care. This amount is determined by the Local Department of Social Services (LDSS)/Human Resources Association (HRA). A copy of the eligibility decision notice with the NAMI amount is sent to the nursing home. NAMI amount is subject to change based on a change in income or circumstance.

Nursing homes that are Healthfirst participating providers are responsible for collecting the NAMI and having the NAMI amount sent to Healthfirst, [in a manner agreed upon by both parties] unless the parties have negotiated other arrangements in the applicable Healthfirst provider participation agreement.

All NAMI and Spend Down payments for Senior Health Partners can be sent to:

Senior Health Partners
Accounts Receivable Department
P.O. Box 48344
Newark, NJ 07101-48344

Authorization Requirements

Nursing Home facilities must obtain authorization from Healthfirst before providing nursing facility services to an eligible Healthfirst member:

- Authorization may be requested by contacting Healthfirst's Care Management Team
- Healthfirst must be informed when any change to an authorized admission occurs.

Nursing Homes can request authorization for the following levels of care:

Skilled Nursing Services: non-permanent rehabilitation stays. See Appendix VIII for additional information.

Long Term Placement (Custodial) Services: medically necessary services for individuals not expected to return home or to a community setting.

- Facilities are responsible for timely submission of application to the LDSS/HRA for State approval of custodial services.
- Requests for retro-authorization of Long-Term Placement (Custodial) Services:
  - Healthfirst will only retro-authorize medically necessary services for a period of 60 days from the date of the request.
  - Healthfirst will not authorize requests for this level of care once a member has been discharged to the community.
- **Note**: There is no opportunity for "Short Term" Custodial Service authorization as it not contractually covered.

Alternate Level of Care (ALOC) Services: ALOC is considered medically necessary only for individuals who have an established discharge plan which cannot be executed due to one or more variables that must be resolved before discharge is completed.

- ALOC requests can only be considered prospectively (no retro-authorization requests will be approved).

Respite Care: scheduled temporary nursing home care for members who are normally cared for in the community. This level of care is meant to provide temporary relief for members' caregiver(s).

- Medical records submitted with authorization requests must indicate that there is a caregiver seeking relief.
- There must be a clear discharge plan in place prior to authorization confirming that member will be discharged back to the community with all prior services in place.
- Respite care authorization is limited to 42 calendar days per year.

Bed Hold Authorization

The nursing home must notify Healthfirst when a bed hold authorization is required. Below is Healthfirst's bed hold reimbursement policy:

For Members Under 21	Payment will be made at 100% of the Medicaid rate for hospital, therapeutic, and hospice leaves of absence. There are no day limits for these members.
For Members Over 21	Hospice related leaves of absence will be paid at 50% of the Medicaid rate otherwise payable to the facility for services rendered. We will not reimburse the facility for more than 14 days in any 12-month period. Hospital leaves of absence are not covered for these members unless the member is receiving hospice services in the nursing home. Therapeutic leaves of absence will be paid at 95% of the Medicaid rate otherwise payable to the facility for services rendered. We will not reimburse the facility for more than 10 days in any 12- month period.

Access to Care and Quality

Healthfirst closely monitors and coordinates care for members that reside in nursing facilities. Healthfirst will work with the facility on the below:

- Development of a Person-Centered Care Plan
- Arrangement of UAS-NY assessments every six months or when the enrollee's condition changes.
- The nursing facility must inform Healthfirst care management of a change in member Status and Sentinel Event to ensure UAS assessment is completed.

- Coordination with the nursing home to share assessment data.
- Review of service coverage and medical necessity
- Reauthorization of stays under concurrent review at identified intervals, as needed
- Ensuring that enrollees have a PCP.

The nursing facility must inform Healthfirst care management of member discharge to the community.

Discharge Planning

If a member chooses to transition back to the community, the Care Management team will work to assure the following:

- Coordination of a formal patient-centered discharge plan involving the member, the member's family, and nursing facility to develop and ensure a safe and appropriate discharge back into the community,
- That the nursing facility work with Healthfirst to reinstate community LDSS coverage, and
- That appropriate community supports are in place prior to discharge.

10.11 Chiropractic Services

On behalf of Healthfirst, American Specialty Health Group, Inc. (ASH) manages chiropractic services for our products. While all utilization management activities related to these services are delegated to ASH, Healthfirst retains ultimate responsibility for those activities. Requests for authorization of payment for chiropractic services must be submitted directly to the benefits manager. All authorization denials are reported to Healthfirst.

10.12 Surgical Procedures of the Eye

On behalf of Healthfirst, EyeMed manages surgical procedures of the eye for our products. While all utilization management activities related to these services are delegated to EyeMed, Healthfirst retains ultimate responsibility for those activities. Requests for authorization of payment for surgical procedures of the eye must be submitted directly to the benefits manager. All authorization denials are reported to Healthfirst.

10.13 Advanced Imaging and Radiology Services

On behalf of Healthfirst, eviCore manages advanced imaging and radiology services for our products. While all utilization management activities related to these services are delegated to eviCore, Healthfirst retains ultimate responsibility for those activities. Requests for authorization of payment for advanced imaging and radiology services must be submitted directly to the benefits manager. All authorization denials are reported to Healthfirst.

10.14 Physical, Occupational, and Speech Therapy

Healthfirst retains ultimate responsibility for physical, occupational, and speech therapy. Requests for authorization of payment for physical, occupational, and speech therapy must be submitted directly to Healthfirst. All authorization denials are also reported to Healthfirst.

10.15 Dialysis Policy

Dialysis is a treatment for individuals whose kidneys are failing. Dialysis treatments remove excess water and toxins from the blood for individuals whose kidneys can no longer perform these functions. Healthfirst covers two types of dialysis treatments for the treatment of both acute kidney ailments and end stage renal disease – Healthfirst covers both hemodialysis and peritoneal dialysis (please refer to your contract to determine which treatment type is reimbursable for your facility).

Dialysis services require preauthorization and are covered for all Healthfirst plans except for Senior Health Partners (our Managed Long Term Care option). The dialysis benefit is carved-out and should be billed to Medicaid Fee for Service directly. Additionally, there are out-of-network service limits for our Essential, Leaf and Commercial plans –

the dialysis benefit is limited to no more than 10 dialysis treatments by a Non-Participating Provider per Member per calendar year.

Servicing providers for individuals with End Stage Renal Disease (ESRD) must complete an End Stage Renal Disease Medical Evidence Report (CMS 2728 form) for all patients undergoing regular dialysis treatment after receiving a diagnosis of end stage renal disease. Completion of the form ensures both that patients' Medicare benefits are activated, and that the servicing provider is appropriately reimbursed for services rendered to these members. The form is due to CMS within 45 days of the date the member starts chronic dialysis treatment at the facility.

11 EMERGENCY CARE

11.1 Emergent Care

Healthfirst members are covered for inpatient and outpatient emergency care services within the Healthfirst geographic service area and when members are traveling in or visiting out-of-area locations.

Emergency services are reimbursed when an emergency medical condition exists or when a Healthfirst provider instructs the member to seek either in-network or out-of-network emergency care as is appropriate to the member's situation. Services must be provided by facilities or healthcare professionals qualified to render emergency medical care.

PRIOR AUTHORIZATION FROM HEALTHFIRST IS NEVER REQUIRED FOR REIMBURSEMENT OF AN EMERGENT MEDICAL CONDITION.

Definition of an Emergency Medical Condition

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

- Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Emergency Guidelines

When a Healthfirst member presents in the emergency room for care, the hospital is responsible for providing medically necessary and appropriate treatment. The hospital must contact the member's PCP as soon as possible to obtain clinical information that may be necessary to provide appropriate treatment.

If a member presents in the emergency room with a non-emergent condition: The hospital should contact the member's PCP and document that contact. The hospital is then responsible for deciding and carrying out the necessary and appropriate course of action. Referral to the member's PCP for non- emergency treatment may be arranged.

If the PCP is referring the member for emergency care: The PCP should send the member to his or her assigned hospital whenever possible or to the emergency room of the closest hospital. The PCP should contact the emergency room by telephone or fax to provide necessary medical information.

Members should be instructed to return to their PCP's office for follow-up, when appropriate, after an emergency room visit. If the member has received emergency care and the follow-up care cannot be safely postponed until the member returns, the member should be instructed to seek follow-up care from the appropriate out-of-area provider.

Emergency Inpatient Admissions

For emergency admissions, prior authorization is not required, but the treating facility or physician must contact Healthfirst within 48 hours of the admission or as soon as possible to ensure proper post-stabilization care and discharge planning. Providers should contact Utilization Management via the telephone and fax numbers listed in Section 1 or through the Healthfirst Information Exchange.

In addition, hospitals are responsible for contacting the member's PCP to advise of the proposed admission and to obtain any relevant information regarding the member's condition, medical history, and other relevant information.

- Healthfirst PCPs who practice in private, community-based settings and do not have admitting privileges at Healthfirst hospitals (Level III providers) should contact their hospital liaison to arrange for admission to the appropriate participating hospital in emergency situations as well as in elective cases.
- If a Healthfirst member is hospitalized for emergency care in a nonparticipating institution, Healthfirst will cover the cost of the emergency services and the cost of all medically necessary inpatient days until such time as the member may be safely transported to a participating facility. Healthfirst's Utilization staff will work with staff at both hospitals to arrange the transfer when the member's attending provider judges it to be safe.

11.2 Urgent Care

Definition of Urgent Medical Condition

Urgent medical conditions are illnesses and injuries of a nature less serious than emergencies but that require services to prevent a serious deterioration of a member's health, and which cannot be delayed (1)without posing an undue risk to the member's well-being or (2) until the member either returns to the Healthfirst service area or can secure services from his or her regular provider.

If the member is within the Healthfirst geographic service area and an urgent medical situation arises, they should contact the PCP to get care on an urgent basis. The PCP may see the member in the PCP's office or may refer the member for treatment of an urgent but non-emergent condition in an urgent care center. If the PCP refers the member to a nonparticipating urgent care center or provider, an authorization from Healthfirst is required. The PCP should document this contact with the member and the recommended course of action in the member's medical record. If the member is out of area when urgent care services are required, the PCP should be contacted as soon as possible for direction, but the member should seek appropriate care in the immediate location.

Medically necessary emergency services and medical care for stabilizing or evaluating an emergency condition do not need prior authorization. If a member believes that a medical emergency exists, they should go to the nearest emergency room or call 911.

12 Medical Management

12.1 Program Overview

The Healthfirst Medical Management Program has been designed to maximize the quality care delivered to Healthfirst members. The program focuses on assisting providers in collaboration with

members/caregivers in planning for, organizing, and managing the healthcare services provided to Healthfirst members to promote member health and well-being. Information and data collected through utilization management procedures are used by the Utilization Management (UM) department to properly allocate resources and to foster efficient and effective care delivery. The Utilization Management

program emphasizes collaboration with network providers, contracted vendor organizations, and other Healthfirst staff to ensure that high-quality healthcare is provided at the most appropriate level by the most qualified panel of providers.

The Utilization Management department is responsible for the following areas:

- Authorization and Notification Processes
- Continuity of Care
- Concurrent and Retrospective Review

Each of these program components, except for Care/Disease Management, is discussed in detail in the following subsections of Section 12. The Healthfirst Care/Disease Management Program is described in Section 13 of the Healthfirst Provider Manual.

12.2 PCP-Directed Care

Providers do not need to submit referrals to Healthfirst for approval when referring to participating providers in the Healthfirst network.

There are no non-emergent, out-of-network benefits for any plan other than Signature (PPO). Except for the Signature (PPO) plan, if the provider wishes to refer a member to a nonparticipating provider, the provider must obtain approval from Healthfirst's Utilization Management department. Please see subsection 12.4 for more information on how to refer members out of network.

General Guidelines

The following guidelines may assist in ensuring referrals are appropriately managed:

- Members should be directed to participating specialists who can best communicate with the member in accordance with the principles of cultural competence. This is to ensure optimal communication between providers and members of various racial, ethnic, and religious backgrounds, as well as individuals with disabilities. For example, members should be referred to specialists who speak the member’s language when the member does not speak or understand English. The Provider Directories provide data on languages spoken by the provider as well as other relevant information, or you may contact Utilization Management for assistance.
- Specialists may assume primary care responsibility for members with life-threatening, degenerative, or disabling conditions requiring prolonged specialty care services. In certain cases, it is more effective for a specialist or specialty care center to manage the full spectrum of care for a particular member. Under these circumstances, the member’s PCP should contact Utilization Management to arrange for the member’s primary and specialty care services to be coordinated and managed by a designated specialty care provider with expertise in the member’s condition.
- Every pregnant/postpartum person must have a principal maternal care provider. However, the designated primary care provider will remain the primary care provider for the pregnant/postpartum person during the pregnancy and postpartum period. When appropriate, the designated primary care provider may also be the

principal maternal care provider. Per NY State Perinatal Standards (https://www.health.ny.gov/health_care/medicaid/standards/perinatal_care/), the principal maternal care provider functions as the pregnant/postpartum person's main maternal care provider and is responsible for leading and coordinating the pregnant/postpartum person's obstetric care throughout the course of the pregnancy and postpartum period. The primary maternal care provider must encourage and assist the pregnant/postpartum person in obtaining necessary medical, dental, mental health, substance use, nutritional, and psychosocial services appropriate to their identified needs as well as refer to the appropriate specialists or community resources. If the PCP and principal maternity provider are not the same person, the PCP is still responsible for encouraging/assisting in obtaining these necessary services. If possible, the PCP, the Ob/Gyn, or the office staff should assist the member in making appointments with specialists and should provide directions to the specialist's office. This is important for ensuring member compliance with specialty referrals and for obtaining prompt access to specialty services for members requiring urgent care. Please see Section 7.2 for additional details. Medicaid members and certain Medicare members are entitled to transportation assistance. Please see Section 10 for additional details.

Ancillary Services

The PCP or specialty care provider may refer a member for ancillary services, such as laboratory or routine X-ray services, by filling out a prescription to order these services.

Prior authorization from Healthfirst-delegated entities, including, but not limited to, radiology, dental, and vision care, is required. Refer to Section 10 and Appendix XI for additional information on this process. Please refer to Appendix XI-B for Leaf Plan provider authorization requirements.

Behavioral Health and Chemical Dependency Services

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

Authorization for routine in-network outpatient behavioral health services is not required. Please note that admissions and the following outpatient services: ECT, neuropsychological testing, partial hospital program, and intensive outpatient treatment, are subject to utilization and medical-necessity review to ensure that the most appropriate treatment and level of care are being provided. Authorization from the Healthfirst Behavioral Health department or the delegated behavioral care management organization is required.

12.3 Authorization of Services

General Requirements

With the exception of emergency care, providers must obtain prior authorization from Healthfirst's Utilization Management department for acute inpatient admissions; selected outpatient procedures, medications, and services, including certain ancillary services; and all out-of-network care. Prior authorization may be requested by the member's PCP or by the specialist. These requirements apply to all Healthfirst HMO plans. Signature (PPO) does not require authorization for out-of-network services.

The following information must be supplied when requesting prior authorization of services:

- Member's name and Healthfirst ID number
- Attending/requesting provider's name and telephone number
- PCP's name (if not the attending/requesting provider)
- Diagnosis and ICD-10 Codes
- Procedure(s) and CPT Code(s) and procedure date(s)
- Services requested and proposed treatment plan
- Medical documentation to demonstrate medical necessity

- For out-of-network services, a letter of medical necessity written by a contracted specialist with justification indicating that the medically necessary treatment is not available in network
- For inpatient admissions: hospital/facility name, expected date of service, and expected length of stay

Please be sure that ALL of the above information is included when you submit a request for prior authorization. If you are calling in the request, please have the information available when you call Utilization Management.

Healthfirst Level III PCPs who do not have admitting privileges at a Healthfirst hospital must contact Healthfirst's Utilization Management department to arrange for elective admissions. In these situations, the PCP, not the admitting liaison, is responsible for obtaining prior authorization.

Please note: Adverse determinations will be made by a clinical peer reviewer.

Standard Timeframes for Prior Authorization Determinations

Utilization Management will make a preauthorization determination within three (3) business days of receipt of all necessary information to make the determination. Providers should submit all necessary information as soon as possible, but in any event no later than 10 (ten) calendar days of receipt of a request from Healthfirst.

If after review of the requested information it is determined that the request does not meet medical necessity criteria or benefit coverage limits, or if the requested information is not received in a timely manner, our Clinical Peer Reviewer will render an adverse determination. If Healthfirst failed to attempt to contact the provider prior to issuing an adverse action, the provider will have the opportunity to request an informal reconsideration of the adverse determination for Medicaid and Commercial plans. If Healthfirst attempted to contact the provider, then the only option for reconsideration is a formal appeal. For Medicare, providers will have the opportunity to request a formal appeal of the adverse determination.

If Healthfirst fails to reach a determination within the required timeframes for Standard or Expedited Determinations noted in this section, it is considered an adverse determination subject to appeal. Healthfirst will send notice of denial on the date review timeframes expire.

Notices of determination decisions are issued to the requesting provider and the member, or to the member's representative, as appropriate. Authorization for services is valid for 90 (ninety) days from the date of issue for most medical/surgical services.

After requesting an authorization, providers are given a notification number that can be used to obtain authorization status. Authorization status may be checked at healthfirst.org/providers. Please allow up to 24 (twenty-four) hours after the authorization is issued for it to be posted on the website.

Expedited Determinations

A Healthfirst member or provider may request an expedited determination regarding service authorization under the following circumstances:

- The request is for healthcare services or additional services for a member undergoing a continued course of treatment.
- The standard process would cause a delay that poses a serious or imminent threat to the member's health.
- The provider believes an immediate determination is warranted.

All requests for expedited determinations must be made by contacting Utilization Management at 1 (888) 394-4327 and faxing documentation containing support for the expedited determination to 1 (646) 313-4603.

If Healthfirst determines that a member's request does not meet the criteria for an expedited determination, the request will be processed automatically under the standard timeframes indicated above, and the member will be notified verbally and in writing of this decision. If a provider requests or supports the member's request for an expedited determination, Healthfirst must expedite the process. The provider/member requesting the expedited

organization determination request will be notified as to Healthfirst's decision orally as fast as the member's condition requires, and in any event within 72 (seventy-two) hours of receipt of the request, and written notice will follow for Healthfirst Commercial, Medicaid, and Medicare plan members and within 72 (seventy-two) hours for all other Healthfirst plans.

Authorization of Inpatient Admissions: Elective Admissions

All elective inpatient admissions require prior authorization. This applies to hospital admissions for medical/surgical services, as well as to facility admissions for inpatient behavioral healthcare and substance abuse services, as well as to Skilled Nursing Facility and Acute Rehab admissions. The prior authorization process allows for pre-admission review of the proposed hospitalization.

Out-of-network providers servicing Signature (PPO) members are encouraged to obtain a pre-service determination prior to an elective admission.

Elective admissions must be scheduled in advance of the hospitalization. The admitting provider must contact Utilization Management at 1-888-394-4327 for prior authorization no later than seven (7) days before admission. The admitting provider must obtain an authorization number from Utilization Management for an approved admission.

This number must be included on all claims submitted in relation to the admission. If questions arise during the prior authorization review as to the appropriateness of the admission, the case will be referred to the Healthfirst Clinical Peer Reviewer for determination. If the requested admission is not approved, the provider may work with Utilization Management to initiate an appeal. The appeal process is discussed in Section 15 of the Healthfirst Provider Manual.

Emergency Admissions

All emergency admissions, including admissions in which the member proceeds directly from the provider's office to the hospital for immediate admission, require notification to Healthfirst. Hospital staff must contact Utilization Management within 48 hours of admission or on the next business day following a weekend admission.

However, prior authorization from Healthfirst is never required for emergency admissions. The staff must provide Utilization Management with details regarding the admission, including the same data elements required for prior authorization of inpatient care as listed in this section. Notification from the member's PCP or admitting provider is also acceptable. Providers may call Utilization Management at 1 (888) 394-4327 or fax information to 1 (646) 313-4603.

12.4 Out-of-Network Services

At times, a Healthfirst HMO member may require healthcare services from a nonparticipating provider. Signature (PPO) does not require authorization for out-of-network services. These situations may arise for reasons of medical necessity or because a particular service or specialty is not available within the Healthfirst network. When this occurs, our Utilization Management department should be contacted at 1 (888) 394-4327, Monday to Friday, 8am–5:30pm. Requests for out-of-network elective admissions, treatments, and specialist authorizations must include the applicable supporting information described below:

- For a treatment only available out of network, a letter of medical necessity written by the member's attending physician, who is qualified to practice in the area of specialty at issue, that the requested service is materially different from the service Healthfirst has approved to treat the member's condition, accompanied by at least two documents from the available medical and scientific evidence that the out-of- network health service is likely to be more clinically beneficial, and not substantially more risky, to the member than the approved in-network service.
- For authorization to an out-of-network hospital or other provider, a letter of medical necessity written by the member's attending physician, who is qualified to practice in the area of specialty at issue, that Healthfirst's in-network healthcare providers do not have the appropriate training and experience to treat the member and recommending an out-of-network provider who does have the appropriate training and experience to provide the requested service.

A determination will be made regarding whether out-of-network care can be supplied by an in-network provider and whether the requested service(s) are medically necessary. Healthfirst will inform you of its decision within three (3) business days of receiving all the information needed to decide. Out-of-network care for all plans must be approved by Utilization Management, which evaluates the case in conjunction with the attending practitioner and the member's PCP.

When a Healthfirst member is referred for out-of-network inpatient hospitalization, the hospital must:

- Verify the member's eligibility at the time of admission.
- Contact Utilization Management to verify that the member's scheduled admission has been preauthorized and to obtain the authorization number for submission with the claim.

Out-of-network services will not be covered in any Healthfirst plan except for emergency services or services authorized by Healthfirst. Members who opt to receive elective out-of-network services without authorization will be held liable for the cost of those services.

Participating providers who knowingly and routinely refer Healthfirst members to nonparticipating providers for non-emergent services may be determined to be in breach of their participation agreement and be subject to termination.

If a Medicare member is referred to an out-of-network provider by an in-network provider, this is considered plan-directed care, and the member will be held harmless except for any copayment responsibility.

Healthfirst members enrolled in Healthfirst's Medicaid, Personal Wellness Plan (PWP/HARP), Child Health Plus, Essential Plan, or Commercial plans who unknowingly receive unauthorized care or emergency services from a nonparticipating provider and receive a "surprise bill," as defined in the New York Financial Services Law, may assign their benefits to the nonparticipating provider and be held harmless for any cost in excess of the amount they would have paid for services if those services had been provided by a participating provider.

12.5 Continuity of Care

Healthfirst has policies to address transition periods when a new member is undergoing a course of treatment prior to enrollment with Healthfirst. This would include treatment with a nonparticipating provider or when a member's provider leaves the Healthfirst network. These policies are required both in Healthfirst's provider agreements, in Section 4403 of the New York State Public Health Law, and are described below.

In all cases, continuity of care with a nonparticipating provider depends upon the provider's acceptance of Healthfirst's reimbursement rates as payment in full. The provider must also agree to do the following:

- Adhere to Healthfirst's quality assurance requirements
- Abide by all Healthfirst policies and procedures
- Provide Healthfirst with medical information related to the member's care
- Obtain prior authorization from Utilization Management for applicable services
- Agree not to "balance-bill" the member for services provided (for Healthfirst Medicaid, CHPlus, Medicare [all plans] members only). Healthfirst Leaf Plan members may be liable for the cost-sharing amounts and may be responsible for the cost of noncovered care.

Continuity of Care Guidelines

Line of Business	New Enrollee	Provider Leaves Network
Medicaid (Including Personal Wellness Plan)	If a new enrollee has an existing relationship with a healthcare provider who is not a member of the contractor's provider network, the contractor shall permit the enrollee to continue an ongoing course of treatment by the non-participating provider during a transitional period of up to sixty (60) days from the effective date of enrollment if the enrollee	The transitional period shall continue up to 90 (ninety) days from the date the provider's contractual obligation to provide services to the contractor's enrollees terminates; or, if the enrollee has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care

Line of Business	New Enrollee	Provider Leaves Network
	has a life- threatening disease or condition or a degenerative and disabling disease or condition. If the enrollee has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of postpartum care directly related to the delivery up to 60 (sixty) days after the delivery.	directly related to the delivery through 60 (sixty) days postpartum. Ninety (90) days or until the Patient Centered Service Plan (PCSP) is in place, whichever is later, for Long-Term Social Services at the same level, scope, and amount as you were receiving. Ninety (90) days for the current care plan or until an alternate care plan is authorized, whichever is later, for new enrollees receiving Adult Day Health Care (ADHC) or AIDS ADHC services. Can keep their service with existing provider for up to one year, unless the enrollee elects to change.
Medicare	For medically necessary treatment associated with a chronic or serious condition, or other Medicare covered services, will provide a limited number of visits with enrollee's current provider or caregiver at the same level, scope, and amount that they were receiving. Will work with enrollee and their primary care provider (PCP) to find an in-network provider that can meet the enrollee's medical needs. For the rest of the pregnancy, if the member has entered the second trimester on the date of enrollment becomes effective. This includes delivery and the provision of postpartum care directly related to the delivery for up to 60 (sixty) days after the delivery. Signature (PPO) members have no restrictions on obtaining out-of-network care.	If you are undergoing a specified course of treatment with a provider who leaves our network, we will authorize a transitional period of up to 90 days from the date the provider leaves Healthfirst to ensure continuity of your care and prevent any disruptions in your treatment plan. In addition, if you are in your second trimester of pregnancy (more than three [3] months pregnant) when your provider leaves our network, we will authorize a transitional period of up to 60 days postpartum (after the baby is born) to ensure continuity of care.
CompleteCare	If the service is regarding a Medicaid-only benefit, the Medicaid rules apply; otherwise, Medicare rules apply.	If the service is regarding a Medicaid-only benefit, the Medicaid rules apply; otherwise, Medicare rules apply.
QHP/EPO	If the enrollee is in an ongoing course of treatment with a non-participating provider when their coverage under this certificate becomes effective, they may be able to receive covered services for the ongoing treatment from the non-participating provider for up to 60 days from the effective date of their coverage under this certificate. This course of treatment must be for a life-threatening disease or condition or for a degenerative and disabling condition or disease. If the enrollee is pregnant at the effective date of enrollment, the transitional period shall	If the enrollee is in an ongoing course of treatment when their provider leaves the network, then the enrollee may be able to continue to receive covered services for the ongoing treatment from the former participating provider for up to 90 days from the date their provider’s contractual obligation to provide services to them terminates; or, if the enrollee is pregnant, for a transitional period that includes the provision of postpartum care directly related to the delivery through 60 days postpartum.

Line of Business	New Enrollee	Provider Leaves Network
	continue for the remainder of the pregnancy, including delivery and the provision of postpartum care directly related to the delivery up to 60 days after the delivery.	
Essential Plan	If the enrollee is in an ongoing course of treatment with a non-participating provider when their coverage under this certificate becomes effective, they may be able to receive covered services for the ongoing treatment from the non-participating provider for up to 60 days from the effective date of their coverage under this certificate. This course of treatment must be for a life-threatening disease or condition or for a degenerative and disabling condition or disease. If the enrollee is pregnant at the effective date of enrollment, the transitional period shall continue for the remainder of the pregnancy, including delivery and the provision of postpartum care directly related to the delivery up to 12 months after the delivery. If the member is currently enrolled in an EP and becomes pregnant, they can choose to remain enrolled in their current EP Plan (rather than being re-evaluated for Medicaid), with no cost sharing.	If the enrollee is in an ongoing course of treatment when their provider leaves the network, then the enrollee may be able to continue to receive covered services for the ongoing treatment from the former participating provider for up to 90 days from the date their provider's contractual obligation to provide services to them terminates; or, if the enrollee is pregnant, for a transitional period that includes the provision of postpartum care directly related to the delivery through 12 months postpartum.

Standing Authorizations

Healthfirst allows standing authorizations for out-of-network specialty care in cases in which the member's diagnosis or condition requires ongoing care from a specialist, specialty center, or specialty institution. In these situations, the PCP or requesting provider must coordinate a standing authorization with the member, the specialist, and Healthfirst.

To arrange this authorization, the requesting provider must call Utilization Management to discuss the treatment plan and the need for the extended authorization. When appropriate, Utilization Management, in consultation with the requesting provider/PCP and the specialist, will issue an authorization designating the approved number of visits, the services to be rendered, and the time period covered by the standing authorization.

In-network specialty care does not require prior authorization when a standing referral is requested by the member's requesting provider/PCP.

Medical Records

When a member selects a new PCP, upon his/her request the former PCP should transfer the member's records to the new provider in a timely manner, thereby ensuring continuity of care.

12.6 Concurrent Review

Healthfirst has implemented a concurrent review program to monitor the allocation of resources during an episode of care. The program uses evidence-based criteria including, but not limited to, Milliman Care Guidelines (MCG) and Healthfirst Medical Policies to review services provided to members. These criteria are available to providers upon request.

Inpatient Concurrent Review

The inpatient concurrent review program comprises three (3) basic components. They are:

1. **Admission Review:** Admission review is based on clinical information provided to verify the appropriateness and medical necessity of the hospitalization. Emergency admissions that occur during weekends or holidays, when Healthfirst is closed, will be reviewed when the office reopens, and a medical-necessity determination will be made, provided that the hospital has complied with the Healthfirst notification policy. All admissions are subject to review for appropriateness and medical necessity, regardless of length of stay. Please refer to Section 12 for more information on this policy.

2. **Continued Stay Review**: Continued stay review is conducted to re-establish that inpatient hospitalization continues to be appropriate and medically necessary. Providers requesting continuation of service authorization will receive a verbal determination, followed by written confirmation, within one (1) day of Healthfirst receiving the necessary information. The notice will include the authorized service(s), the number of authorized visits or sessions, and the next expected review date.

3. **Discharge Planning:** Discharge planning begins prior to admission for elective admissions. For an emergency admission, the process begins with the first review of the case. The goal of discharge planning is to move members efficiently and effectively through the different levels of care required to manage and treat their medical condition.

Outpatient Concurrent Review

Medical/Surgical/Behavioral Health Services: Outpatient concurrent review focuses on the effective allocation of resources during an episode of care to ensure that care is provided at the most appropriate level and is coordinated among all disciplines, that continued benefits exist for the service, and that problematic cases and quality issues have been identified.

Providers must furnish clinical information to Utilization Management to support continued authorization of services before the expiration of the authorized treatment period. Providers requesting continuation of service authorization will receive a verbal determination, followed by written confirmation, within one (1) day of Healthfirst receiving the necessary information. The notice will include the authorized service(s), the number of authorized visits or sessions, and the next expected review date.

Community-Based Services Concurrent Review

Community-Based Services: These services, which include Long-Term Services and Supports (LTSS), are typically ongoing services in the home, with a special focus on either rehabilitation or helping an LTSS- eligible beneficiary remain in their home. Concurrent review of these services is defined as a request for continued services, or a request for a change in the level of care. Providers must furnish required information, which may include clinical information from a treating physician or primary care provider, as well as progress notes or status reports from an agency providing the services. Some community-based services may be terminated in accordance with state requirements if the necessary documentation is not received in time to perform a concurrent review.

12.7 Retrospective Review

Retrospective reviews are performed after healthcare services have been provided. Healthfirst conducts retrospective reviews to evaluate the medical necessity for services that were not preauthorized or reviewed concurrently.

Healthfirst will make retrospective determinations within 30 (thirty) days of receiving the necessary information. Notices will be sent to members on the date of a full or partial payment denial in the form of an Explanation of Benefits (EOB). All inpatient hospital admissions are subject to review for appropriateness and medical necessity, regardless of length of stay.

We may reverse a preauthorized treatment, service, or procedure on retrospective review only when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the preauthorization review
- The relevant medical information presented to us upon retrospective review existed at the time of the preauthorization but was withheld or not made available to us
- We were not aware of the existence of such information at the time of the preauthorization review
- The treatment, service, or procedure being requested would not have been authorized had we been aware of such information
- The determination is made using the same specific standards, criteria, or procedures that were used during the preauthorization review.

13 Care Management

Clinical Operations brings added value to our members by providing proactive and comprehensive care management and outreach for those diagnosed with high-risk conditions, illnesses, and special situations and needs. Our collaborative process of assessment, planning, facilitation, and advocacy—coupled with a comprehensive portfolio of programs—helps our members better manage their overall health and well-being and navigate the complexities of the healthcare system.

5 Care Management teams work together to provide a variety of clinical, outreach, and educational programs. These teams are:

- **Long-Term Care:** Provides longitudinal Care Management to adult members who receive Long-Term Care Services and Supports (LTSS), including those in Senior Health Partners, Complete Care and Medicaid
- **Pediatrics**: Provides longitudinal, episodic and programmatic care management to children who are part of the child waiver program who have special needs, including medically complex foster children
- **D-SNP:** Provides longitudinal programmatic care management to Medicare/Medicaid duals who are enrolled in the Life Improvement Plan (LIP) or Connections plan
- **Complex Care:** Provides programmatic care management to members with high-risk Diabetes, HIV, Maternity and other conditions, as needed
- **Behavioral Health**: Provides longitudinal and episodic care management for members with behavioral health issues as well as children diagnosed with social/emotional disturbances and foster children

Members are identified for Care Management services through a variety of channels including self-referrals, provider referrals, predictive risk algorithms, claims or because they are part of a care-managed line of business, such as MLTC. Members are screened to receive care management and/or care coordination by the Healthfirst interdisciplinary care team. Care Managers and Care Coordinators will work with members and their families, PCPs, other attending providers, facilities, and other service providers to assess, plan, coordinate, monitor, and evaluate the member's level of function and to support and empower the member in their healthcare decisions to improve their quality of life.

After an initial assessment, care plans are developed that include interventions to educate, monitor, and evaluate both the member’s and the caregiver's ability to maintain their optimal level of function and wellness in the community. These Care Management programs are member-centric and are developed with the member to ensure they meet the member’s needs, goals and preferences. The member's care plan is an organized map of problems, goals, and interventions that are managed proactively with the member and their interdisciplinary care team to improve health outcomes, reduce unnecessary costs, and improve access to care and services, including those that address the Social Determinants of Health.

Healthfirst is committed to increasing the quality of life and decreasing mortality and morbidity in all members through a dedicated care/case management approach.

Healthfirst Model of Care (MOC) for Medicare Special Needs Plans

The Healthfirst Model of Care is the framework for a comprehensive and collaborative care management delivery system to promote, improve, and sustain member health outcomes across the care continuum in accordance with the requirements set forth by the Centers for Medicare & Medicaid Services. The program provides primary, specialty, and acute medical care services and Medicaid-covered long-term care services where applicable. It coordinates these services to address acute medical needs and to manage chronic conditions while allowing members to remain safe and secure in their own homes. The goals of the Model of Care consist of:

- Improving access to essential medical, mental health, long-term care, and social services
- Improving access to affordable care
- Ensuring coordination of care through an identified point of contact

- Addressing Social Determinants of Health to improve health equity
- Ensuring seamless transitions of care across healthcare settings, providers, and health services
- Enhancing access to preventive health services
- Assuring appropriate utilization of healthcare services
- Improving beneficiary health outcomes across the continuum of care
- Maintaining member at home at the highest functional level possible for as long as possible

These goals are accomplished via:

- The administration of an initial and annual comprehensive health-risk assessment and the development of an individualized care plan
- Risk-stratification and assignment of members with complex medical and psychosocial needs to a case manager
- Provision of an adequate network of providers who can meet the special needs of the membership
- Effective collaboration with an interdisciplinary care team; training of stakeholders on the MOC effective analysis of data toward meeting goals; and ongoing identification of process improvements with designated stakeholders, as well as communication of the results to same

  Complete Training below:
  Special Needs Model of Care- 2024

Interdisciplinary Care Team

Healthfirst assigns an interdisciplinary care team to each member in care management which plays an important role in the development and implementation of a comprehensive individualized plan of care for each member.

Members of the interdisciplinary care team may include some or all of the following:

- Primary care physician
- Nurse practitioner, physician's assistant, mid-level provider
- Social worker, community resources specialist
- Registered nurse
- Restorative health specialist (physical, occupational, speech, recreation)
- Behavioral health specialist (psychiatrist, psychologist, licensed social worker, substance use disorder clinician)
- Board-certified physician
- Dietitian, nutritionist
- Pharmacist, clinical pharmacist
- Disease management specialist
- Nurse educator
- Pastoral specialists
- Caregiver/family member
- Preventive health/health promotion specialist

The interdisciplinary care team works together to manage each member's care by performing duties that include some or all of the following:

- Develop and implement an individualized care plan with the member/caregiver
- Conduct care coordination meetings on a regular schedule
- Conduct face-to-face meetings
- Maintain a web-based meeting interface
- Maintain web-based electronic health information
- Conduct case rounds on a regular schedule
- Maintain a call line or other mechanism for beneficiary inquiries and input
- Conduct conference calls among plan, providers, and beneficiaries

- Develop and disseminate newsletters or bulletins
- Maintain a mechanism for beneficiary complaints and grievances
- Use email, fax, and written correspondence to communicate

Initial and annual assessments are analyzed to determine the need for add-on services and benefits. These needs are incorporated into the individualized care plan for each member.

Complex Care Management Programs

Complex Care Management Programs target members diagnosed with high-risk conditions, illnesses, special situations or needs and emphasize outreach, education, and intervention through collaboration with each member's healthcare team, including PCPs, hospitals, specialists, home care, DME companies, etc. Our highly trained team of nurses and social workers work by telephone with the interdisciplinary care team to address and enforce compliance, educate members about managing their condition, coordinate care, select services, and educate/inform members of available treatment options. Currently, our Complex Care team manages a variety of conditions, including Diabetes, HIV and High-Risk Maternity.

HIV

Healthfirst is committed to increasing the quality of life of, and to decreasing mortality and morbidity in, the HIV/AIDS population. Emphasis of the program is based on member assessment and coordination of care with the PCP, infectious disease clinic, immunologist, or HIV specialist provider. The goals are member education, coordination of medical care to help prevent opportunistic infections, and early identification of behavioral health and/or community resource needs. This program was developed in accordance with HIV/AIDS clinical practice guidelines published by the AIDS Institute, New York State.

High-Risk Maternity

Healthfirst has implemented member education programs and care management programs focused on pregnancy and newborn care. All pregnant women enrolled in these programs are sent educational materials endorsed by the American Congress of Obstetricians and Gynecologists (ACOG). These materials include information about prenatal care, fetal development, nutrition, preterm labor, and vaccinations. Members identified as "high-risk" are followed by a registered nurse for education, outreach, and prenatal and post-natal care. Healthfirst offers an incentive program to encourage prenatal care. Please see Section 14 for details.

The high-risk maternity program is designed to improve outcomes for mothers and newborns. All pregnant members are stratified using a predictive algorithm which aims to identify mothers at risk of a pre-term delivery. The algorithm uses a variety of factors, including prior delivery history, conditions, demographics and social vulnerabilities to identify high risk members who are then referred for care management. The Nurse Care Manager will conduct a pre-natal assessment with the member to identify barriers to optimal care and link the member and her family with appropriate providers and community resources to ensure that she receives needed services and to identify any obstacles to care. The care manager will encourage early and continuous prenatal care, develop a prenatal plan of care, coordinate care, encourage and/or provide HIV testing and counseling with clinical recommendation, and coordinate post-partum and newborn care. The standard of care for the maternity program follows the New York State Law 85.40, PCAP Guidelines.

Specific program components include:

- Identifying pregnant members
- Using a predictive algorithm to identify high-risk pregnant members
- Providing community outreach services through affiliated hospitals and clinics
- Educating members by telephone and through literature mailed to members
- Assessing pregnant members for risk factors and complications
- Coordinating care in collaboration with the member's obstetrical provider for high-risk pregnancies

Important: Please refer pregnant women under your care who meet these diagnostic criteria, as well as any other high-risk Healthfirst obstetrical members, to the Care Management program by calling 1 (888) 394-4327 or faxing a referral to 1 (646) 313-4603.

Care Coordination Management Programs

Care Coordination Management programs target members requiring assistance, synchronization, and support in obtaining care and emphasize outreach and education in handling and dealing with chronic conditions or sudden, unexpected acute illness. Care management is effectuated by collaborating with each member's healthcare team, including PCPs, hospitals, clinics, specialists, home care, DME companies, etc. Our highly trained team of nurses works by telephone in clinics, in emergency rooms, and on units at several of our participating hospitals in collaboration with the interdisciplinary care team to address and enforce compliance, educate members about managing their condition, coordinate care, select services, and educate/inform members of available treatment options.

14 Clinical Performance Management

14.1 Overview and Philosophy

The Clinical Quality and Population Health Strategy Program (the "Program") maintains an organization-wide commitment that supports processes designed to improve the quality and safety of clinical care and the quality of service provided to our members. The Program utilizes clinical and service indicators to plan, implement, monitor, and improve the organization's commitment to improve quality, maximize safe clinical practices, and enhance service delivery to our members.

Key Objectives of the Program:

1. To establish and maintain a Clinical Quality and Population Health Strategy Program that demonstrates a commitment from the highest governing body of Healthfirst to every employee of the organization and to provide the highest possible quality in clinical care and service delivery to our members.
2. To share with participating providers clinical and service performance indicators by which care and member satisfaction are measured and to hold those providers accountable in the implementation of actions designed to improve performance.
3. To establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring, and evaluating performance to improve desired outcomes.
4. To demonstrate a quality process that ensures compliance with all rules and regulations set forth by local and federal regulatory agencies that affect relevant aspects of the organization's business, service, and clinical operations.
5. To implement and monitor educational materials and programs designed to empower members to take better care of themselves.

Scope of the Program

The Program is applicable to all Healthfirst products. Multiple areas across the organization participate in overall quality improvement efforts. The overall goal of the Program is to include both administrative and clinical initiatives that are monitored regularly and evaluated annually.

Clinical performance activities, when applicable, shall be conducted in accordance with the National Committee for Quality Assurance (NCQA) Standards for the Accreditation of Managed Care Organizations and/or other reporting requirements as promulgated by the different regulatory agencies that oversee the organization, such as the New York State Department of Health (NYSDOH), Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and the Centers for Medicare & Medicaid Services (CMS). Activities fall into two (2) major categories: activities that improve the quality and safety of clinical care and activities that improve the quality of service provided to Healthfirst members.

14.2 Reporting Requirements and Quality Programs

Healthfirst is required to report to federal, New York State, and New York City regulatory authorities on a variety of data elements, including clinical studies and quality-related indicators. To maintain compliance with these requirements, Healthfirst relies upon its provider network for comprehensive, accurate, and timely information. Healthfirst also expects its participating providers to follow all public health and regulatory guidelines related to the reporting of communicable diseases, the delivery of preventive care services, procedure consents (e.g., sterilization/hysterectomy), child abuse and domestic violence, and any other required data sets.

This section of the Provider Manual describes the range of regulatory reporting requirements and provider data requirements mandated by CMS, the NYSDOH, the OMH, OASAS, and Healthfirst. It also describes the Quality Program's tools, support, and educational initiatives that Healthfirst has implemented to help providers satisfy these regulatory requirements.

Risk Adjustment: Member Diagnosis Information and Coding Requirements

Medicare, NYS-Medicaid, and New York State Health Exchange Programs utilize ICD-10-CM as the official diagnosis code set for each respective risk-adjustment model. Accordingly, ICD-10 diagnosis codes are required in the determination of risk-adjustment factors. Accurate and appropriate ICD-10 codes must be submitted for each beneficiary.

Coding and Medical Record Documentation:

- As a standard policy, Medicare, NYS-Health Exchange, and NYS-Medicaid programs require accuracy and specificity in diagnostic coding
- Use current ICD-10-CM diagnostic coding conventions
- Ensure office staff is up-to-date on the basics of ICD-10-CM coding
- Code to the highest level of specificity known
- Clinical specificity of a disease/condition can be expressed through the fourth (4th), fifth (5th), sixth (6th), and/or seventh (7th) digit of some ICD-10-CM diagnostic codes
- Specificity of coding is based on the accuracy of information documented in the accompanying medical records
- Medical records are the source for all diagnosis codes
- Verify that the medical record supports diagnosis codes
- Healthfirst will deny all claims submitted that do not have the appropriate fourth (4th) and/or fifth (5th) digit in the ICD-10-CM diagnostic codes

Guidelines When Managing Medical Records:

As per provider and member agreements with Healthfirst, access to medical records must be available for verification of diagnosis (please refer to your agreement)

- Include the member's identification on each page of the medical record, and the date of service. Include the signature of the person(s) providing treatment, reason for the visit, care rendered, conclusion and diagnosis, and follow-up care plan in all medical records
- Documentation in the medical record of encounters with members must include all conditions and comorbidities being treated and managed
- Include the provider's credentials on the medical record, either next to his/her signature or preprinted with the provider's name on the practice's letterhead
- Report and submit all diagnoses that impact the member's evaluation, care, and treatment; reason for the visit; coexisting acute conditions; chronic conditions or relevant past conditions
- Medical records must reflect the codes submitted

Resources

- For more information on Medicare program: https://www.cms.gov/medicare/coding/icd10
- For more information on Medicaid program: www.health.state.ny.us
- For more information on the Health Exchange program: www.hhs.gov/
- For more information on ICD-10-CM: http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10

Quality Assurance Reporting Requirements (QARR)

QARR are a series of measures designed to examine managed care plan performance in several key areas by NYSDOH. These measures are largely adopted from the NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®), with additional New York State-specific measures added to address public health issues of particular significance in New York.

HEDIS consists of more than ninety (90) measures, and QARR has one NYS-specific measure across six (6) domains of care. Highlights of the four (4) domains from HEDIS/QARR that are greatly impacted by the performance of a plan's participating providers are presented here.

Domain	Measures
Effectiveness of Care	• Adherence to Antipsychotic Medications for Individuals with Schizophrenia • Adolescent Preventive Care • Antidepressant Medication Management • Appropriate Testing for Children with Pharyngitis • Appropriate Testing for Children with Upper Respiratory Infection • Asthma Medication Ratio • Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis • Breast Cancer Screening • Cardiac Rehabilitation • Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia • Care for Older Adults • Cervical Cancer Screening • Childhood Immunization Status • Chlamydia Screening in Women • Colorectal Cancer Screening • Comprehensive Diabetes Care • Controlling High Blood Pressure • Diabetes Monitoring for People with Diabetes and Schizophrenia • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications • Follow-Up After High-Intensity Care for Substance Use Disorder • Follow-Up After Emergency Department Visit for Mental Illness • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence • Follow-up After Hospitalization for Mental Illness • Follow-up Care for Children Prescribed ADHD Medication • Immunizations for Adolescents • Kidney Health Evaluation for Patients with Diabetes • Lead Screening in Children • Metabolic Monitoring for Children and Adolescents on Antipsychotics • Non-Recommended Cervical Cancer Screening in Adolescent Females • Non-Recommended PSA-Based Screening in Older Men • Osteoporosis Management in Women who had a Fracture • Persistence of Beta-Blocker Treatment After a Heart Attack • Pharmacotherapy for Opioid Use Disorder • Pharmacotherapy Management of COPD Exacerbation • Potentially Harmful Drug-Disease Interactions in Older Adults • Risk of Continued Opioid Use • Statin Therapy for Patients with Cardiovascular Disease • Statin Therapy for Patients with Diabetes • Transitions of Care • Use of Imaging Studies for Low Back Pain • Use of High-Risk Medications in Older Adults • Use of Opioids at High Dosage • Use of Opioids from Multiple Providers • Use of Spirometry Testing in the Assessment and Diagnosis of COPD • Viral Load Suppression • Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents

Domain	Measures
Access and Availability of Care	• Adults' Access to Preventive/Ambulatory Health Services • Annual Dental Visit • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment • Initiation of Pharmacotherapy upon New Episode of Opioid Dependence • Prenatal and Postpartum Care • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Experience of Care	• CAHPS Health Plan Survey 5.0H, Adult Version • CAHPS Health Plan Survey 5.0H, Child Version • QHP Enrollee Experience Survey
Utilization and Relative Resource Use	• Acute Hospital Utilization • Ambulatory Care • Antibiotic Utilization • Child and Adolescent Well-Care Visits • Frequency of Selected Procedures • Identification of Alcohol and Other Drug Services • Inpatient Utilization – General Hospital/Acute Care • Mental Health Utilization • Plan All-Cause Readmissions • Well-Child Visits in the First 30 Months of Life

Performance in the HEDIS/QARR data sets is one of the core indicators on which Healthfirst plan-wide quality improvement efforts are focused.

It is extremely important to note the following:

- HEDIS/QARR measures are primarily based on preventive health standards and clinical practice guidelines issued by expert panels and community respected organizations such as the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), American Diabetes Association (ADA), American College of Obstetrics and Gynecology (ACOG), and the American College of Cardiology (ACC)
- HEDIS/QARR requires specific technical specifications on how data is reported for each measure (see Appendix XVI).
- Documentation is key, starting from the medical records to the business office submission of encounter and claims data. There are measures such as well-child visits in the Medicaid product that can only be reported through claims and encounter data, but only if the appropriate coding and timing of service were submitted to the plan.
- To assist providers, the Clinical Quality department will routinely make available listings of members to the appropriate providers indicating services that were not reflected on the encounter and claims data submitted (members missing services). Providers are asked to review their records to see whether these services were rendered but not reported to Healthfirst. If the services were rendered, providers are asked to submit the claims/encounter data to Healthfirst as soon as they are identified. If they were not but the service is recommended for the member, the provider is asked to reach out to the member to offer the service. Staff from the Clinical Quality department will work with providers closely to monitor provider-specific initiatives and quality measure rates.

Provider Network Reports

On a quarterly basis, Healthfirst submits its Health Provider Network (HPN) report to the State, listing all participating providers. This submission includes provider license numbers, Medicaid provider numbers, office locations and hours, provider types and specialties, etc. Healthfirst must attest to the accuracy of this provider information with a notarized affidavit. It is imperative that the information you give us about your practice— such as office address and office hours, your credentials and license/provider numbers—be accurate at the time and be updated promptly whenever

there is a change. To submit any change in your information, fill out the Demographic Change Form on our website at healthfirst.org or call Provider Services at 1 (888) 801-1660.

Reporting Requirements for the New York State Cancer Registry (NYSCR)

The Cancer Research Improvement Act of 1997 amended section 2401 of the Public Health Law. Under this law, all managed care organizations certified pursuant to Article 44 are required to report cancer cases to the NYSCR. A prescribed list of data elements to track cancer incidence has been developed. Data is collected from the encounter forms submitted to Healthfirst by providers. Healthfirst providers must submit encounter forms to document services rendered and may be requested to forward additional information to support the reporting requirements of the NYSCR. For more information on the NYSCR, visit **https://www.health.ny.gov/statistics/cancer/registry**.

Public Health and Communicable Disease Reporting

NYS Public Health Law and the NYC Health Code require that suspected or confirmed diagnoses of communicable diseases be reported to the local health department in the county in which the member resides within 24 hours of diagnosis. Some diseases warrant prompt action and should be reported immediately by phone.

A directory of local health departments can be found here: https://www.nysacho.org/directory

NYC DOHMH's Provider Access Line (PAL): 1 (866) 692-3641.

For a list of communicable diseases, reporting requirements, and forms, go to:

- **NYSDOH website**: **www.health.ny.gov/professionals/diseases/reporting/communicable**
- **NYC DOHMH website**: **https://www1.nyc.gov/site/doh/providers/reporting-and-services/notifiable-diseases-and-conditions-reporting-central.page**

Special Reporting Requirements:

1. **Sexually Transmitted Infections (STIs)**
    a. **HIV** – Report within 14 days of positive test results. Use the required NYS HIV/AIDS Medical Provider Report Form (PRF). Call the HIV Surveillance Provider line at 1 (212) 442-3388 to arrange for pick-up of the form. To protect patient confidentiality, faxing or mailing reports is not permitted. For more information, visit https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv.page or https://www.health.ny.gov/diseases/aids/index.htm.
    b. **Chlamydia, Gonorrhea, Granuloma Inguinale, Neonatal Herpes (infants aged ≤ 60 days), Lymphogranuloma venereum, and Syphilis** – Report within 24 hours via the Reporting Central NYCMED at www.nyc.gov/nycmed. For clinical guidance and resources on STIs, visit https://www1.nyc.gov/site/doh/providers/health-topics/stds.page and https://www.health.ny.gov/diseases/communicable/std/providers.htm
2. **Tuberculosis** – Report within 24 hours through the Reporting Central via NYCMED at www.nyc.gov/nycmed. For more resources, visit https://www1.nyc.gov/site/doh/providers/health-topics/tuberculosis.page and https://www.health.ny.gov/diseases/communicable/tuberculosis.
3. **Immunizations** – Report all immunizations given to members younger than 19 years within 14 days of administration or immunization-related adverse events through the Citywide Immunization Registry (CIR), which can be accessed at nyc.gov/health/cir or the New York State Department of Health using the New York State Immunization Information System (NYSIIS) at https://commerce.health.state.ny.us/. To register for CIR, visit https://www1.nyc.gov/site/doh/providers/reporting-and-services/citywide-immunization-registry-cir.page, and for NYSIIS, visit https://www.health.ny.gov/prevention/immunization/information_system.
4. **Lead Poisoning** – Report blood lead levels ≥ 10 µg/dL among NYC residents within 24 hours. Providers using a point-of-care test (and clinical laboratories) should report all blood lead levels < 10 µg/dL within five days.
    a. **For children age 18 and younger**, report using the CIR.
    b. **For adults**, report by calling 1 (646) 632-6102 or faxing the result to 1 (646) 632-6105. For more information, visit https://www1.nyc.gov/site/doh/health/health-topics/lead-poisoning-for-healthcare-providers.page and https://www.health.ny.gov/environmental/lead/health_care_providers/index.htm

5. **Perinatal Hepatitis B** – All pregnant women must be screened for Hepatitis B surface antigen (HBsAg) during pregnancy (preferably in the first trimester). Report cases online by completing an electronic URF (eURF) or by faxing the IMM-5 Reporting Form to 1 (347) 396-2558. The IMM-5 Reporting Form can be accessed here: https://www1.nyc.gov/assets/doh/downloads/pdf/imm/perinatal-hepb.pdf.

Child Abuse and Domestic Violence

It is important that providers and their staff be alert to potential cases of child abuse, domestic violence, intimate partner violence (IPV), and adult and elder abuse. An Abuse Assessment Screen is recommended for all new members during annual follow-ups and when child abuse/domestic violence is suspected (including in same-sex relationships). Reporting of child abuse or maltreatment is mandatory for all healthcare professionals. Call 911 if the child or adult is in imminent danger. To report child abuse/maltreatment and domestic or intimate partner violence, call the numbers below:

- New York Statewide Central Registry of Child Abuse and Maltreatment: 1 (800) 635-1522
- NYC 24-Hour Domestic Violence Hotline: 1 (800) 621-HOPE (1 800 621-4673)

For more resources, visit https://www1.nyc.gov/site/doh/providers/health-topics/domestic-violence.page, https://www.health.ny.gov/professionals/ems/policy/02-01.htm, and https://www1.nyc.gov/site/ocdv/index.page.

Smoking Cessation

Tobacco has been linked to lung cancer and other deadly chronic diseases. We encourage you to help our members fight their tobacco addiction and make it a part of your routine health assessment. At every clinic visit:

- Identify whether a member is a smoker
- Document the smoker status in the member's chart as a vital sign
- Provide smoking cessation resources, such as:
    - **NY State Smoker's Quitline** – 1 (866) NY-QUITS or 1-866-697-8487
    - **Smoking Cessation Centers** – for a list of smoking cessation centers in NYC and Long Island, visit www.nysmokefree.com, https://www1.nyc.gov/site/doh/health/health-topics/smoking-nyc-quits.page, and http://www.cdc.gov/tobacco/how2quit.htm
- Treat by introducing pharmacological and smoking cessation counseling therapies

For more smoking cessation resources and information, visit https://www1.nyc.gov/site/doh/providers/health-topics/smoking-and-tobacco-use.page and https://www.nysmokefree.com.

Member Rewards Program

Through Healthfirst's Quality Programs, members may be entitled to the following incentives.

The **Healthfirst Member Rewards Card Program** is a way for Healthfirst members to earn rewards for getting needed care. The program is available to Healthfirst Medicaid, Child Health Plus, Personal Wellness Plan (PWP), Essential Plan (EP) and Medicare Advantage members. Members can qualify for reward cards by completing select preventive screenings and health initiatives, such as well-child visits, diabetic eye exam, completion of health risk assessments, mammograms, and colorectal screenings. Reward forms can be found on the Provider Portal at **https://hfproviderportal.org**. Members can fill out a form and mail or fax the form back to Healthfirst or let us know they completed any eligible preventive screenings/health initiatives through the Healthfirst mobile app (coming soon for Medicare and EP members!)

14.3 Clinical Practice Guidelines

Clinical practice guidelines (Appendix XII) are systematically developed standards that help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. The endorsement of clinical practice guidelines gives Healthfirst the ability to measure the impact of guidelines on outcomes of care and may reduce practice variations in diagnosis and treatment. In addition to guidelines and recommendations that the

CMS, the NYSDOH, and the local departments of health require, participating providers are expected to comply with the guidelines Healthfirst adopts.

Healthfirst has adopted preventive care and practice guidelines that are based on nationally accepted guidelines that are reviewed and updated at least every two (2) years, unless otherwise specified. Healthfirst adopts guidelines upon the recommendation and approval of the Healthfirst Quality Improvement Committee (QIC). These guidelines are communicated to providers – including performance indicators chosen by the clinical members of the Committee – via the Provider Manual, mailings/newsletters, and the Healthfirst website. Performance against chosen indicators is measured annually – adoption of preventive guidelines is measured utilizing HEDIS/QARR measurement tools, and other clinical guidelines are measured using focused studies methodologies, as appropriate.

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

To obtain a copy of the list of guidelines required by the NYSDOH and the list of guidelines adopted by Healthfirst, visit the Provider Resources section of **https://hfproviderportal.org**.

14.4 Studies, Surveys, and Investigations

Studies – Medicaid and Managed Long Term Care (MLTC)

Every two years, the Managed Care Organizations (MCOs) participating with Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), and Managed Long-Term Care (MLTC) programs are required by the NYSDOH to conduct a Performance Improvement Project (PIP) in a priority topic area or a topic relevant to the MCOs' population demographics. A PIP, as defined by the NYSDOH, is a methodology for facilitating MCO- and provider-based improvements in quality of care. PIPs place emphasis on evaluating the success of interventions to improve quality of care. Through the PIPs, MCOs and providers determine what processes need to be improved and how they should be improved. Providers are strongly encouraged to participate in the conduct of these studies and in the implementation of action plans to improve performance. Participation can be accomplished by becoming a member of Healthfirst's Quality Improvement Committee (QIC).

Healthfirst is also mandated to participate in the NYSDOH's focused clinical studies annually. The NYSDOH determines the topic of focus. Participating providers, as applicable, are expected to cooperate with medical-record reviews necessary to conduct these studies, to comply with medical-records' standards, and to meet required performance thresholds established for the project. The projects, their results, and updates are published on the Healthfirst website at **https://healthfirst.org** and reported out semiannually at the QIC. For information on how to become a member of Healthfirst's QIC, or to obtain copies of the projects, please contact the Clinical Quality department.

Contract Period	Study Topic
2020-2022	Improving the Oral Health Outcomes of our 21- to 64-Year-Old Medicaid Population Through the Increased Utilization of Preventive Dental Care (MMC PIP) Improving the Health Outcomes of our HARP Population with Diabetes Mellitus Through the Early Identification & Management of Members at Risk for Complications due to Uncontrolled HbA1c, Blood Pressure, and Smoking (HARP PIP) Improving Rates of Social Determinants of Health Screening for the MLTC General Membership (MLTC PIP)

Studies – Medicare and Special Needs Plans (SNP)

Each year, Managed Care Organizations participating with Medicare Advantage Organization (MAO) and Special Needs Plans (SNPs) are required by CMS to conduct a Chronic Care Improvement Program (CCIP) for a topic that is relevant to the MCOs' member populations. The topic for the CCIP is selected from a list of chronic conditions provided by CMS. The CCIP is aimed at promoting effective management of chronic disease and improving care and health outcomes for members with chronic conditions over a three-year period.

Contract Period	Study Topic
2022-2024	Utilizing Innovative Technologies, Expanded Care Coordination, and Interdepartmental Collaboration To Improve the Diabetes Outcomes Among our High-Risk MAO Membership (MAO CCIP)

Member Satisfaction Surveys

The NYSDOH and CMS conduct annual member satisfaction surveys for applicable plan products—administered by third-party survey vendors—and provide the plans with their individual results. The NYSDOH and CMS use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys and the Qualified Health Plan Enrollee Experience Survey (QHPEES) as their survey tools. The CAHPS surveys and the QHPEES are a set of standardized questions that assess member satisfaction with the experience of care. The surveys are based on randomly selected samples of members from the MCO and summarize satisfaction with the experience of care through ratings and composites. The members' perception and experience with their providers impact a major portion of these ratings and composites. It is important that providers participating with Healthfirst conduct the delivery of services in their offices and facilities at the highest-quality level, ensuring that the needs of their patients (our members) are met to their satisfaction. Results of these surveys are communicated to providers through reporting, newsletters, our website, and/or special mailings. If you need more information about the CAHPS surveys, please visit the NCQA website, www.ncqa.org. If you need more information about the QHPEES, please visit www.CMS.gov.

Quality-of-Care Investigations

To ensure the quality and safety of the services provided to its members, and to improve member satisfaction, Healthfirst responds to any identified concerns or issues regarding provider performance through a quality review process. Review of quality-of-care referrals can include, but is not limited to, medical record review, provider contact, member contact, referral for peer review, interdepartmental review, review by the Medical Director, and review by the clinical members of the Healthfirst QIC. All clinical quality-of-care referrals are trended and tracked to identify patterns. When the inquiry/review has been completed and a final disposition is assigned to the referral, the outcome/recommendation is communicated to the referring and concerned parties, as appropriate. Information about the inquiry and review is forwarded to the Credentialing department for inclusion in the provider's files.

14.5 Quality Improvement – Medicare

Healthfirst's participation in the Medicare Advantage Program requires additional reporting requirements. The program incorporates the mandatory quality standards for the Medicare program. The Medicare program is operated under the auspices of the U.S. Department of Health and Human Services – Centers for Medicare & Medicaid Services (CMS). In order to meet these important initiatives that ensure our Medicare members receive the highest quality of care possible, providers are expected to comply with the requirements of Healthfirst, CMS, and the Quality Improvement Organization (QIO) designated as the review agent for CMS.

The Medicare Stars Rating system, a program administered by CMS, measures the quality of Medicare Advantage plans and supports CMS' efforts to drive improvements in Medicare quality and improve the level of accountability for the care provided by physicians, hospitals, and other providers. CMS publishes the star ratings each year to assist beneficiaries in finding the best plan for them and to determine MA Quality Bonus Payments.

The Stars Rating system is consistent with CMS' Three Aims: better care, healthier people/healthier communities, and lower costs through improvements.

The measures in the Medicare Stars Rating system fall into the following domains:

- Staying Healthy: Screenings, Tests, Vaccines
- Managing Chronic Conditions
- Member Experience with Health Plan
- Member Complaints and Changes in the Health Plan's Performance
- Health Plan Customer Service
- Drug Safety and Accuracy of Drug Pricing

The most recent measure-set used in the Stars program can be found on the CMS website: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html

Member surveys

Medicare members may be asked to provide feedback by answering up to three surveys per year. Not all Medicare members receive these three annual surveys:

1. **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey:** Provided to Medicare members to rate their satisfaction with their doctors and the plan. Members may be asked questions like:
    a. In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment as soon as you thought you needed one?
    b. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
    c. How often did your health plan's customer service give you the information or help you needed?
2. Health Outcomes Survey (HOS): Provided to Medicare members to rate their physical and mental health. Members may be asked questions like:
    a. In the past 12 months, did a doctor or other healthcare provider advise you to start, increase, or maintain your level of exercise or physical activity?
    b. Has your doctor or other healthcare provider done anything to help prevent falls or treat problems with balance or walking?
    c. Have you ever talked with a doctor, nurse, or other healthcare provider about leaking of urine?
3. Health Risk Assessment (HRA) Survey: The HRA survey is given once a year to all Medicare members. Members are to complete the HRA survey within 90 days of enrolling in a SNP plan, and once a year after that. This survey asks about health status and to identify any health conditions or concerns a member may have.

14.6 Quality Evaluation of Providers

Healthfirst uses standardized and evidence-based tools to evaluate the quality of providers in our network. Healthfirst evaluates the quality of providers by applying an Overall Quality Score (OQS), formerly known as Overall Quality Rating (OQR), a numerical score on a scale of 1.0 to 5.0 that summarizes the provider's weighted average performance on select quality measures. The quality measures used to determine the OQS (as well as their respective cut points and target rates) are informed by the Medicare Stars Rating system and the New York State Department of Health Medicaid, Essential Plan, and HARP Incentive Programs, which are updated yearly. Program parameters (measure weights, cut points, and target rates) are modified at the discretion of Healthfirst to adjust for Healthfirst-specific goals or network performance. Healthfirst's detailed methodology for calculating OQS is available upon request.

Providers are evaluated on several domains for quality, such as:

- **Adult and Pediatric Preventive Care** (e.g. measures related to well-care visits, screenings, and immunizations
- **Chronic Care Management** (e.g., measures related to asthma and diabetes)
- **Acute Care Management** (e.g., measures related to pharyngitis and bronchitis)
- **Efficiency of Care** (e.g., measures related to hospital utilization rates and medication adherence)
- **Enrollee Experience and Satisfaction with Care**

Providers will have access to their quality data and performance through Healthfirst's online reporting tools and electronic reports distributed by Healthfirst. Healthfirst will review providers' performances throughout the calendar year (January–December) for which the program is being administered. Healthfirst will calculate and share final performance and OQS results with providers eligible for evaluation by late Q2 or early Q3 of the following year.

Providers falling at or below the Minimum Quality Targets / Score will receive an indication of such in electronic reports distributed by Healthfirst and will be given the opportunity to work with Healthfirst on improving performance.

Providers can appeal their Overall Quality Score by following the guidelines briefly described in Section 16.2 of this Provider Manual. Healthfirst reserves the right to deny or disqualify appeals, as applicable.

For additional information, please email HQIP@Healthfirst.org

15 Appeals and Grievances

Please Note:

- **Medicare** related information can be found in sections 15.1-15.7
- **Medicaid/CHPlus/Commercial** related information can be found in sections 15.8-15.18

15.1 Provider Notice Requirements – Medicare

Because Healthfirst serves various types of members who are covered under a variety of commercial and governmental contracts, the requirements for appeals and grievances may differ among the different products offered. The title bar above each section indicates the program(s) for which the information applies. The sections within Appendix XIII contain copies of all forms, notifications, and documents referenced in this section.

Member Dissatisfaction with Specialist Providers

Members who are not satisfied with the care provided by a particular specialist provider have the option of switching to an alternative in-network provider of the same specialty if a suitable alternative exists. The member's PCP must be involved in the transition of the member to an appropriate specialist and should discuss the issue with the member. The PCP may also suggest that the member obtain a second opinion prior to changing a specialist altogether.

If the PCP feels strongly that the specialist with whom the member is dissatisfied is uniquely qualified to deal with the member's medical needs, the PCP should discuss this with the member to continue the existing relationship. If the member still wants to change specialists, the PCP should refer the member to a new specialist and inform him/her to contact Member Services to file a grievance against the initial specialist.

Noncovered Benefits

If the provider recommends a course of treatment or service that is a noncovered benefit, the provider must:

- Inform the member, in writing, that the service or item may not be covered by Healthfirst and that the member will be responsible for payment of those services, OR
- If the provider is willing to waive payment, inform the member that he or she will be held harmless for payment if Healthfirst determines that the treatment or service is not covered. Where a provider has not been given a list of covered services by Healthfirst or the provider is uncertain as to whether a service is covered, the provider should make reasonable efforts to contact Healthfirst to obtain a coverage determination prior to advising a member about coverage and liability for payment and prior to providing the service.

15.2 SNF/HHA/CORF Provider Service Terminations – Medicare

Grijalva Decision

Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) providers are responsible for delivering the Notice of Medicare Non-Coverage (NOMNC) to Medicare managed care members prior to the cessation of services for medical necessity determinations. For denials of SNF 100-day Benefit Exhaustion, admission to SNF, Home Care or CORF that is Not Covered, or when single service ends but skilled stay continues, the Notice of Denial of Medical Coverage (NDMC) will be issued. The delivery must be made to the managed care member two (2) days before the termination of the covered services and will not be considered valid until the member signs and dates the notice. If the member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the member's legally authorized representative. If no authorized representative has been appointed, then the facility should seek the requested signature from the caregiver on record

(i.e., the family member involved in the plan of treatment). If the member has no legally authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the member.

The Notice of Medicare Non-Coverage will be faxed to you, along with every preauthorization and concurrent authorization approval letter issued on behalf of Healthfirst members. It is imperative that you keep this form on file until it is time to present it two (2) days before discharge or within the last two sessions of home health services or therapy/rehabilitation. In addition, it is important that you understand that Healthfirst will not be responsible for any charges that extend past the authorized amount due to the failure of a provider/facility to deliver the notice and secure a member's signature.

Request of Immediate Quality Improvement Organization (QIO) Review (QIO Appeal) of SNF/HHA/CORF Provider Service Terminations

A member receiving skilled provider services in a SNF, HHA, or CORF who wishes to appeal a Healthfirst decision to terminate such services because care is no longer medically necessary must request an immediate QIO review of the determination, in accordance with CMS requirements.

When to Issue Detailed Explanation of Non-Coverage

Once the QIO receives an appeal, it must issue a notice to Healthfirst that a member appealed the termination of services in SNF/HHA/CORF settings. Upon receipt of this notice, Healthfirst is responsible for issuing the Detailed Explanation of Non-Coverage – a written notice that is designed to provide specific information to Medicare members regarding the end of their SNF, HHA, or CORF care (See Appendix XIII).

Healthfirst must issue a Detailed Explanation of Non-Coverage (DENC) to both the QIO and the member no later than the close of business when the QIO notifies Healthfirst that a member has requested an appeal.

Healthfirst is also responsible for providing any pertinent medical records used to make the termination decision to the QIO, although the QIO will seek pertinent records from both the provider and Healthfirst.

Immediate QIO Review Process of SNF/HHA/CORF Provider Service Terminations

On the date that the QIO receives the member's request, the QIO must notify Healthfirst and the provider that the member has filed a request for immediate review. The SNF/HHA/CORF must supply a copy of the Notice of Medicare Non-Coverage and any other information that the QIO requires to conduct its review. The information must be made available by phone, by fax, or in writing by the close of the business day of the appeal request date.

Healthfirst must supply a copy of the Notice of Medicare Non-Coverage, Detailed Explanation of Non-Coverage, and any medical information that the QIO requires to conduct its review. The information must be made available by phone, by fax, or in writing by the close of the business day that the QIO notifies Healthfirst of an appeal. If a member requests an appeal on the same day the member receives the Notice of Medicare Non- Coverage, then Healthfirst has until close of business the following day to submit the case file.

The QIO must solicit the views of the member who requested the immediate QIO review. The QIO must make an official determination of whether continued provider services are medically necessary and notify the member, the provider, and Healthfirst by the close of the business day after it receives all necessary information from the SNF/HHA/CORF, Healthfirst, or both. If the QIO does not receive the information it needs to sustain the Healthfirst decision to terminate services, then the QIO may make a decision based on the information at hand or it may defer its decision until it receives additional required information. If the QIO defers its decision, then coverage of the services by Healthfirst will continue and the QIO will refer violations of notice delivery to the CMS regional office.

A member should not incur financial liability if, upon receipt of the Notice of Medicare Non-Coverage:

- The member submits a timely request for immediate review to the QIO that has an agreement with the provider;
- The request is made either in writing, by telephone, or by fax by noon (12pm) of the next day after receiving the notice;

- Healthfirst meets its time-frame obligations to deliver medical information and a Detailed Explanation of Non-Coverage to the QIO; and,
- the QIO either reverses the Healthfirst termination decision or the member stops receiving care no later than the date that the member receives the QIO's decision.

The member will incur **one day** of financial liability if the QIO upholds the Healthfirst termination decision and the member continues to receive services until the day after the QIO's decision. This should be the same date as the Healthfirst initial decision to terminate services.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited appeal with Healthfirst. Healthfirst will expedite the request for an expedited appeal if the QIO receives a request for an immediate QIO review beyond the noon (12pm) filing deadline and forwards that request to Healthfirst. Healthfirst would generally make an expedited decision about the services within 72(seventy-two) hours. Financial liability applies in both the immediate QIO review and Healthfirst expedited review situations.

If an appeal occurs during a weekend, a Healthfirst Care Manager will contact the nursing office or SNF/HHA/CORF administrator on duty to facilitate the delivery of the Detailed Explanation of Non-Coverage.

15.3 Notification to Members of Non-Coverage of Inpatient Hospital Care – Medicare

In instances where Healthfirst has authorized coverage of the inpatient hospital admission of a Medicare member, either directly or by delegation (or the admission constitutes emergency or urgently needed care), Healthfirst is required to issue the member a written notice of non-coverage only under the circumstances described below.

Hospital Discharge Notification Process

Healthfirst delegates the issuance of discharge notices to all its participating hospitals. Specifically, participating hospitals must:

- Issue the Important Message from Medicare About Your Rights (see Appendix XIII) and explain discharge rights to beneficiaries within two (2) calendar days of admission. They must also obtain the beneficiary's signature or his/her representative's. If a member refuses to sign the notice, the hospital must annotate the refusal.
- Deliver a copy of the signed notice not more than two (2) calendar days before discharge. In short-stay situations, when inpatient stays are five (5) days or fewer, hospitals are not required to deliver a follow-up notice as long as the initial notice was delivered within two (2) calendar days of discharge.
- If a member disputes (appeals) the discharge and contacts the Quality Improvement Organization (QIO) for an immediate review, Healthfirst will complete and fax the Detailed Notice of Discharge (DNOD) to the hospital administrator or nursing director on duty (the member's medical record must be faxed to Healthfirst by 4pm that day).
- The hospital must deliver a copy of the DNOD to the member. The hospital may not create its own DNOD and deliver it to the member without Healthfirst's approval. Healthfirst will also fax a copy of the DNOD to the QIO for review and/or an expedited reconsideration. The QIO and/or Healthfirst will work with the hospital and attending physician to determine if discharge is appropriate.
- If an appeal occurs during a weekend, a Healthfirst Care Manager will contact the nursing office or hospital administrator on duty to facilitate the delivery of the DNOD.

Template documents to be used for this process are available on the CMS website at www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage. For additional information, please visit our website at **https://www.hfproviders.org/.**

Requesting Immediate Quality Improvement Organization (QIO) Review of Inpatient Hospital Care

A member remaining in the hospital who wishes to appeal the Healthfirst discharge decision that inpatient care is no longer medically necessary must request an immediate QIO review of the determination in accordance with CMS requirements. A member will not incur any additional financial liability if he/she:

- Remains in the hospital in inpatient care;
- Submits the request for immediate review to the QIO that has an agreement with the hospital;
- Makes the request either in writing, by telephone, or by fax; and
- Makes the request before the end of the day of discharge.

The following rules apply to the immediate QIO review process:

- On the date that the QIO receives the member's request, the QIO must notify Healthfirst that the member has filed a request for immediate review.
- Healthfirst and/or the hospital must supply any information that the QIO requires to conduct its review. This must be made available by phone, by fax, or in writing by the close of business of the first full working day immediately following the day the member submits the request for review.
- In response to a request from Healthfirst, the hospital must submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day Healthfirst makes its request.
- The QIO must solicit the views of the member who requested the immediate QIO review.
- The QIO must make an official determination of whether continued hospitalization is medically necessary and notify the member, the hospital, and Healthfirst by close of business of the first working day after it receives all necessary information from the hospital, Healthfirst, or both.

A member who fails to request an immediate QIO review in accordance with these requirements may file a request for an expedited appeal with Healthfirst. Healthfirst is encouraged to expedite the request for an expedited appeal. Likewise, the QIO is encouraged to expedite a request for immediate QIO review if received after the noon (12pm) filing deadline. The request must also be forwarded to Healthfirst.

Thus, Healthfirst would generally make an expedited decision about the services within 72 (seventy-two) hours; however, the financial liability rules governing immediate QIO review do not apply in an expedited review situation. This means that the member could be financially liable if the discharge decision is upheld.

Liability for Hospital Costs

The presence of a timely appeal for an immediate QIO review as filed by the member or member representative in accordance with this section entitles the member to automatic financial protection by Healthfirst. This means that if Healthfirst authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, Healthfirst continues to be financially responsible for the costs of the hospital stay (less any member copayments, coinsurance, or deductibles) until noon (12pm) of the calendar day following the day the QIO notifies the member of its review determination.

15.4 Organization Determinations and Reconsiderations (Appeals)– Medicare

When Healthfirst receives a request for payment or to provide services to a member, it must determine whether payment and/or coverage is necessary and appropriate.

If the determination is not made in a timely manner or is unfavorable, the member has the right to request a reconsideration or appeal.

A member who disagrees with a practitioner's decision about a request for a service or a course of treatment has a right to request an organization determination from Healthfirst. The member should be referred to their EOC or should contact Healthfirst Member Services for additional information.

Type of Request	Definitions	Stakeholders Who Can Submit		
		Member (Includes AOR)	Contracted Provider (INN)	Non-Contracted Provider (OON)
Appeal (Pre-Payment)	The review of adverse organization determinations on the healthcare services an enrollee believes he or she is entitled to receive, including delayin providing, arranging for, or approving the healthcare services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service	Yes	Yes	Yes
Appeal (Post-Payment)		Yes	No	Yes
Coverage Request (OD/CD)	Request for a decision made by or on behalf of a plan regarding payment or benefits to which an enrollee believes he or she is entitled. OD = Organization Determination (Part C) CD = Coverage Determination (Part D)	Yes	Yes	Yes

Healthfirst is required to make organization determinations and process appeals as expeditiously as the member's health status requires, but no later than indicated in the following chart:

Time Frames for Organization Determinations and Reconsiderations (Appeals)	
Organization Determinations	**Reconsiderations (Appeals)**
Standard – Not to exceed 14 calendar days. The 14-day deadline may be extended by 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.	**Standard (Service-Related)** – Not to exceed 30 calendar days. The 30-day deadline may be extended by 14 calenda days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member. **Standard Only –** Payment/Claims-Related Not to exceed 60 calendar days
Expedited – Not to exceed 72 hours. The 72- hour deadline may be extended by 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.	**Expedited –** Not to exceed 72 hours. The 72-hour deadline may be extended by 14 calendar days if the member requires the extension or Healthfirst justifies the need for additional information that will benefit the member.

A member has a right to appeal if the member believes that:

- Healthfirst has not paid for emergency, post-stabilization, or urgently needed services
- Healthfirst has not paid a bill in full
- A noncontracting medical provider or facility or supplier furnished health services that should have been provided by, arranged for, or reimbursed by Healthfirst

- Services that are the responsibility of Healthfirst to provide or pay for have not been received or paid for
- A previously authorized ongoing course of treatment has been reduced or prematurely discontinued and the services are still medically necessary
- An organization determination has not been made within the appropriate time frames
- Noncovered services that should be provided, arranged, or reimbursed have not been provided, arranged, or reimbursed

Time Frames and Methods for Submitting Standard Appeals

Appeal requests can be made in writing or orally within 60 (sixty) calendar days from the date of the notice of organization determination. Healthfirst may extend the time frame for filing a request for reconsideration for good cause. Appeals received after the 60-day time frame must be in writing and state why the request for an appeal was not filed on time.

A member or a member's representative may also request a standard appeal request of an organization determination in writing or orally. A member can name a relative, friend, advocate, attorney, doctor, or someone else to act on his/her behalf; in some cases, others authorized under state law may act on behalf of the member. Providers and/or member advocates acting on behalf of a member must complete an Appointment of Representative Statement (Appendix XIII-E) for the services in question.

Requests for Additional Medical Documentation

Healthfirst will make reasonable efforts to request clinical documentation to substantiate services in a timely manner in the event the information is not submitted with the initial request. Providers should understand that delays or failures to submit necessary clinical information may put a member's health in jeopardy.

If further information about the member's appeal is required to render a reconsideration decision, providers must submit the additional information in a timely manner to allow for resolution within regulatory time frames.

For Expedited Reconsiderations

Participating providers should submit all supporting clinical information when requesting expedited considerations of an appeal. If additional information is needed to help resolve the submitted appeal, Healthfirst will make reasonable efforts to contact the provider to request such information. Any additional clinical documents should be submitted within 24 hours and can be faxed to the Appeals and Grievances department at 1 (646) 313-4618.

For Standard Reconsiderations

If additional information is needed to help resolve a standard appeal, Healthfirst will make reasonable efforts to contact the provider to request such information. Any additional information requested should be submitted within 10 calendar days and can be faxed to the Appeals and Grievances department at 1 (646) 313-4618.

Appeal Determinations

If Healthfirst reverses an initial adverse organization determination, then services will be authorized or provided as expeditiously as the member's health condition requires, but no later than 30 (thirty) calendar days from the date the request for standard appeal was received or no later than upon expiration of an extension; and within 72 hours from the date the request for expedited appeal was received or no later than upon expiration of an extension. For payment-related requests, payment will be made no later than 60 (sixty)calendar days after the appeal request was received.

If Healthfirst upholds an initial adverse organizational determination upon appeal, the case will be referred to the Independent Review Entity (IRE) contracted by CMS for an independent review.

If CMS' contractor upholds the Healthfirst adverse organization determination, the contractor will notify the member in writing and explain further appeal options that may be available to the member.

If CMS' contractor reverses the Healthfirst appeal determination for standard service requests, Healthfirst will effectuate the services appealed within 14 (fourteen) calendar days of receipt of the IRE's notice, and if the member's condition does not allow for this, then services will be authorized within 72 hours from the date of the IRE notices. IRE reversals of expedited service request appeals will be authorized or provided within 72 hours of receipt of the IRE notice. Payment requests that the IRE reverses will be effectuated within 30 (thirty) calendar days of receipt of the IRE's notice.

If Healthfirst does not complete an expedited appeal process within 72 hours or a standard appeals process within 30 (thirty) calendar days or a payment-related request within 60 (sixty) calendar days, the case will be automatically referred to CMS' contractor for an independent review.

A member who wishes to submit a verbal request for an expedited appeal should be directed to call 1 (877) 779-2959.

For Dual-eligible members: If Healthfirst upholds an initial adverse organizational determination upon appeal, the case will be referred to the Integrated Administrative Hearing Office (IAHO) for an independent review.

If the IAHO upholds the Healthfirst adverse organization determination, the IAHO will notify the member in writing and explain further appeal options that may be available to the member.

If the IAHO reverses the Healthfirst appeal determination for standard service requests, Healthfirst will effectuate the services appealed.

If CMS' contractor upholds the Healthfirst adverse organization determination, the contractor will notify the member in writing and explain further appeal options that may be available to the member.

If CMS' contractor reverses the Healthfirst appeal determination for standard service requests, Healthfirst will effectuate the services appealed within 14 (fourteen) calendar days of receipt of the IRE's notice, and if the member's condition does not allow for this, then services will be authorized within 72 hours from the date of the IRE notice. IRE reversals of expedited service request appeals will be authorized or provided within 72 hours of receipt of the IRE notice. Payment requests that are reversed by the IRE will be effectuated within 30calendar days of receipt of the IRE's notice.

If Healthfirst does not complete an expedited appeal process within 72 (seventy-two) hours or a standard appeals process within 30 (thirty) calendar days or payment related within 60 (sixty) calendar days, the case will be automatically referred to CMS' contractor for an independent review.

A member who wishes to submit a verbal request for an expedited appeal should be directed to 1 (877) 779-2959.

Please Note: Dual-Eligible Members Only

CompleteCare members have both Medicaid and Medicare benefits and have different options when filing an appeal for services covered under the benefit package. For Healthfirst services funded by the state contract, members must follow Medicaid appeal rules. For services funded through the Medicare program, members must follow Medicare appeal rules. For services covered by both Medicaid and Medicare funding, members can follow either Medicaid or Medicare rules. If a member chooses to pursue Medicaid appeal rules to challenge an organizational determination or action, he/she has 60 (sixty) calendar days from the date on the Notice of Denial of Coverage issued by Healthfirst to also pursue a Medicare appeal, regardless of the status of the Medicaid appeal. However, if a member chooses to pursue a Medicare appeal, he or she may not file an appeal under Medicaid. Healthfirst determines whether Medicaid, Medicare, or both cover a particular service.

15.5 Expedited Organizational Determinations and Appeals

Expedited Organizational Determination

If a Healthfirst member, appointed representative, or member's provider believes an expedited organizational determination is required because a delay would significantly increase risk to the member's health, the Healthfirst

member, their appointed representative, or the provider may call Healthfirst at 1 (888) 394-4327 to request an expedited organizational determination.

If Healthfirst denies the request for an expedited organizational determination, Healthfirst will notify the member or the member's representative and the provider in writing within three calendar days (Medicare and Leaf Plans) or three business days (Medicaid) and include the member's right to an expedited grievance. Healthfirst will then process the organizational determination using the standard determination time frames.

If a provider requests or supports the member's request for an expedited organizational determination, Healthfirst must automatically expedite the organizational determination.

- Within 72 hours (Medicare and Leaf Plans) or three business days (Medicaid) of receipt of the request, we will call the member, the member's designee, and the provider to notify them of the determination we have made.
- Written notice will follow within one calendar day of the determination. If the member requests an extension or Healthfirst needs additional information, we will extend the time frame up to 14 calendar days.
- The member, the member's designee, and the provider will be notified in writing of the extension and will be provided with the right to file an expedited grievance if he or she disagrees with Healthfirst's decision to grant an extension.

Expedited Appeal

If a Healthfirst member or that member's provider believes an expedited appeal is required because a delay would significantly increase risk to the member's health, the member or the member's appointed representative may request an expedited appeal by calling Healthfirst at 1 (877) 779-2959.

- If Healthfirst denies the request for an expedited appeal, Healthfirst will notify the member and/or the member's representative and review the appeal using the standard appeal process. If a provider requests or supports the member's request for an expedited determination or appeal, Healthfirst must automatically expedite the review.
- The member's provider can also request an expedited appeal if the denial was made during a concurrent review (request for extension of services beyond the time or quantity currently authorized).

In addition, the member or the member's designee may provide additional information to Healthfirst, either in person or in writing, including evidence and allegations of fact or law related to the issue in dispute. If further information regarding the member's appeal is required to render the reconsideration decision, providers must submit the additional information in a timely manner. For an expedited appeal, additional information must be provided within three business days from the date of Healthfirst's receipt of the appeal.

The time frame for appeal resolution may be extended up to 14 days if the member, the member's designee, or the member's provider requests an extension orally or in writing. The expedited appeal may be extended by Healthfirst for up to 14 days if Healthfirst justifies the need for more information and believes the extension is in the best interest of the member.

Oral appeals may be requested by calling 1 (888) 260-1010. Any oral appeal can be followed up with a written submission for the request. Please send such requests to our Appeals and Grievances department:

Healthfirst Appeals and Grievances Department
P.O. Box 5166
New York, NY 10274.

Appeal Determinations

Standard appeals: Healthfirst will make a determination with regard to a standard appeal within 30 calendar days from the date we received the appeal.

Expedited appeals: Healthfirst will make a determination with regard to an expedited (fast-track) appeal within the lesser of 72 hours of receipt of the request (Healthfirst Leaf Plan and Medicare Plan members) or three business

days from receipt of request (Medicaid members) or two business days of receipt of the necessary information to conduct the appeal for all members.

Initial adverse organizational determination:

- If Healthfirst reverses an initial adverse organizational determination, then services will be authorized or provided as expeditiously as the member's health condition requires, but no later than 30 calendar days from the date the request for standard appeal was received or no later than upon expiration of an extension; and within 72 hours from the date the request for expedited appeal was received or no later than upon expiration of an extension. For payment-related requests, payment will be made no later than 60 calendar days after the appeal request was received.
- If Healthfirst upholds an initial adverse organizational determination upon appeal, the case will be referred to the Independent Review Entity (IRE) contracted by CMS for an independent review.
- If CMS' contractor upholds the Healthfirst adverse organizational determination, the contractor will notify the member in writing and explain further appeal options that may be available to the member.

If CMS' contractor reverses Healthfirst's appeal determination for standard service requests, Healthfirst will effectuate the services appealed within 14 calendar days of receipt of the IRE's notice, and if the member's condition does not allow for this, then services will be authorized within 72 hours from the date of the IRE notice. IRE reversals of expedited service request appeals will be authorized or provided within 72 hours of receipt of the IRE notice. Payment requests that are reversed by the IRE will be effectuated within 30 calendar days of receipt of the IRE's notice.

If Healthfirst does not complete an expedited appeal process within 72 hours or a standard appeal process within 30 calendar days, the case will be automatically referred to CMS' contractor for an independent review.

A member who wishes to submit a verbal request for an expedited appeal should be directed to 1 (877) 779-2959.

15.6 Coverage Determinations for Part D Prescription Drugs – Medicare

Most Healthfirst Medicare plans offer Medicare prescription drug coverage (Part D). Generally, the members must share costs for their prescription drugs. Drug categories on the formulary include generic, branded, and specialty. Members in our Signature (HMO), Signature (PPO), Improved Benefits Plan, Life Improvement Plan, Connection Plan, and CompleteCare pay cost shares for drugs. These cost shares are determined by the level of "Extra Help" the individual member receives. These three plans have a five-tier formulary.

- Tier 1: Preferred Generic Drugs
- Tier 2: Non-Preferred Generic Drugs
- Tier 3: Brand and Generic Drugs
- Tier 4: Non-Preferred Drugs
- Tier 5: Specialty Drugs

Healthfirst Signature (HMO), Signature (PPO)and 65 Plus Plan, however, are designed to be the recommended plans for Medicare beneficiaries who do not qualify for "Extra Help," either in the form of Low Income Subsidy (LIS) for Part D or Medicare Savings Programs (MSP) for medical benefits. As such, these plans offer a comprehensive benefit package, including additional benefits not covered by Original Medicare, but at a $0 monthly premium, making them a high-value yet affordable choice. Healthfirst Signature (HMO), Signature (PPO)and 65 Plus Plan have a six-tier prescription drug formulary.

- Tier 1: Preferred Generic Drugs
- Tier 2: Non-Preferred Generic Drugs
- Tier 3: Brand and Generic Drugs
- Tier 4: Non-Preferred Drugs
- Tier 5: Specialty Drugs
- Tier 6: Supplemental Drugs

Coverage determinations include exception requests. An exception request is the way a member can exercise his or her right to ask for an "exception" to the formulary—in other words, to request lower cost sharing, coverage of a drug not included on the formulary, or to have a utilization management requirement waived. A supporting statement from the prescribing provider must accompany an exception request.

Healthfirst strongly encourages and recommends that a prescribing provider review the current Medicare Part D formularies to identify the drugs that are covered for Healthfirst members. The formularies can help a provider identify the therapy or therapies that will be least expensive for the member. In general, the lower the drug tier, the lower the cost of the drug. The formulary can also help a provider identify the drugs and therapies that Healthfirst prefers. The formularies were developed by a Pharmaceutical and Therapeutics (P&T) Committee comprising a national panel of clinicians. The formulary can help providers understand the Healthfirst strategy for managing the pharmacy benefit. Healthfirst recognizes that sometimes this strategy may not align with a provider's treatment criteria.

Prior Authorization (PA)

Healthfirst Medicare Plan requires a member, or his or her provider, to request prior authorization for certain drugs. This means the member must obtain prior approval for a prescription from Healthfirst Medicare Plan before the prescription is filled. If you do not obtain approval, Healthfirst Medicare Plan may not cover the drug.

- **Quantity Limit (QL):** For certain drugs, Healthfirst Medicare Plan limits the amount of the drug that it will cover.
- **Step Therapy (ST):** In some cases, Healthfirst Medicare Plan requires that the member first try certain drugs to treat their medical condition before we will cover another drug for that condition.

Healthfirst's Medicare formulary, as well as Prior Authorization (PA), Step Therapy (ST), and Quantity Limit (QL) criteria listings, can be found on Healthfirst's public website, **https://healthfirst.org/formulary**.

To initiate a coverage determination request, including a request for a Part D drug that is not on the formulary (formulary exception), please contact the CVS Caremark Prior Authorization department, 7am–5:30pm MST, Monday to Friday, in one of the following ways:

- **CALL** CVS Caremark at 1-855-344-0930, 7am–5:30pm MST, Monday to Friday
- **FAX** CVS Caremark at 1-855-633-7673, 7am–5:30pm MST, Monday to Friday
- **WRITE** to CVS Caremark at:
  CVS Caremark Part D Services Attention: Prior Authorization – Part D MC109
  P.O. Box 52000
  Phoenix, AZ 85072-2000

Medicare Part D Appeals

A member's appointed representative or his or her prescribing provider may request that a coverage determination be expedited. Time frames begin after receipt of the request. A member may appeal an adverse coverage determination; however, if an exception request for a non-formulary drug is approved, the member cannot request an exception to the copayment that must be paid for the drug.

A member has a right to appeal if he or she believes that Healthfirst/CVS Caremark, Inc. did any of the following:

- Decided not to cover a drug, vaccine, or other Part D benefit,
- Decided not to reimburse a member for a Part D drug that he/she paid for,
- Asked for payment or provided reimbursement with which a member disagrees,
- Denied the member's exception request,
- Made a coverage determination with which the member disagrees.

Appeals for Part D Prescription Drugs

- **CALL** CVS Caremark at 1-855-344-0930, 7am–5:30pm MST, Monday to Friday
- **FAX** CVS Caremark at 1-855-633-7673, 7am–5:30pm MST, Monday to Friday

- **WRITE** to CVS Caremark at:
  CVS Caremark Part D Services Attention: Prior Authorization – Part D MC109
  P.O. Box 52000
  Phoenix, AZ 85072-2000

Complaints About Part D Prescription Drugs

Write to:

CVS Caremark
Attn: Grievance Department MC 121
P.O. Box 53991
Phoenix, AZ 85072-3991

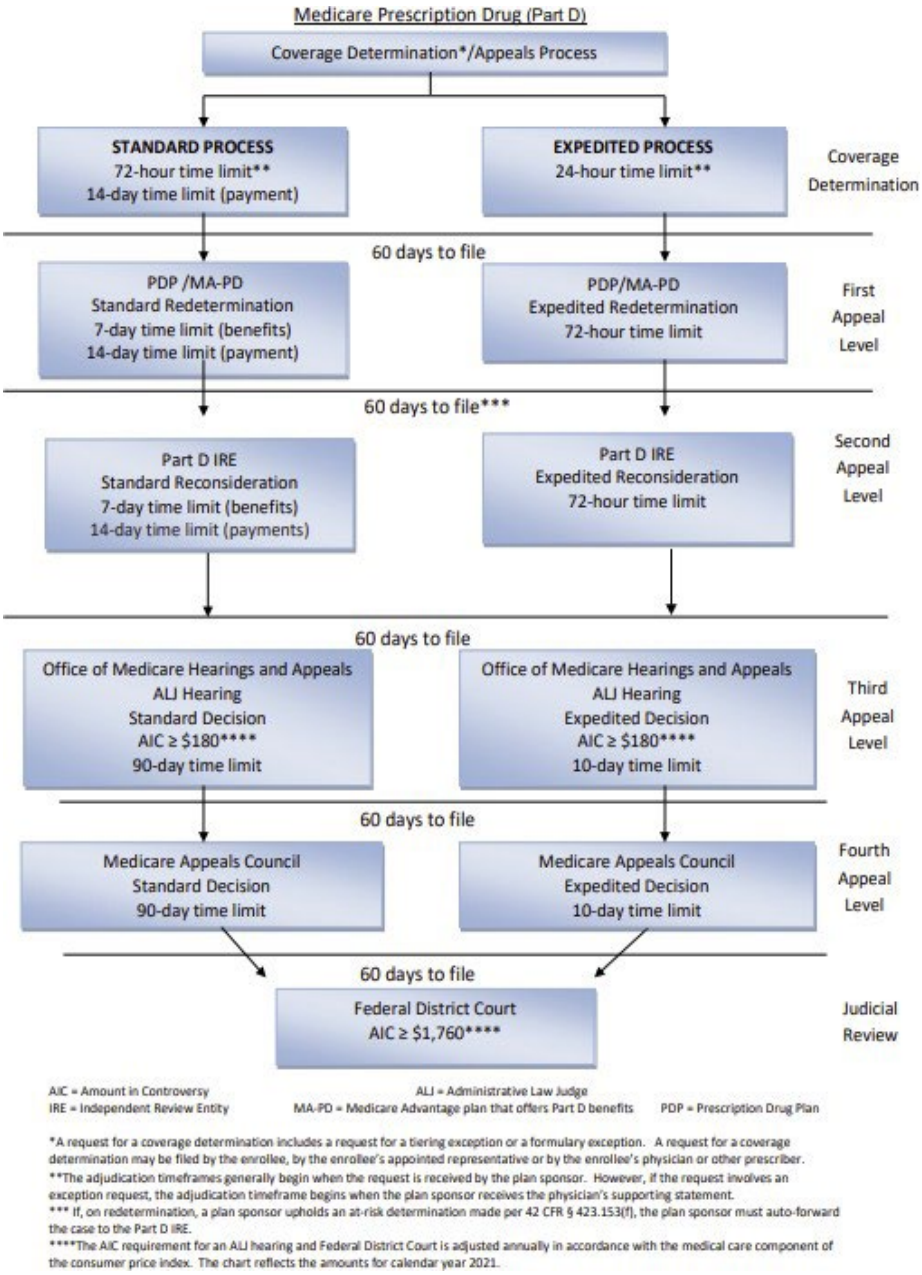
If CVS Caremark fails to meet coverage determination or redetermination time frames, it must automatically forward the member's request(s) to the Independent Review Entity (IRE) contracted by CMS.

If the IRE upholds the Healthfirst adverse coverage determination, the IRE will notify the member in writing and explain further appeal options that may be available to the member.

Time Frames for Coverage Determinations and Appeals

CVS Caremark is required to make coverage determinations and to process appeals as expeditiously as the member's health status requires but no later than is indicated in the following chart:

Medicare Prescription Drug (Part D) Time Frames for Appeals



15.7 Coverage Determinations for Prescription Drugs – Medicaid, CHPlus and Leaf Plans

The formulary outlining the Medicaid, Child Health Plus, and Leaf Plans pharmacy benefits can be found on the Healthfirst website **https://healthfirst.org/formulary**. Coverage determinations include requests for prior authorization or formulary exceptions.

Healthfirst strongly encourages/recommends that a prescribing provider review the current Medicaid, CHPlus,and Leaf Plan formularies to identify the drugs that are covered for Healthfirst members. The formulary can help a provider identify the therapy or therapies that will be least expensive for the member. In general, the lower the drug tier, the lower the cost of the drug. In addition, the formulary can help a provider identify the drugs and therapies

that are preferred by Healthfirst. The formulary was developed by a Pharmaceutical and Therapeutics Committee (P&T) comprising a national panel of clinicians. The formulary can help providers understand the Healthfirst strategy for managing the pharmacy benefit. Healthfirst recognizes that sometimes this strategy may not align with a provider's treatment criteria.

Some covered drugs may have additional requirements or limits on coverage. These requirements or limits may include:

- **Prior Authorization**: Healthfirst requires prior authorization for certain drugs. This means that approval from Healthfirst must be obtained before the prescription is filled. If approval is not obtained, Healthfirst may not cover the drug. In order to obtain prior authorization, prescribers should contact CVS Caremark at 1 (877) 433-7643 and be prepared to provide relevant clinical information that supports the medical necessity of the required medication. A comprehensive formulary is also available on the Healthfirst website https://healthfirst.org/formulary or by contacting the Member Services department at 1 (866) 463-6743.
- **Quantity Limits:** For certain drugs, Healthfirst limits the amount of the drug that is covered.
- **Step Therapy:** In some cases, Healthfirst requires a member to first try certain drugs to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat the medical condition, Healthfirst may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, Healthfirst will then cover Drug B. However, if it is a new member who has already tried Drug A before taking Drug B, Healthfirst will not require the member to try Drug A again. You should notify us if this is the case.

You can ask Healthfirst to make an exception to these restrictions or limits. Please contact CVS Caremark at 1 (877) 433-7643 for information about how to request an exception.

To initiate a coverage determination request, including a request for a drug that is not on the formulary (formulary exception), please contact the CVS Caremark Prior Authorization department in any of the following ways:

Coverage Determinations for Medicaid and CHPlus	**Phone:** 1 (877) 433-7643 Calls to this number are free, 8:00am–6:00pm CST **Fax:** 1 (866) 848-5088 While no specific form is required, the NY State Medicaid Standard Global Prior Authorization form can be found at the website: www.hfproviders.org. **Mail:** Attn: Healthfirst NY Medicaid Prior Authorization 1300 E. Campbell Road Richardson, TX 75081
Coverage Determinations for Leaf Plans	**Phone:** 1 (800) 294-75979 Calls to this number are free, 8:00am–6:00pm CST **Fax:** 1 (866) 836-0730 While no specific form is required, the NY State Medicaid Standard Global Prior Authorization form can be found at the website: www.hfproviders.org. **Mail:** Attn: Healthfirst NY Medicaid Prior Authorization 1300 E. Campbell Road Richardson, TX 75081

Healthfirst's formulary, as well as Prior Authorization (PA), Step Therapy (ST) and Quantity Limit(QLL) criteria listings, can be found on Healthfirst's public website: https://healthfirst.org/formulary

15.8 Action Denial Notice – Medicaid and CHPlus

An action can be considered any of the following activities of the plan or its delegated entities that results in:

- The denial or limited authorization of a Service Authorization Request, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service, which must be mailed to a Medicaid enrollee on the date of such denial, whether it is a partial or full denial (this is done in the form of an Explanation of Benefits)
- The denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner, as defined by applicable state law and regulation
- Failure of Healthfirst to act within the time frames for resolution and notification of determinations regarding Complaints, Action Appeals, and Complaint Appeals provided in Section 15.6 of this manual
- The restriction of an enrollee to certain network providers under the Contractor's Recipient Restriction Program

For Medicaid Actions, a written notice of an adverse determination for any partial or full denial of a prior, concurrent, or retrospective request for authorization will be sent to a Medicaid member and provider using the NYS Department of Health–approved Initial Adverse Determination letter. This letter will include:

- The reasons for the determination, including the clinical rationale, if any
- Instructions on how to initiate internal appeals (standard and expedited) and eligibility for external appeals
- Notice of the availability, upon request of the enrollee or the enrollee's designee, of the clinical review criteria relied upon to make such determination

The notice will also specify what, if any, additional necessary information must be provided to, or obtained by, the MCO in order to render a decision on the appeal

- A description of action(s) to be taken
- A statement that the MCO will not retaliate or take discriminatory action if an appeal is filed
- The process and time frame for filing/reviewing appeals, including the enrollee's right to request an expedited review
- The enrollee's right to contact NYS Department of Health, with the Department's toll-free number, regarding their complaint
- Fair Hearing Notice, including Aid to Continue rights in the Managed Care Action Taken form
- A statement that notice is available in other languages and formats for special needs and how to access these formats

15.9 Action Appeals – Medicaid and Medicaid Advantage Plus

An Action Appeal is a request for a review of an Action (see Glossary of Terms, Section 18 rof Manual). A member or a member's designee shall have no more than 60 (sixty) calendar days after receipt of the notice of the Action determination for Medicaid Managed Care to file an appeal, which may be submitted orally by calling Member Services or by written request.

An oral Action Appeal can be filed by calling the Healthfirst Member Services toll-free telephone during normal business hours, as well as via a telephone system available to take after-hours calls. If a member's designee makes the request, the plan may ask for the enrollee's written consent for representatives to request a plan appeal, grievance, or fair hearing on their behalf. Providers may request an appeal or a fair hearing but may not request Aid Continuing.

Providers should submit supporting clinical information along with the request for appeal, and in any event should do so within 10 calendar days of the request. Clinical documentation can be faxed to the Appeals and Grievances department, fax no.1 (646) 313-4618.

Healthfirst will request any clinical documentation required to substantiate services within five (5) days of receipt of the partial information. Failure to provide requested clinical information within five days may jeopardize a member's health.

Within 15 (fifteen) calendar days of receipt of the appeal, Healthfirst shall provide written acknowledgment of the Action Appeal, including the name, address, and telephone number of the individual Healthfirst designates to respond

to the appeal and what additional information, if any, must be provided in order for the organization to render a decision.

Healthfirst shall designate one or more qualified personnel to review the Action Appeal, provided that when the Action Appeal pertains to clinical matters, the personnel shall include licensed, certified, or registered healthcare professionals.

Healthfirst must allow the member or his/her designee, both before and during the Action Appeals process, the opportunity/ability to examine the member's case file, including medical records and any other documents and records considered during the Action Appeals process. The member may submit evidence and documentation to support their appeal in writing or in person. The member or his/her designee is subject to the Release of Information process.

Initial and Final adverse determinations are compliant with 42 CFR 438 requirements.

Clinical Matters

The determination of an appeal on a clinical matter is made 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 as defined in Article 49 of NYS Public Health Law.

Nonclinical Matters

The determination of an appeal on a matter which is not clinical shall be made by qualified personnel at a higher level than the personnel who made the Action determination.

Timeliness of Action Appeals Determination

Healthfirst shall seek to resolve all appeals in the most expeditious manner. Healthfirst must resolve an Action Appeal as fast as the member's condition requires and no later than 30 (thirty) calendar days from the date of receipt of the Action Appeal.

Healthfirst must resolve Expedited Action Appeals as fast as the member's condition requires but within 72hours of the date of the receipt of the Expedited Action Appeal.

Time frames for Action Appeal resolution may be extended for up to 14 (fourteen) calendar days if requested by Healthfirst, the member, his or her designee, or the provider if it is in the best interest of the member. We will make reasonable efforts to give prompt oral notice of an extension and written notice within two calendar days.

In the event Healthfirst requires additional information to process the appeal, Healthfirst shall request the additional information in writing.

If Healthfirst does not make a determination within the time frames specified, as applicable, this shall be deemed to be a reversal of the Utilization Review agent's adverse determination.

15.10 Expedited Appeals – Medicaid and Medicaid Advantage Plus

A Healthfirst member, his or her representative, or a participating provider may request expedited consideration of an appeal if the standard time frame would seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Expedited appeals are processed within 72 hours. Time frames for Action Appeal resolution may be extended for up to 14 (fourteen) calendar days if requested by Healthfirst, the member, his or her designee, or the provider if it is in the best interest of the member. Plans must make reasonable efforts to give prompt oral notice of an extension and written notice within two calendar days. We will provide reasonable access to our clinical peer reviewer within one business day of receiving an expedited appeal.

If the member's designee makes the request, the plan may ask for the enrollee's written consent for representatives to request a plan appeal, grievance, or fair hearing on their behalf. Providers may request an appeal or a fair hearing but may not request Aid Continuing.

Providers should submit supporting clinical information along with the expedited appeal request, and in any event, within 24 hours of the expedited request. Clinical documentation can be faxed to the Appeals and Grievances department at 1 (646) 313-4618.

Healthfirst will request any clinical documentation required to substantiate services. However, failure to provide requested clinical information in a timely manner may put a member's health in jeopardy.

Notice of an Action Appeal Determination

The notice of a determination on an appeal shall include the detailed reasons for the determination and, in cases where the determination has a clinical basis, the clinical rationale for the determination.

Medicaid and Medicaid Advantage Plan

Healthfirst will Immediately notify by phone, and send written notice to, the member, his or her designee, and the provider (where appropriate) within 24 hours of the Action Appeal determination.

15.11 Member Rights to a Fair Hearing – Medicaid, Medicaid Advantage Plus

Medicaid and Medicaid Advantage Plus members may request a Fair Hearing regarding adverse determinations concerning:

- Enrollment, disenrollment, eligibility
- Denial, termination, suspension, or reduction of a clinical treatment or other benefit package services by Healthfirst that is covered under the Medicaid benefit
- Healthfirst's lack of reasonable promptness to act regarding these services

The Appeals and Grievances department will issue the Fair Hearing Form, which contains the member's Fair Hearing Rights with instructions on how to request a Fair Hearing, along with its final adverse determination when Healthfirst has denied a request to approve a benefit package service ordered by a participating provider.

For Medicaid Advantage Plus members, the Appeals and Grievances department will issue the Fair Hearing Form with the final adverse determination on an Action Appeal of the denial of Medicaid-only services.

If you have questions about the Fair Hearing process or would like additional information, please call Provider Services at 1 (888) 801-1660.

15.12 External Review – Medicaid, Medicaid Advantage Plus, Healthfirst Leaf Plans, and Commercial Plans

For external appeals related to a concurrent or retrospective review, members and their healthcare providers can request an external appeal for the following types of denials:

- Non-medically necessary services (they may be considered experimental or investigational)
- Clinical trials or treatments of rare diseases
- When out-of-network services are denied as result of their being:
    - materially different from in-network services
    - considered treatment for a rare disease.

If both the member and Healthfirst agree to waive the Healthfirst appeals process, then the member must ask for the external appeal within four (4) months of when the member made the agreement from the date of the denial determination. If this occurs, Healthfirst will provide a written letter with information regarding filing an external appeal to the member within twenty-four (24) hours of agreement to waive the internal appeal process.

Providers may elect to file an external appeal on behalf of the member within 60 (sixty) days of the final adverse determination.

Members are also instructed about the external appeal process at the time of the internal appeal determination if any part of the denial determination is upheld. Healthfirst provides a copy of the External Appeal Process developed jointly by the State Department of Health (SDOH) and the State Department of Financial Services (DFS), including an application and instructions to members or providers regarding how to request an external appeal.

Members will be provided instructions on how to file an appeal with their final adverse determination letter.

For Providers

Healthfirst will forward an external appeal application for providers to appeal a concurrent or retrospective final adverse determination within three (3) calendar days of the provider's request.

The external appeal determination decision will be made in thirty (30) days; however, more time may be needed if the external appeal reviewer needs to obtain more information (up to five [5] additional days).

The member and Healthfirst will be notified of the final determination within two (2) days after the external appeal decision is made. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

Providers must not seek reimbursement (except for copayments, coinsurance, or deductibles, where applicable) from members when a provider-initiated external review of a concurrent adverse determination determines that the healthcare services are not medically necessary.

The member's healthcare provider can request an expedited external appeal if the delay could cause the member serious harm. These expedited external appeal determinations will be made within three (3) days, and notification by phone or fax to the member and Healthfirst will occur. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

In most cases, Healthfirst will retain financial responsibility for external appeals that have been assigned to a certified external appeal agent. Providers are responsible for the costs of an unsuccessful appeal of a concurrent adverse determination. Providers and Healthfirst will share the cost of the external review when a concurrent adverse determination is upheld in part. If Healthfirst reverses a denial which is the subject of an external appeal after assignment to a certified external appeal agent but prior to assignment of a clinical peer reviewer, Healthfirst shall be responsible for the administrative fee as assessed.

15.13 Member-Initiated Complaints – Medicaid

If a member has a problem, he/she can speak with his/her PCP or call or write to Member Services. Most problems can be resolved right away. If a member has a problem or dispute with the care he/she is receiving, he/she can file a complaint with Healthfirst. Problems that are not resolved right away over the phone, and any complaint received via mail, will be handled according to our complaint procedure described below.

Members can ask someone they trust (such as a legal representative, a family member, or a friend) to file the complaint for them. If a member's designee makes a request, the plan may ask for the enrollee's written consent for representatives to request a plan appeal, a grievance, or a fair hearing on their behalf. Providers may request an appeal or a fair hearing but may not request Aid Continuing.

A member also has the right to file a complaint with the local area office of the New York State Department of Health or local Department of Social Services:

To file with the New York State Department of Health, members may call 1 (800) 206-8125 or write to NYSDOH Division of Managed Care, Bureau of Managed Care Certification and Surveillance: Corning Tower ESP Room 1911, Albany, NY 12237.

To file with the City of New York, members may call the Human Resources Administration, Medicaid Assistance Program Helpline at 1 (800) 505-5678.

A member may also contact their local Department of Social Services with their complaint at any time.

A member may call the State Department of Financial Services at 1 (800) 342-3736 if their complaint involves a billing problem.

If a member needs help because of a hearing or vision impairment, or if he/she needs translation services or help filing forms, we can help. Healthfirst will not take any action against the member for filing a complaint.

How to File a Complaint with the Plan

To file by phone, a member can call Member Services at 1-866-463-6743. If a member calls Healthfirst after hours, they can leave a message and Healthfirst will return the call the next working day. If we need more information to make a decision, we will inform the member.

A member can write to us with a complaint or call the Member Services number and request a complaint form, which, when complete, should be faxed to 1 (646) 313-4618 or mailed to:

Healthfirst Appeals and Grievances Department
P.O. Box 5166
New York, NY 10274-5166

What Happens Next?

If we don't solve the member's problem right away over the phone, we will send him/her a letter within 15 (fifteen) business days. The letter will tell the member who is working on the complaint, how to contact this individual, and whether more information is needed.

A member's complaint will be reviewed by one or more qualified people. If the complaint involves clinical matters, the case will be reviewed by one or more qualified healthcare professionals.

If additional information is needed from the provider to help resolve the submitted complaint, Healthfirst will make reasonable efforts to contact the provider. Additional informational documents should be submitted within 10 calendar days and can be faxed to the Appeals and Grievances department, at 1 (646) 313-4618.

After We Review the Complaint

We will let the member know our decision within 45 (forty-five) calendar days of when we have all the information, we need to answer the complaint, but the member will hear from us within no more than 60 (sixty)calendar days from the day we get the original complaint. We will write the member and tell him/her the reasons for our decision.

When a delay would risk the member's health, we will let the member know of our decision within 48 (forty- eight) hours of when we have all the information, we need to answer the complaint, and in any event, within seven (7) days from the day we receive the original complaint. We will call the member with our decision. The member will also receive a letter within three (3) business days from oral notification.

We will inform the member how to appeal our decision if he/she is not satisfied, and we will include any forms needed. If we are unable to make a decision about a member's complaint because we don't have enough information, we will send a letter to let the member know.

Appeal of Complaints

If a member disagrees with a decision we made about his/her complaint, he/she can make a complaint appeal personally or ask someone he/she trusts to file the appeal. If a member is not satisfied with what we decide, the member has 60 (sixty) business days to file an appeal in writing after receiving our decision. If a member submits an oral appeal of a complaint decision via phone, we will send a form containing a summary of their appeal which must be signed and returned.

What Happens After We Receive the Member's Complaint Appeal?

After we get a member's complaint appeal, we will send him/her a letter within 15 (fifteen) business days. The letter will tell him/her who is working on the complaint, how to contact this individual, and whether more information is needed.

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 was not involved in making the first decision about the complaint.

- If we have all the information we need, the member will receive our decision in 30 (thirty) business days.
- If a delay would risk his/her health, he/she will receive our decision within two (2) working 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, he/she or someone on his/her behalf can file a complaint at any time with the New York State Department of Health at 1 (800) 206-8125.

15.14 Complaints and Grievances – Commercial & CHPlus

A member may file either a complaint or a grievance with Healthfirst and ask that we address the issue and resolve it for the member. The circumstances surrounding whether an issue is deemed a complaint rather than a grievance differ slightly.

- A complaint is any general problem or dissatisfaction a member may have with Healthfirst.
- A grievance is a more specific complaint that a member may have regarding a particular decision Healthfirst made about a member's coverage.

It is important to understand that complaints and grievances do not involve our decisions regarding the medical necessity of the treatment.

Once Complaint or Grievance is Received

When the complaint or grievance is received, whether it is sent to us in writing or explained to us over the phone, Healthfirst will investigate and respond as quickly as possible.

Within 15 (fifteen) business days of receiving the complaint or grievance, Healthfirst will acknowledge in writing that the concerns are being reviewed. The acknowledgment will include the name, address, and telephone number of the individual assigned to respond to the complaint. Our acknowledgment will also tell the member if any additional information is needed to investigate the matter.

Healthfirst will assign staff trained to investigate and resolve member complaints and grievances to respond to their concerns. If a complaint or grievance involves clinical issues, we will designate qualified, clinically trained staff that will include at least one licensed, certified, or registered healthcare professional.

Healthfirst will resolve by phone any complaint or grievance in which a delay would significantly increase the risk to a member's health within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of the grievance. Written notice will be provided within 72 hours of receipt of the complaint or grievance.

Resolutions for Different Types of Complaints or Grievances Filed

- If a grievance filed by or on behalf of a commercial member is about a request for a service or treatment that has not yet been provided (a "pre-service grievance"), we will resolve it within 15 (fifteen) calendar days of receiving all the information needed to complete the investigation and send written notification of resolution.
- If the grievance is in regards to a claim for a service or treatment that has already been provided(a "post-service grievance"), it will be resolved within 30 (thirty) calendar days of receiving all the information needed to complete the investigation. All other grievances unrelated to a claim or request for service will be resolved with 45 (forty-five) calendar days of receiving all the information needed to complete the investigation.

- If a complaint or grievance filed by or on behalf of a Child Health Plus (CHPlus) member is about a referral or covered benefit, we will resolve the complaint within 30 (thirty) calendar days of receiving all the information needed to complete the investigation. All other complaints and grievances will be resolved within 45 (forty-five) calendar days after all necessary information to complete the investigation is received.

Healthfirst will send the member (or his/her designated representative) a notice with our response, which will include information about the basis for our determination or a written statement that insufficient information was presented or available to reach a determination. Additionally, information on how to file an appeal, including the clinical rationale for the decision, will be provided if the complaint involves a clinical matter.

Dissatisfaction with Complaint or Grievance Determinations

Commercial members not satisfied with our grievance determination may call the New York State Department of Health's Bureau of Consumer Services, or the state's designated independent Consumer Assistance Program.

If a CHPlus member is not satisfied with our response to his/her complaint or grievance, the member (or someone writing on the member's behalf) will have 60 (sixty) business days from the date they receive our response to their complaint or grievance to file an appeal.

Appeals Process

Within 15 (fifteen) calendar days of receiving the appeal, Healthfirst will provide a written notice letting the member or his/her designee know that we have received it. This notice will provide the name, address, and telephone number of the person who will be responding to the appeal. The notice may also include a request for more information if it is needed to make a decision about the appeal.

If additional information is needed from the provider to help resolve the submitted complaint/grievance, Healthfirst will make reasonable efforts to outreach the provider. Additional informational documents should be submitted within 10 calendar days and can be faxed to the Appeals and Grievances department at 1 (646) 313-4618.

The appeal will be decided by qualified staff members who were not involved in our initial determination. If the appeal involves a clinical matter, it will be decided by licensed, certified, or registered healthcare professionals who were not part of the original decision.

Healthfirst will provide a response to an appeal, in which a delay would greatly increase the risk to the member's health, within two (2) business days after receiving all information needed to conduct our review. All other appeals will be responded to within 30 (thirty) calendar days after receiving all information needed to conduct our review. The notice of our decision regarding the appeal will include the reason(s) for our decision and additional appeal rights, if any. Additionally, if the appeal involved a clinical matter, we will include the clinical factors that led to our decision.

15.15 Standard Appeals – Commercial, CHPlus

A Child Health Plus (CHPlus) or Commercial member or a member's designee shall have 45 (forty-five) or 180 days, respectively, from the date an adverse determination notice is received to file a standard appeal.

Healthfirst will accept an oral or written standard appeal. An oral appeal can be filed by calling our toll-free Member Services number, Monday to Friday, 8am–8pm.

We will send a notice that the appeal has been received for review within 15 (fifteen) calendar days of our receiving the request. The appeal will then be investigated, and a decision made within 30 (thirty) calendar days for standard CHPlus appeals.

Appeals for Commercial members are conducted according to the following timelines:

- Appeals related to a preauthorization request will be decided within 30 (thirty) calendar days of receipt of the appeal request.
- Appeals related to a retrospective appeal will be decided within 30 (thirty) calendar days of receipt of the appeal request.

- Expedited appeals will be determined within the earlier of 72 hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

Healthfirst's failure to render a determination of an appeal within 30 (thirty) calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination. Once we make a decision for all types of appeals, the member or member's designee, as appropriate, will be notified within two (2) business days of our reaching a decision. This notice will include the reasons (and any related medical information) for our decision and further appeal rights.

Providers should submit clinical information along with the request for an appeal, and in any event, within 10 calendar days of the request. Clinical documentation can be faxed to the Appeals and Grievances department at 1 (646) 313-4618.

Healthfirst will request any clinical documentation required to substantiate services. However, failure to provide requested clinical information in a timely manner may put the member's health in jeopardy.

15.16 Appealing the Grievance – CHPlus, Commercial (Small Group)

A member or a member's designee shall have 60 (sixty) business days after receipt of notice of the grievance determination to file an appeal.

Within 15 (fifteen) business days of receipt of the appeal, Healthfirst shall provide written acknowledgment of the appeal, including the name, address, and telephone number of the individual whom Healthfirst designates to respond to the appeal and what additional information, if any, must be provided for the organization to render a decision.

> **Clinical Matters:** The determination of an appeal on a clinical matter is made 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 as defined in Article 49 of the NYS Public Health Law.
>
> **Nonclinical Matters:** The determination of an appeal on a nonclinical matter shall be made by qualified personnel at a higher level than the personnel who made the grievance determination.

Healthfirst individual market commercial members do not have grievance appeal rights. If a Healthfirst Leaf Plan member is dissatisfied with the grievance determination, they may call the New York State Department of Health at 1-800-206-8125 or write to them at New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.

Timeliness of Appeals Determination

Healthfirst shall seek to resolve all appeals of grievances in the most expeditious manner and shall make a determination and provide notice no more than two (2) business days after the receipt of all necessary information when a delay would significantly increase the risk to a member's health. Grievance appeals for pre-service grievances will be decided within 15 (fifteen) calendar days of receipt of the appeal. Post-service grievance appeals will be decided within 30 (thirty) calendar days of receipt of the appeal. All other grievance appeals (e.g., for issues not related to a claim or request for a service or treatment) will be decided within 30 (thirty) business days after the receipt of all necessary information.

Notice of Appeals Determination

The notice of an appeal determination shall include the detailed reasons for the determination, and in cases where the determination has a clinical basis, the clinical rationale for the determination.

Healthfirst shall not retaliate or take any discriminatory action against a member for filing an appeal or grievance.

15.17 Expedited Appeals – Commercial, CHPlus

A Healthfirst member, the member's representative, or a participating provider may request expedited consideration of an appeal if the standard time frame would seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Expedited appeals are processed within two (2) business days from receipt of requested information and within no more than 72 hours from receipt of the request. The notice of determination regarding the appeal will include the reason(s) for a Healthfirst decision, including any clinical factors. Appeals for services previously provided are not eligible for an expedited appeal. Appeal of claims determinations are also not eligible for an expedited appeal.

Participating providers should submit clinical documentation when submitting requests for expedited consideration of an appeal. Clinical documents should be submitted via fax to the Appeals and Grievances department within 24 hours of receiving the request. The fax number is 1 (646) 313-4618. Delay in submission or lack of clinical documentation may slow the appeal process. For questions, please call 1 (877) 779-2959.

15.18 External Review – Commercial, CHPlus

External Appeal

In connection with a concurrent or retrospective review, members and a member's healthcare providers can request an external appeal for four (4) types of adverse determinations:

1. services deemed not medically necessary,
2. services deemed experimental or investigational (these include clinical trials and treatments for rare diseases),
3. services denied because they are not materially different from services available in-network, or
4. in the instance of a denied referral to an out-of-network, nonparticipating provider.

A member may elect to file an external appeal at the time of the initial adverse determination if s/he and Healthfirst both agree to waive Healthfirst's internal appeals process.

- If both the member and Healthfirst agree to waive the Healthfirst appeals process, then the member must ask for the external appeal within four (4) months of the date of the denial determination.
- If filing as the member's designee, providers must file an external appeal on behalf of the member within four (4) months of the final adverse determination.
- If filing on their own and not on the member's behalf, providers must file an external appeal within sixty (60)days of the final adverse determination.

Members are also instructed about the external appeal process at the time of the internal appeal determination if any part of the denial determination is upheld. Healthfirst provides a copy of the External Appeal Process developed jointly by the State Department of Health and the State Department of Financial Services (DFS), including an application and instructions to members or providers to request an external appeal.

Members must file their external appeal with the DFS within four (4) months of the time that Healthfirst gave the notice of final adverse determination from the appeals process.

For Providers

Healthfirst will forward an external appeal application for providers to appeal a concurrent or retrospective final adverse determination within three (3) calendar days of the provider's request.

The external appeal determination decision will be made in 30 (thirty) days; however, more time (up to five (5) additional days) may be needed if the external appeal reviewer needs to obtain more information.

The member and Healthfirst will be notified of the final determination within two (2) business days after the external appeal decision is made. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

Providers must not seek reimbursement (except for copayments, coinsurance, or deductibles, where applicable) from members when a provider-initiated external review of a concurrent adverse determination determines that the healthcare services are not medically necessary.

The member's healthcare provider can request an expedited appeal if the delay could cause the member serious harm. These expedited external appeal determinations will be made within three (3) days, and notification by phone or fax to the member and Healthfirst will occur. The external appeal agent may also notify providers of the outcome of the member's external appeal, where appropriate.

In most cases, Healthfirst will retain financial responsibility for external appeals that have been assigned to a certified external appeal agent. Providers are responsible for the costs of an unsuccessful appeal of a concurrent adverse determination. Providers and Healthfirst will share the cost of the external review when a concurrent adverse determination is upheld in part. If Healthfirst reverses a denial that is the subject of an external appeal after assignment to a certified external appeal agent but before assignment of a clinical peer reviewer, Healthfirst shall be responsible for the administrative fee as assessed.

16 Provider Compensation

16.1 Payees

Billing and reimbursement policies serve as a supplement to the Provider Compensation section of the Provider Manual. Please refer to Appendix XIV-A for a complete list of coding requirements.

As detailed in Section 3.1 of this manual, Healthfirst contracts with providers through participating hospitals (Level I providers) or directly with individual providers or provider groups (Level II and Level III providers). For all Level I providers who are covered by the hospital agreement with Healthfirst and who practice in hospital outpatient departments or hospital-owned community-based sites, payment is made directly to the hospital. Level II and Level III providers and provider groups receive payment from Healthfirst directly.

16.2 The Healthfirst Quality Incentive Program (HQIP)

Healthfirst's mission is to provide the best possible quality and experience of care to our members. We recognize the importance of the relationships providers have with their patients in achieving this goal. To support providers in their efforts, Healthfirst established the Healthfirst Quality Incentive Program (HQIP), an annual program that incentivizes superior performance on select measures which are consistent with national and state-level benchmarks for quality of care. By achieving or surpassing the clinical performance goals set in HQIP, providers can earn quality incentive payments based on their Overall Quality Score (OQS) and/or measure-specific rates/scores.

Participation in HQIP is limited to providers that take risk on Healthfirst members and/or meet membership thresholds determined by Healthfirst. Healthfirst PCPs participating in our Medicaid, CHPlus, QHP, HARP, Medicare, Complete Care, and FIDA Plans may be eligible to earn quality incentive payments while delivering the superior healthcare and satisfaction to Healthfirst members that we all strive for.

Healthfirst will share quality data and scoring, including OQS, with providers participating in HQIP on a regular basis. If a provider participating in HQIP believes there are discrepancies or inaccuracies with their quality scoring, they may communicate this to Healthfirst through their Network Management Representative or Clinical Quality Manager. If a provider would like to contest their Final HQIP results and/or OQS, they may do so by filing an appeal with Healthfirst. To briefly summarize:

- Healthfirst will accept appeals after HQIP Final Preview results are shared with providers.
- Providers must notify Healthfirst of their intention to appeal by sending an email to HQIP@healthfirst.org briefly outlining on what grounds they plan to appeal within ten (10) business days of Final results being released by Healthfirst. Providers must also (securely) provide any and all documentation supporting their appeal to HQIP@healthfirst.org within 10 business days of their initial written notification.
- Healthfirst will strive to make a formal decision within 45 business days of receiving a complete appeal proposal. All appeal decisions will be reviewed and approved by Healthfirst's Executive Team, including the Chief Medical Officer. Any decisions made by Healthfirst will be considered final and adjustments to final quality scoring and incentive earnings, if any, will be made accordingly.
- Not all measures will be eligible for appeal and some appeals may be denied if the basis of the appeal does not meet the criteria outlined by Healthfirst.

For more information about the Healthfirst Quality Incentive Program, email HQIP@healthfirst.org.

16.3 Specialty Care and Specialists

Specialty care providers, including HIV specialist PCPs, are compensated on a fee-for-service basis. Mental Health providers are reimbursed at the APG rate for services to Medicaid and Leaf Plan members and are reimbursed according to a set fee schedule for Healthfirst Medicare members. Substance Use Disorder (SUD) providers are reimbursed according to a set fee schedule.

16.4 Obstetrical Care

Healthfirst reimburses for obstetrical care on a fee-for-service basis or based on specific contractual arrangements. In all cases, the provider must submit claims for each service rendered. Claims should be submitted for payment of prenatal and post-partum visits, as well as for delivery. Cases requiring more than seven (7) prenatal visits or more than one (1) post-partum visit may be subject to retrospective medical record review by the Healthfirst Medical Management department.

16.5 Family Planning Services

Depending on the product and plan, Healthfirst reimburses for family planning services provided to its members.

Essential Plan 200-250, Essential Plans 1&2, CHPlus, Leaf Plan, Leaf Premier Plan, and EPO members may get family planning and reproductive health services through any in-network provider without approval from or notification to Healthfirst or their PCP. Healthfirst will not pay claims for any of the aforementioned members who seek family planning and reproductive health services from out-of-network providers.

Members enrolled in Medicaid and Essential Plan 3 & 4 may get family planning and reproductive services, without a PCP referral, from either in-network or out-of-network providers that accept Medicaid.

Medicare and CompleteCare members also have access to family planning services.

16.6 Healthfirst Payment in Full/Member Hold Harmless

Pursuant to their provider contract, participating providers are prohibited from seeking payment, from billing, or from accepting payment from any member for fees that are the legal obligation of Healthfirst, even if Healthfirst becomes insolvent or denies payment on a claim, regardless of the reason. Participating providers must refund all amounts incorrectly collected from Healthfirst members or from others on behalf of the member. As permitted by a provider's contract with Healthfirst and by applicable law, Healthfirst will recoup payments inappropriately made by a member from a provider's future claims payments and will remit the amount to the member.

Healthfirst is not financially responsible for reimbursing non-covered services provided to members. Please see Section 2 for additional information on the procedure to be followed to bill and collect from members for non- covered services.

With the exceptions of deductibles, copayments, or coinsurance, all payments for services provided to Healthfirst members constitute payment in full, and providers may not balance-bill members for the difference between their actual charges and the reimbursed amounts. Any such billing is a violation of the provider's contract with Healthfirst and of applicable New York State law. Where appropriate, Healthfirst will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.

Additionally, per requirements set forth by the Centers for Medicare & Medicaid Services (CMS), dual-eligible members will not be held responsible for any cost-sharing for Medicare services when the state is responsible for paying those amounts. Providers must accept Healthfirst's payment as payment in full or bill the appropriate state source (i.e., Medicaid FFS). This requirement applies to all dual-eligible individuals and not just to those members enrolled in a Medicare Advantage Dual Eligible Special Needs Plan (SNP) or Medicare-Medicaid Plan (MMP).

17 Billing & Claims Processing

Billing and reimbursement policies serve as a supplement to the Provider Compensation section of the Provider Manual. Please refer to Appendix XIV for a complete list of coding requirements.

17.1 Member Eligibility

Payment for services rendered is subject to verification that the member was enrolled in Healthfirst at the time the service was provided and to the provider's compliance with the Healthfirst Medical Management and prior authorization policies at the time of service.

Providers must verify member eligibility at the time of service to ensure the member is enrolled in Healthfirst. Failure to do so may affect claims payment. Note, however, that members may retroactively lose their eligibility with Healthfirst after the date of service. Therefore, verification of eligibility is not a guarantee of payment by Healthfirst. Please contact Overpayment Recovery at 1 (866) 635-1520 in cases where members retroactively lose coverage so that you can obtain further information, including any other payor that may be billed.

Claims submitted for services rendered without proper authorization will be denied for "failure to obtain authorization." No payment will be made.

In certain cases, a managed care plan member, including Healthfirst members, may change health plans during the course of a hospital stay. When this occurs, providers should bill the health plan to which the member belonged at the time of admission to the hospital.

17.2 General Billing and Claim Submission Requirements

Submitting Claims Electronically

For all electronic claims, Healthfirst utilizes the Emdeon clearinghouse and MD On-line, a free online service for providers who do not have claims submission software. Claims submitted electronically receive a status report indicating the claims accepted, rejected, and/or pending, and the amount paid on the claim once it has been finalized. Claims submitted electronically must include:

- Healthfirst Payer ID Number 80141 on each claim
- Complete Healthfirst Member ID Numbers (see member ID card or monthly enrollment roster)
- A National Provider Identifier (NPI) should reside in:
    - 837 Professional (HCFA) - Loop 2310B Rendering Provider Identifier, Segment/Element NM109.NM108 must qualify with an XX (NPI);
    - 837 Institutional (UB04) - Loop 2010AA Billing Provider, Segment/Element NM109. NM10 must qualify with an XX (NPI).

To sign up for electronic billing with Emdeon, providers must contact their software vendor and request that their Healthfirst claims be submitted through Emdeon. Providers can also direct their current clearinghouse to forward claims to Emdeon. Please call Healthfirst at 1 (888) 801-1660 to set up electronic billing. To sign up for electronic billing with MD On-line or for more information, visit www.healthfirstmdol.com or call 1 (888) 499-5465. Providers who sign up for electronic billing may also sign up for electronic fund transfer/electric remittance advice (EFT/ERA). See Section 17.5 for more information.

Reports are available through billing software vendors to review electronic submission of claims and rejection errors. Although this may be an optional feature, providers are encouraged to obtain this reporting tool to better manage their submissions. The following are two (2) report options providers should review for claim submission activity:

The Initial Acceptance Report (R022/RPT-05)

The R022 report shows that the clearinghouse accepted the claim submission and routed it to the designated insurance carrier. Acceptance of a claim on the R022 report is acceptance by the clearinghouse and not by the Plan.

Providers should wait until they receive confirmation on the Insurance Carrier Rejection Report (R059).

Insurance Carrier Rejection Report (R059/RPT-11)

The R059 report consists of two (2) summaries. The first section confirms that the claims were accepted by Healthfirst. The second section lists the claims rejected and the reason(s) for each rejection. This report may be used to substantiate timely filing to Healthfirst.

Note: In 2009, both the R022 and R059 reports were discontinued and replaced with the RPT reports.

Submitting Claims on Paper

All paper claims should be submitted to:

Healthfirst Claims Department
P.O. Box 958438
Lake Mary, FL 32795-8438

All paper claims should include the National Provider Identifier (NPI) and well as the Healthfirst-assigned Provider ID Number (the latter is not required for electronic claims). The Healthfirst Provider ID is a unique provider number for each practice site and hospital affiliation he/she has and must be included with paper claims.

The letter after the hyphen—A, B, C, D, etc.—corresponds to one (1) of the provider's practice sites. The two (2) digits at the end of the provider number correspond to the provider's hospital affiliation. The following table illustrates the potential provider numbers an individual practitioner may have:

	Number of Hospitals					
Number of Practice Sites	1		2		3	
1	123456-A12		123456-A12 123456-A20		123456-A12 123456-A20 123456-A26	
2	123456-A12 123456-B12	123456-A12 123456-B12	123456-A20 123456-B20	123456-A12 123456-B12	123456-A20 123456-B20	123456-A26 123456-B26
3	123456-A12 123456-B12 123456-C12	123456-A12 123456-B12 123456-C12	123456-A20 123456-B20 123456-C20	123456- A12 123456-B12 123456-C12	123456-A20 123456-B20 123456-C20	123456-A26 123456-B26 123456-C26

If the member's PCP is affiliated with the same hospital as the specialist, the specialist should choose the provider number by first matching the hospital code and then selecting the letter (A, B, C, etc.) that corresponds to the practice site where the services were rendered. To confirm the correct provider number, please call Provider Services at 1 (888) 801-1660.

Note for group practices and facilities: When submitting claims, please ensure separate billing NPI and provider NPI numbers are entered in the appropriate fields. Office visit claims submitted for the group practice owner, with an organization NPI number instead of the individual NPI number, cannot be processed.

Claims Submission and Encounter Data

Healthfirst is required to report encounter data to New York State, CMS, and other regulatory agencies which lists the types and number of healthcare services members receive. Encounter data is essential for claims processing and utilization reporting as well as for complying with the reporting requirements of CMS, New York State, and other governmental and regulatory agencies. Further, for some Healthfirst providers, it will impact the provider's eligibility for bonuses paid for certain preventive care services. It is essential that this information be submitted in a timely and accurate manner.

For participating providers who are paid on a fee-for-service basis, the claim usually provides the encounter data Healthfirst requires. In addition, participating Healthfirst providers reimbursed on a capitated basis are still required to submit claims so that encounter data is reported to Healthfirst.

Healthfirst submits encounter and claims data monthly to the NYSDOH Office of Managed Care Medicaid Encounter Data System (MEDS). MEDS serves as the information warehouse by which the state has the capacity to monitor, evaluate, and continuously improve its managed care programs. It is essential that providers submit claims promptly for all services, including capitated services. MEDS is the standard by which the performance of Healthfirst and other managed care organizations is measured. To meet the state mandate, Healthfirst requires its providers to satisfy MEDS requirements when submitting claims and encounter information. Please refer to the Claims section (see Section 17) for the specific requirements when submitting claims or encounters. Please refer to each reporting measure as described in this section for specific measure requirements.

Present on Admission (POA)

The POA indicator applies to diagnosis codes for certain healthcare claims. POA indicator reporting is mandatory for claims involving inpatient admissions to general acute care hospitals or other facilities. It clarifies whether a diagnosis was present at the time of admission. Healthfirst requires POA indicators for all primary and secondary diagnosis codes as well as the external cause of injury codes, regardless of the manner in which claims are submitted (i.e., paper or electronic). Please refer to the instructions provided by CMS regarding identification of the POA for all diagnosis codes for inpatient claims submitted on the UB-04 and ASCX12N 837 Institutional (837I) forms.

Requirements for Billing by Facilities

Facilities, including hospitals, must submit inpatient and outpatient facility claims on the UB-04 or on electronic media:

- Report the name, NPI, and Healthfirst provider ID number of the attending provider in Field 76 (Healthfirst provider ID number is not required on electronic transactions).
- Include the Healthfirst authorization number on claims submitted for inpatient services. Claims will be matched to prior authorization data in the Healthfirst system and processed in accordance with applicable Healthfirst policies and procedures.

Professional services that are not part of the facility claim should be billed on a CMS 1500 form.

Facilities billing on behalf of employed providers must submit claim reporting data on the UB-04 for outpatient services or directly to Healthfirst via electronic claim submission. Report the name, NPI, and Healthfirst provider ID number of the attending provider in Field 76 (Healthfirst provider ID number is not required on electronic transactions).

Required Data Elements and Claim Forms

Prior to being adjudicated, all claims are reviewed within the Healthfirst Claims department for completeness and correctness of the data elements required for processing payments, reporting, and data entry into the Healthfirst utilization systems. If the following information is missing from the claim, the claim is not “clean” and will be rejected:

Data Element	CMS 1500	UB-04
Patient Name	X	X
Patient Date of Birth	X	X
Patient Sex	X	X
Subscriber (Member) Name/Address	X	X

Data Element	CMS 1500	UB-04
Healthfirst Member ID Number (including Client Identification Number [CIN] for all newborn babies, when applicable)	X	X
Coordination of Benefits (COB)/other insured's information	X	X
Date(s) of Service	X	X
ICD-9 Diagnosis Code(s), including 4th and 5th Digit when Required (ending 9/30/2015) ICD-10 Diagnosis Code(s), including 4th, 5th, 6th, and 7th Digit when Required (beginning 10/1/2015)	X	X
CPT-4 Procedure Code(s)	X	X
HCPCS Code(s)	X	X
Service Code Modifier (if applicable)	X	X
Place of Service	X	
Service Units	X	X
Charges per Service and Total Charges	X	X
Provider Name	X	
Provider Address/Phone Number	X	
National Provider Identifier – NPI (Healthfirst does not accept legacy provider ID numbers submitted on HIPAA standard transactions)	X	X
Tax ID Number	X	X
Healthfirst Provider Number – **For Paper Claims Only**	X	X
Healthfirst Payer ID Number 80141 – **For EDI Claims Only** (refer to Section 17.2)	X	X
Hospital/Facility Name and Address		X
Type of Bill		X
Admission Date and Type		X
Patient Discharge Status Code		X
Condition Code(s)		X
Occurrence Codes and Dates		X

Data Element	CMS 1500	UB-04
Value Code(s)		X
Revenue Code(s) and corresponding CPT/HCPCS Codes when billing outpatient services		X
Principal, Admitting, and Other ICD-9 (ending 9/30/2015); ICD-10 (beginning 10/1/2015) Diagnosis Codes		X
Present on Admission (POA) Indicator (if applicable)		X
Attending Physician Name and NPI		X
Healthfirst Authorization Number	X	X

CMS 1500 forms and UB-04s can be used to bill fee-for-service encounters. The UB-04 form should be used by facilities and by facilities billing on behalf of employed providers.

Claims Editing

Healthfirst strives to offer our members high-quality health care at affordable rates. To facilitate this objective, Healthfirst reviews claims submissions for accuracy via its claims editing programs. Healthfirst claims edits follow national industry standards designed to align with CMS standards for concepts such as the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State- specific coding, billing and payment policies, as well as national physician specialty academy guidelines (coding and clinical).

Per New York state guidelines with respect to behavioral health and substance abuse parity, Healthfirst does not have any exclusions, modifications or exceptions that would cause behavioral health or substance abuse claims to adjudicate differently solely based upon their claim type. All claim types are expected to follow and be adjudicated according to the industry standard coding, billing and payment principles described above.

17.3 Time Frames for Claim Submission, Adjudication, and Payment

Timely Claim Submission

Providers should submit all claims within 30 (thirty) days of the date of service for prompt adjudication and payment. However, claims for services that are submitted later than the time period set forth in the provider's agreement with Healthfirst will not be paid except under certain circumstances. In no event will Healthfirst pay claims submitted more than 180 (one hundred eighty) days after the date of service. Please refer to Section 17.2 for electronic and paper submission of claims.

Late Claim Submission

In certain circumstances, Healthfirst will process claims submitted after the time period required under the provider's agreement with Healthfirst. Please note that "unclean" claims that are returned to the provider for necessary information are adjudicated according to the original date of service. They do not fall into the category of exceptions to the time period required. The following situations allow for special handling of claims. Claims must be submitted with a written explanation and appropriate documentation showing the date the claim came within the provider's control.

Reason for Delay	Time Frame for Submission
Litigation involving payment of the claim	Within 60 (sixty) calendar days from the time the submission came within the provider's control
Medicare or other third-party processing delays affecting the claim	Within 60 (sixty) calendar days from the time the submission came within the provider's control
Original claim rejected or denied due to a reason unrelated to the 180-day rule	Within 60 (sixty) calendar days of the date of notification (submit with original EOP)
Administrative delay (enrollment process, rate changes) by NYSDOH or other State agencies	No time frame
Delay in member eligibility determination	Within 60 (sixty) days from the time of notification of eligibility (submit with documentation substantiating the delay)
PRO denial/reversal	No time frame
Member's enrollment with Healthfirst was not known on the date of service	Within 60 (sixty) days from the time the member's enrollment is verified. Providers must make diligent attempts to determine the member's coverage with Healthfirst

The Insurance Carrier Rejection Report—R059/RPT-11 (refer to Section 17.2)—may be used to substantiate timely filing to Healthfirst.

Healthfirst adjudicates and pays all claims for its Medicaid, FHP, CHPlus, and commercial plans according to Section 3224-a of the New York State Insurance Law, also known as New York's "prompt pay" law. Healthfirst adjudicates and pays all claims for its Medicare lines of business pursuant to Section 3224-a of the New York State Insurance Law, except that the applicable prompt-pay interest rate shall be that applicable to Medicare fee-for- service interest rate. Out-of-network Medicare claims are adjudicated pursuant to the applicable regulations governing Medicare Advantage Plans.

Grace Period Impact to Commercial and Leaf Plan Providers

Provider payment is subject to member's insurance coverage status; refer to Section 4.4: Eligibility Verification. Members who receive advance premium tax credit (APTC) subsidies are entitled to a 90-day premium payment grace period. Claims submitted during days 31–90 of the member's grace period will not be subject to prompt-pay provisions until the member pays their premium in full. Providers are not permitted to balance-bill members during days 31–90 of their grace period. If the member's premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the member premium is not paid in full by the end of the grace period, claims incurred during days 31–90 of the grace period will be denied.

17.4 Coordination of Benefits (COB)

Coordination of benefits (COB) ensures that the proper payers are held responsible for the cost of healthcare services and is one of the factors that can help hold down copayments and premiums. Healthfirst follows all standard guidelines for COB and coordinates benefits for medical and pharmacy benefits. Healthfirst requires a primary carrier Explanation of Payment (EOP) when Healthfirst is the secondary payer before appropriate claims payment can be issued. Members are asked to provide information about other insurance plans under which they are covered, including at a pharmacy where members have other pharmacy coverage.

Healthfirst Is Always the Secondary Payer in the Following Circumstances

- Workers' compensation
- Automobile medical
- No-fault or liability auto insurance

Healthfirst Does Not Pay for Services Provided Under the Following Circumstances When There Is COB

- The Department of Veterans Affairs (VA) or other VA facilities (except for certain emergency hospital services)
- When VA-authorized services are provided at a non-VA hospital or by a non-VA provider

The Following Applies to Healthfirst Medicare Plan Only

Healthfirst will use the same guidelines as Medicare for the determination of primary and secondary payer. As a result, Healthfirst is the secondary payer for all of the cases listed above as well as for the following:

- Most Employer Group Health Plans (EGHP)
- Most EGHPs for disabled members

All benefits payable under an EGHP in the case of individuals who are entitled to benefits solely or partly based on end-stage renal disease (ESRD) during a period of 30 (thirty) months. (This applies to all services, not just to ESRD. If the individual entitlement changes from ESRD to over 65 [sixty-five] or disability, the coordination period will continue.)

17.5 Explanation of Payment (EOP)/Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)

The EOP describes how claims for services rendered to Healthfirst members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim. There are separate EOPs for inpatient facility services and for outpatient services. The outpatient services EOP includes outpatient facility services, provider services, and ancillary services such as DME (see Appendix XIV-C). The EOP shall include the following elements:

- Name and Address of Payor
- Toll-free Number of Payor
- Subscriber's Name and Address
- Subscriber's Identification (ID) Number
- Member's Name
- Provider's Name
- Provider Tax Identification Number (TIN)
- Claim Date of Service
- Type of Service
- Total Billed Charges
- Allowed Amount
- Discount Amount
- Excluded Charges
- Explanation of Excluded Charges (Denial Codes)
- Amount Applied to Deductible
- Copayment/Coinsurance Amount
- Total Member Responsibility Amount
- Total Payment Made and to Whom

The EOP is arranged numerically by member account number. Inpatient facility claims are sorted separately from all other claims. Each claim represented on an EOP may comprise multiple rows of text. The line number indicated

below the date of service identifies the beginning and end of a particular claim. Key fields that will indicate payment amounts and denials are as follows:

- **Paid Claim Lines:** If the Paid Amount field reads greater than zero (0), the claim was paid in the amount indicated.
- **Denied Claim Lines**: If the Not Covered field is greater than zero (0) and equal to the allowed amount, the service was denied.
- **Claim Processed as a Capitated Service:** If the amount in the Prepaid Amount field is greater than zero (0), the service was processed as a capitated service.
- **End of Claim:** Each claim is summarized by a claim total. If there are multiple claims for a single member, the EOP also summarizes the total amount paid for that member.

Providers may receive a copy of an EOP by:

1. Logging into the Healthfirst Provider Portal at **https://hfproviderportal.org**
2. Entering the associated claims number under the “Claims Search” tab
3. Clicking on the link under “Claim Number,” available on the next screen

You may also call 1 (888) 801-1660 to request a copy of an EOP.

Previous And New Account Balance On EOPs

Effective 10/6/2021, the Explanation of Payments (EOP) document has been updated to include providers previous and new account balances with Healthfirst. The additional information will assist providers in account reconciliation efforts especially when you have a negative balance with Healthfirst. The specific changes are made to the first page of the EOP (where you usually see your check or non-payment summary).

For further details on specific changes made to the EOP document, please refer to the alert posted on the Healthfirst portal at **https://hfproviderportal.org**

Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA)

Healthfirst’s Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) program is a convenient service for the automatic reimbursement of Healthfirst claims.

EFT is the direct electronic deposit of claim reimbursements into your bank account, and ERA is the statement that allows you to reconcile these reimbursements to your member accounts. Advantages of these programs include:

- Prompt payment – no waiting for checks to clear
- Reduced paperwork
- No lost checks or mail delay
- Savings of administrative and overhead costs
- Simplified and organized recordkeeping
- Improved cash flow.

You must be able to submit claims electronically to use EFT/ERA. When claims are submitted for payment, the payment is deposited electronically into your bank account. Capitation checks can also be deposited directly into your account. When you enroll in EFT/ERA, you will continue to receive an Explanation of Payment (EOP) for a sixty (60)-day grace period. The EOP shows the member’s name, dates of service, services rendered, and amounts of Healthfirst payments. After the grace period, you will receive only the ERA. Bank statements will continue to reflect deposited amounts and dates of deposit. Your clearinghouse/software vendor must be able to accept the ERA file, which is in the 835 HIPAA standard format.

Please visit our Healthfirst Provider Portal by logging in at **https://hfproviderportal.org** for information on how to enroll in EFT/ERA. You can find this information in the “Forms” section on the Provider Resources Center after logging in to the portal. You can also call Change Healthcare at 1(800) 956-5190.

17.6 Claim Inquiries, Corrected Claims, Claim Reconsideration, and Appeals Process

Claim Inquiries

Providers can review the status of claims submissions in the Claims Search section of the Healthfirst Provider Portal at https://hfproviderportal.org. Providers may also call Provider Services at 1 (888) 801-1660 to access claim status on a service line or service code basis instead of a whole claim.

As described below, Healthfirst provides a two (2)-level process for providers to appeal a claim denial or payment which the provider believes was incorrect or inaccurate. Please note that the provider appeal process described in this section (Section 17) does not apply to utilization management determinations concerning medical necessity. See Section 15 for information on medical necessity appeals.

Corrected Claims Definitions

Rejected Claim: A claim that was received by Healthfirst and determined to be unclean, such as a non-standard claim form or a standard claim form that is illegible. A Rejected Claim is never loaded to the adjudication system. The Rejected Claim is returned to the provider, along with the reason for the rejection.

Resubmitted Claim: A claim that Healthfirst rejects, and that the provider resubmits after the appropriate changes to the claim have been made. Healthfirst must receive a Resubmitted Claim within the timely filing guidelines for new claims. Note: A Resubmitted Claim is always treated as a new claim.

Accepted Claim: A claim that was received by Healthfirst and passed all criteria for intake. Accepted Claims are loaded to the adjudication system. The system then makes a final determination to pay or deny the Accepted Claim.

Corrected Claim: An Accepted Claim that is subsequently determined by the provider to require revisions or corrections. The Corrected Claim has changes to the data elements that will potentially affect the payment of the claim.

EDI Corrected Claims

When submitting an EDI Professional and/or Institutional Corrected Claim to Healthfirst, the following requirements must be met:

- The claim type/frequency (CLM05-03) must be a 7. Ex. CLM*8084*96.98***11>B>7*Y*A*W*I*P~
- The Healthfirst original claim ID must be sent in the REF*F8 segment in the 2300 loop. The Healthfirst claim ID is made up of a two-digit branch code, a six-digit batch date, a three-digit batch sequence, and a two-digit sequence ID. The Healthfirst claim ID can be found on the EOP and/or 835. Ex. REF*F8*0104141539061~

Paper Corrected Claims

When submitting a Paper Professional and/or Institutional Corrected Claim to Healthfirst, the provider should stamp or handwrite on the claim “CORRECTED” or “CORRECTED CLAIM” and must include the original claim number being corrected.

Note: Corrected Claims submission must follow timely filing guidelines for new claims (refer to Section 17.3 for timely filing rules).

Requests for Review and Reconsideration of a Claim

At times, a provider may be dissatisfied with a decision made by Healthfirst regarding a claim determination.

Providers who are dissatisfied with a claim determination made by Healthfirst must submit a written request for review and reconsideration and provide all supporting documentation to Healthfirst within 90 (ninety) calendar days from the

paid date on the provider's Explanation of Payment (EOP). Written requests, including attachments, are accepted via the Healthfirst Provider Portal and hfproviderportal.org. They may also be sent to the following address:

Healthfirst Correspondence Unit
P.O. Box 958438
Lake Mary, FL 32795-8438

All written requests for review and reconsideration submitted via the provider website or via mail should include the following information:

- a copy of the EOP
- the claim
- supporting documentation
- a written statement explaining why you disagree with Healthfirst's determination as to the amount or denial of payment

Examples of information and supporting documentation that should be submitted with written requests for review and reconsideration include:

- A written statement explaining why you disagree with Healthfirst's claim determination
- Provider's name, address, and telephone number
- Provider's identification number
- Member's name and Healthfirst identification number
- Date(s) of service
- Healthfirst claim number
- A copy of the original claim or Corrected Claim, if applicable
- A copy of the Healthfirst EOP
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification (e.g., copy of Healthfirst Member ID card)
- Evidence of timely filing
- RO59 Report (Insurance Carrier Rejection Report) or Emdeon Vision "Claim for Review" or "Claim Summary" Report
    - Healthfirst does not accept documentation from internal billing practice software as proof of timely filing. In addition, Healthfirst does not accept copies of certified mail or overnight mail receipts unless the receipt can be definitively connected to the claim submission.
- Copy of the approval number issued by Medical Management

Healthfirst will investigate all written requests for review and reconsideration, and within 30 (thirty) calendar days from the date of receipt of the provider's request for review and reconsideration will issue a written explanation stating that the claim has been either reprocessed or the initial denial has been upheld.

Healthfirst will not review or reconsider claims determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the 90 (ninety)-calendar-day time frame, the request is deemed ineligible and will be rejected. Providers will not be paid for any services, irrespective of the merits of the underlying dispute if the request for review and reconsideration is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider Services Unit at 1 (888) 801-1660.

Claim Appeals Process

Providers who are dissatisfied with the outcome of the review and reconsideration may submit a written request for a formal appeal within 60 (sixty) calendar days from the date listed on the Reconsideration Determination Letter.

Providers should submit all written requests for an appeal of a claim determination to the following address:

Healthfirst Provider Claim Appeals
P.O. Box 958431
Lake Mary, FL 32795-8431

Providers should provide a written statement explaining why they disagree with Healthfirst's decision regarding the review and reconsideration, a copy of that determination, and, if the provider submitted the request for review and reconsideration via the Healthfirst provider website, the specific Healthfirst tracking number.

Providers should also specify the name, address, and telephone number of an individual who may be contacted regarding the appeal and include any additional relevant documentation to support the provider's position (see above for examples of documentation). Healthfirst will not accept claims appeals from providers that are not made in writing and that fail to address the reason for the appeal.

For appeals on payment rates, providers should specify in writing the basis for the dispute and enclose all relevant documentation, including, but not limited to, contract rate sheets or fee schedules.

Healthfirst will investigate all written requests for appeal, and within 30 (thirty) calendar days from the date of receipt of the provider's request for appeal will issue a written explanation stating that the claim has been either reprocessed or upheld.

Healthfirst will not consider appeals that are not submitted according to the procedures set forth above. Ifa provider submits a request for appeal after the 60 (sixty)-calendar-day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for appeal is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to Provider Services at 1 (888) 801-1660.

Fraud, Waste, and Abuse Appeals Process

See Section 3.3 for details of Fraud, Waste, and Abuse claims appeals policy.

17.7 Overpayments, Duplicate Payments, and Underpayments

Healthfirst periodically reviews payments made to providers to ensure claims are paid accurately pursuant to the terms of a provider contract, State or Federal rules and regulations, or coding standards. If Healthfirst identifies that it has overpaid a provider for certain services, Healthfirst will notify the provider and recoup the overpayment amount according to the procedures detailed below, and any applicable requirements under Section 3224-b of the New York State Insurance Law or other applicable law or regulation. The lookback period is determined by the type of overpayment and applicable Federal and State regulations.

We Will Provide Notice of Overpayments Before Seeking Recovery

If Healthfirst determines that an overpayment has occurred, Healthfirst will provide 60 (sixty) days' advance written notice to the provider who has been overpaid before engaging in any overpayment recovery efforts.

This notice will include the member's name, service dates, payment amount(s), proposed adjustment, a reasonably specific explanation of the reason for the overpayment, and the proposed adjustment. In response to a notice of overpayment, the provider may either (1) dispute the finding or (2) remit payment to Healthfirst as outlined below.

Common overpayment reasons include but are not limited to:

- Retro-disenrollment, member no longer active for the date of service
- Retroactive identification of COB
- Subrogation / other third-party liability
- Duplication of claims or services

- Errors in modifier usage
- Excessive units billed
- Unbundling
- Pre-admission testing
- Overlapping dates of service
- Fee schedule updates
- Post-payment level of care or DRG appropriateness audits
- Preauthorization of services does not exclude claims from review as an overpayment or initiation of recovery activities where overpayments are identified.

If You Agree That We Have Overpaid You

If a provider agrees with Healthfirst's overpayment determination as detailed in the overpayment notice, providers may voluntarily submit a refund check made payable to the corporate entity named on the demand letter (e.g., Healthfirst PHSP, Inc.; Healthfirst Health Plan, Inc.) within 60 (sixty) days from the date Healthfirst mailed the overpayment notice. Providers should further include a statement in writing regarding the purpose of the refund check (e.g., payment of identified overpayment) that should include Member Name, Healthfirst ICN number and Vendor ID, and a copy of the overpayment notice to ensure the proper recording and timely processing of the refund.

Refund checks should be mailed to

Healthfirst PHSP Inc, LB#8115
PO Box 95000
Philadelphia, PA 19195-0001.

If You Disagree That We Overpaid You

If a provider disagrees with Healthfirst's overpayment determination as detailed in the overpayment notice, the provider must submit a request for Review and Reconsideration, as detailed in Section 17.6, within 90 (ninety) days from the date the overpayment notice was mailed. Upon making a determination on the provider's appeal request and supporting documentation, Healthfirst will provide written notice of the appeal determination. If Healthfirst upholds the overpayment determination, providers may submit an appeal, as detailed in Section 17.6, within 60 (sixty) days: (1) a written request for an appeal, and (2) any supporting documentation. If Healthfirst again upholds the overpayment determination, providers may pursue any other legal recourse available to them under their provider agreement and applicable law.

If You Fail to Respond to an Overpayment Notice

If a provider fails to dispute or otherwise respond to an overpayment notice within 60 (sixty) days from the date Healthfirst mailed the overpayment notice, the provider will be deemed to have acknowledged and accepted the overpayment amount demanded, and Healthfirst will offset the overpayment amount against current and future claim remittance(s) until the full overpayment amount is recovered by Healthfirst.

Underpayments

After a provider has complied with the Review and Reconsideration Process and/or the Claims Appeals Process as detailed in Section 17.6, if Healthfirst agrees with the provider's assertion that Healthfirst has underpaid any claim(s) to the provider, Healthfirst will reprocess underpaid claims. Underpayments may be offset against any overpayments dating as far back as the claimed underpayment that have not yet been recouped. Prior to such offset, however, Healthfirst shall ensure compliance with the provisions in this section (Section 17.7) regarding notice of overpayments to the provider.

Provider Identified Overpayments

If a provider determines that it has been overpaid by Healthfirst, the provider shall send a refund check to Healthfirst PHSP, Inc. at the below noted address within 60 days of identification. The provider shall also include with the refund

check a cover letter explaining the reasons for the overpayment, identifying the specific Healthfirst claim numbers (including member name, ID, and dates of service) or invoices that were the source of the overpayment, providing contact information for someone who can speak on the overpayment should Healthfirst have any questions regarding the repayment, and any supporting documentation or additional information that may explain the overpayment.

Overpayment refund checks should be mailed to

Healthfirst PHSP Inc., LB#8115
PO Box 95000
Philadelphia, PA 19195-0001.

17.8 Avoidable Readmission Reimbursement Policy

Healthfirst's Avoidable Readmission Reimbursement Policy is designed to reduce avoidable readmissions to improve quality of care. Healthfirst will deny any claim for an acute-care hospital admission that meets the criteria for an avoidable readmission, as defined in this policy. This policy applies to all inpatient claims across all lines of business.

An avoidable readmission is one that occurs within 30 days of discharge of the index (i.e., initial) admission from the same hospital or hospital system for the same diagnosis group to the index admission, provided that no exceptions apply.

Subsequent admissions will not be subject to denial under this policy if any of the following is true:

- Patient transferred from out of network (OON) to in network (INN)
- Patient transferred to an inpatient rehabilitation facility
- Patient transferred to a skilled nursing facility (SNF)
- Patient transferred to receive care not available at the first facility
- The subsequent admission was a planned readmission for repetitive treatments (e.g., chemotherapy for cancer)
- The subsequent admission was a scheduled readmission for elective procedures
- Patient left Against Medical Advice (AMA) from the index admission
- Patient expired during the subsequent admission
- Patient was enrolled in hospice during the subsequent admission
- The index admission and/or subsequent admission was for: trauma, burns, malignancies, cystic fibrosis, eye, mental health, substance use disorders, and sickle cell crisis
- The subsequent admission was to a psychiatric/substance abuse unit or facility
- The subsequent admission was related to treatment for pregnancy and/or newborns, or
- The subsequent admission occurred more than 30 days from discharge from the index admission.

If you feel a claim was denied in error or would like to dispute a denial, please follow the claim reconsideration and appeal process outlined in Section 17.6 of your Healthfirst Provider Manual.

If Healthfirst determines that the admission is a readmission of the index admission, the hospital will be notified of the claims denial. Denial of payment for the claim will be upheld unless it can be shown that the admission does not meet the criteria for an Avoidable Readmission

As part of the medical review process, Healthfirst requires:

- Medical records from both admissions, and a letter or summary document identifying the pages in the applicable medical records that contain information pertinent to the review, and supporting information that affirms that any of the exception criteria listed above are met, if relevant.
- A clinical narrative containing the following elements:
    - An explanation of how the treatment of the member in the first hospitalization meet the clinical needs of the member’s condition;

- An explanation of how the member's condition during the first hospitalization was stabilized prior to discharge (i.e., improvement in the member's condition upon discharge compared to presentation to the emergency department); and
- A demonstration that an adequate discharge plan was developed and set up timely for the member with any necessary services, medication, and follow-up treatment needed to avoid re-hospitalization.

Failure of the hospital to provide complete medical records from the index hospitalization and readmission hospitalization for review and reconsideration may result in an adverse determination under the reconsideration process.

If it is determined on appeal that the readmission did not meet the criteria for an Avoidable Readmission, the admission will be reimbursed in accordance with the terms of the applicable Participating Hospital Agreement.

Healthfirst reserves the right to look back within the maximum allowed recovery time frame per state guidelines or per specific provider contract to identify any claims that may be for an Avoidable Readmission.

Healthfirst reserves the right to deny the claim or to recoup and/or recover monies previously paid on a claim that is within the guidelines of this policy.

Members may not be charged for hospital admissions denied as Avoidable Readmissions under this policy.

18 Glossary of Terms

Access to Care: The extent to which a patient/member is able to obtain healthcare services at the time they are needed or within a preset time frame as established by Healthfirst or by regulatory agencies. Access, including telephone access, is defined by the availability and acceptability of medical services to the member, the location of healthcare providers, transportation, hours of operation, the cost of care, and the ability to schedule appointments.

Action: A service authorization determination or other activity of Healthfirst or its subcontractor that results in the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; failure to provide services in a timely manner, as defined by applicable state law and regulation and Section 15 of the Medicaid Contract; or failure of Healthfirst to act within the time frames for resolution and notification of determinations regarding Complaints, Action Appeals, and Complaint Appeals.

Additional Benefits: Healthcare services not covered by original Medicare and reductions in premiums or cost-sharing for Medicare-covered services.

Advance Directives: Legal documents allowing competent adults to provide information regarding treatment should they become incapacitated and unable to speak for themselves.

Ancillary Services/Providers: A term used to describe the additional services and the providers/facilities of those services that are related to medical care. They include apnea or sleep study centers, fetal/uterine monitoring, audiology and hearing services; chiropractors, dental care; diagnostic imaging and radiology services; dentists, dialysis; durable medical equipment; home healthcare and home infusion therapy; hospice, laboratory services; orthotic and prosthetic equipment; outpatient rehabilitation; pharmacy services; physical, occupational, and speech therapy; skilled nursing facilities; and routine vision care.

Appeal: A formal request by a provider or member for review and reconsideration of a health-plan decision. An appeal request initiates a formal review process.

Applied Behavior Analysis (ABA): An evidence- based approach to systematically improve behavior and skills related to core impairments associated with autism spectrum disorder (ASD) for ages identified to benefit from such interventions. ABA services support learning and assist with the development of social, behavioral, adaptive, motor, vocational, and cognitive skills. Using behavioral principles (such as positive reinforcement, or the use of rewards), ABA encourages development of desired behaviors in place of any maladaptive or harmful behaviors a child may be using. ABA also seeks to generalize adaptive behaviors to new environments or situations and narrow the conditions under which negative behavior occurs. To increase opportunities for behavioral improvement, ABA requires active and consistent parent or guardian involvement.

Appropriate Transfer: One in which the transferring hospital provides medical treatment to reduce the risks to the individual, sends all relevant medical records to the receiving hospital, and uses qualified personnel and transportation equipment for the transfer.

Authorization Number: A unique number generated by the Medical Management department when a request for authorization of services has been approved. Authorization numbers are communicated to the provider of service; they should be referenced on all claims and correspondence related to those services.

Authorized Services: Medical, ancillary, or behavioral healthcare services that require authorization beyond a routine referral from the Medical Management department. Generally, authorization must be obtained in advance of services for the provider to receive reimbursement.

Auto-Assignment: A process by which an eligible person, mandated to enroll in managed care but who has not enrolled within sixty (60) days, is assigned to a Prepaid Health Services Plan (PHSP) or HMO contracted with a local Department of Social Services such as a Medicaid Managed Care Provider.

Balance Billing: A provider billing a member for the difference between the amount the provider charges for the services rendered and the amount the provider has been reimbursed for the health plan. Healthfirst providers are prohibited from balance-billing members for any covered services.

Behavioral Health Services: Services to address mental health disorders and/or chemical dependency.

Beneficiary: An eligible person is an individual who the Center for Medicaid Services (CMS) determines to be eligible for Medicaid and who meets all the other conditions for enrollment in the health plan.

Benefits: The services to which health plan members are entitled under their designated Healthfirst program.

Capitation Payment: A fixed amount of money paid to a provider, hospital, or other provider per- member-per-month to cover the cost of a specific scope of services which must be provided or arranged for by the provider pursuant to the provider's contract with Healthfirst.

Care Management: The process of planning for treatment and services, assessing the appropriateness of services, and following up to review the effectiveness of services to ensure that members receive efficient, effective, high-quality care that meets their healthcare needs in a cost-effective manner.

Center for Health Dispute Resolution (CHDR): An independent CMS contractor that reviews appeals by members of Medicare managed care plans.

Centers of Medicare & Medicaid Services (CMS): An organization within the United States Department of Health and Human Services that administers the Medicare program and certain aspects of State Medicaid programs; formerly known as the Healthcare Financing Administration.

Chemical Dependence Services: Examination, dependency, level-of-care determination, treatment, rehabilitation, or habilitation of persons suffering from chemical abuse or dependence; includes the provision of alcoholism and/or substance abuse services.

Child/Teen Health Program (C/THP): This is a program of early and periodic screening, including inter- periodic, diagnostic, and treatment services that New York State offers all Medicaid-eligible children younger than age 21. Care and services are provided in accordance with the periodicity schedule and guidelines developed by the NYSDOH. The services include administrative services designed to help families obtain services for children including outreach, information, appointment scheduling, administrative care management, and transportation assistance to the extent that transportation is included in the benefit package.

Claim Review/Reconsideration: The process by which a claim is reviewed at the provider's request to reconsider the payment determination made when the claim was processed.

Clean Claim: A claim for services that includes all required information and documentation, passes all system edits, and does not require any additional review to determine the medical necessity and appropriateness of services provided.

Clinical Peer: A provider having the same or a substantially similar specialty as the provider under review during the hearing process.

Coinsurance: A fixed percentage of the total amount paid for a healthcare service that can be charged to a member on a per-service basis.

Concurrent Review: An assessment of inpatient hospital care or ambulatory services by trained clinical review staff, during the period that those services are being provided, to assess the appropriateness and duration of care and treatment plans and to facilitate discharge planning.

Coordination of Benefits (COB): The process of assigning primary, secondary, and residual financial responsibility for coverage of healthcare services when an individual is eligible for benefits from more than one insurer or benefits program.

Copayment: A fixed amount that can be charged to a member on a per-service basis.

Cost Sharing: The amount of deductibles, coinsurance, and copayments that the member is responsible for paying on a per-service basis.

Covered Services: Services that must be furnished or paid for in accordance with the subscriber agreement or Evidence of Coverage between the health plan and the member, or covered by the applicable Medicaid, Medicare or CHP program.

Current Procedural Terminology (CPT): A recognized industry standard of descriptive terms and code identifiers for reporting medical services and procedures performed by physicians and other healthcare providers. CPT codes are used in conjunction with ICD-9 diagnostic codes for claims data and other reporting of services provided.

Credentialing: This process reviews and verifies a provider's credentials and experience prior to said provider's being approved for participation in a health plan. Specific review criteria are applied to ensure that the provider's credentials are appropriately verified initially and at ongoing intervals.

Cultural Competence: A provider's effective method of communicating with members who have limited proficiency in English or limited reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities, in order to facilitate the member's decision-making regarding medical treatment options. In addition, cultural competence includes offering the option of receiving no treatment.

Custodial Care: Care furnished for the purpose of meeting nonmedically necessary personal needs which could be provided by a person without professional skills or training.

Detoxification Services: Medically Managed Detoxification Services; and Medically Supervised Inpatient and Outpatient Withdrawal Services as defined in Appendix K – Prepaid Benefit Package Definitions of Covered and Noncovered Services of the Medicaid Managed Care Contract.

Direct Access: Access to specialty care services that do not require a referral from the member's PCP. Members may access these services at their own discretion without prior approval.

Direct Admission: This is a situation in which a member has been seen in the provider's office and the provider has made a determination that immediate admission to an inpatient hospital facility is medically necessary.

Disenrollment: Disenrollment is the process by which a member's entitlement to receive services from a health plan is terminated and the member is removed from the plan. Reasons for disenrollment may include, but not be limited to, loss of eligibility as well as disenrollment "for cause."

Discharge Planning: The planning and arranging for post-hospital services to ensure that members are discharged from inpatient care with timely arrangements in place for all necessary and appropriate post- hospital care.

Drug Formulary: A continuously updated list of preferred prescription medications. For Healthfirst, the formulary is developed by the Healthfirst Medical Affairs department and takes into consideration cost and efficiency. The formulary contains FDA-approved brand-name and generic drugs.

Durable Medical Equipment (DME): Equipment that can withstand repeated use by one (1) member, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the member's home.

Effective Date of Enrollment: The date on which a health plan member can begin to receive services from the health plan.

Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA): A convenient service for the automatic reimbursement of Healthfirst claims. EFT is the direct electronic deposit of claim reimbursements into a provider's bank account, and ERA is the statement that allows providers to reconcile these reimbursements to their member accounts.

Eligible Person: An individual who the local Department of Social Services or State authority determines to be eligible for Medicaid and who meets all the other conditions for enrollment in the health plan.

Emergency Medical Condition – PHSP: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of that person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient services that are (i) furnished by a provider qualified to provide emergency services and (ii) needed to evaluate or stabilize an emergency medical condition.

Enrollment Broker: An agent or contractor of the state or county who assists in educating and enrolling potential managed care members, assists in explaining the differences between managed care and fee- for-service, and offers nonbiased enrollment counseling.

Enrollment Roster: A report circulated each month to participating primary care providers to identify and provide demographic information on the health plan members who are in that provider's member panel for that month.

Evidence of Coverage (EOC): The contract between the member and Healthfirst Medicare putting forth the terms of the coverage for medically necessary healthcare services.

Explanation of Payment (EOP): A form or report that provides a detailed explanation of the payment or denial of payment in response to a provider's claim for reimbursement of services.

External Appeal: A request to the state for an independent review of a health plan's denial of services.

Extra Help: Medicare members with limited income and resources may qualify for financial assistance with paying for prescription drug costs (i.e., monthly premium, yearly deductible, and prescription coinsurance payments). The Centers for Medicare & Medicaid Services (CMS) provide (or pay for) extra help. The amount of extra help depends on the individual's income and resources.

- **Please Note**: Medicare members who have lost their Medicaid status are required to reapply for Extra Help.

Family Planning Services: Offering, arranging, and furnishing of those health services which enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unintended pregnancies. Family planning and reproductive healthcare include the following medically necessary services and related drugs and supplies that are furnished or prescribed by or under the supervision of a physician or nurse practitioner:

- Contraception, including insertion or removal of an IUD, insertion or removal of Norplant, and injection procedures involving pharmaceuticals such as Depo-Provera.
- Screening and treatment for STDs.
- Screening for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease, pregnancy, and pelvic abnormality/pathology.
- Termination of pregnancy services (provider must document duration of pregnancy).
- Such services include those education and counseling services needed to render the services effective.

Fee-for-Service (FFS): The traditional healthcare payment system under which providers receive a payment for each service provided based upon a contractually agreed-upon fee schedule.

Grace Period: A 'grace period' is a period of extra time that a member is given to pay their monthly premium should they miss a payment. The grace period provision for a Leaf Plan or Leaf Plan Premier member depends on the subsidy or tax credit that the member qualifies for. Members who receive no premium subsidies or federal tax credits

have up to 30 days to pay their premium after their premium due date. Members who receive premium subsidies have up to 90 days to pay their premium after their premium due date.

Grievance Process: The formal process by which health plan members or providers can communicate complaints and seek remedies from the health plan.

Guaranteed Eligibility: The period beginning on the member's effective date of enrollment with the health plan and ending six (6) months thereafter during which the enrollment of and capitation payments on behalf of the member continue even if a change in the member's financial or other circumstances ordinarily would have rendered him or her ineligible to receive any Medicaid-reimbursed services.

Health Care Proxy: A formal document that enables a health plan member to designate a trusted individual to make healthcare decisions on his or her behalf should the member lose the ability to make decisions on his or her own.

Health Plan Employer Data and Information Set (HEDIS®): HEDIS is a set of standardized performance measures designed to ensure that consumers, purchasers, and the general public can access information that allows for reliable comparison of the performance of different healthcare plans.

Home Health Agency: A licensed or certified agency under Part A of Medicare that provides intermittent skilled nursing care and other therapeutic services in the member's home.

Home Healthcare: Services provided by a Home Health Agency. The services may consist of the following:

- intermittent or part-time nursing visits rendered by an RN;
- intravenous therapy as ordered by the provider;
- home health aid services under the direction and supervision of an RN;
- other health services to be delivered in the home setting as requested/approved by the PCP/specialist and authorized by Medical Management.
- Home Healthcare services may require the use of durable medical equipment, oxygen and respiratory equipment, and other medical supplies.

Hospice: An organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill members and their families.

International Classification of Diseases, 9th Edition (Clinical Modification) (ICD9-CM): This is an industry standard listing and coding system used by providers for reporting medical conditions and diagnoses. ICD-9 codes are used in conjunction with CPT-4 codes for claims data and other clinical data reporting.

Informed Consent: A legal concept requiring the member, the member's guardian, or the member's legal representative to be advised of and to understand the risks of a proposed medical procedure or treatment prior to approving such procedure or treatment. Informed consent is usually provided in writing.

In-Network: The designation given to medical care services provided by providers, hospitals, and other providers that have participation agreements with the health plan.

Lock-in Period: The time beginning 90 days after the effective date of enrollment in the health plan by a social services official and ending 12 months after the effective date of enrollment, during which the member may not dis-enroll from the health plan except for certain specified reasons.

Low Income Subsidy (LIS): See Extra Help.

Marketing: Any activity of the health plan by which information about the health plan is made known to eligible persons for the purpose of persuading them to enroll with the health plan.

Managed Care: A comprehensive, coordinated approach to the provision of healthcare services that combines medical services with administrative procedures to ensure timely access to high-quality, medically appropriate, and cost-effective care. Managed care emphasizes primary and preventive care and focuses on the appropriate utilization of specialty care, emergency room services, and inpatient hospital care.

Medicare Advantage Organization: A public or private entity organized and licensed by the state as a risk-bearing entity that is certified by CMS as meeting the Medicare Advantage plan contract requirements. Formerly Medicare + Choice Organization.

Medicare Advantage Plan: Health benefits coverage offered under a policy or contract by a Medicare Advantage Organization that includes a specific set of benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the Medicare Advantage Organization. Formerly Medicare + Choice Plan.

Medicaid: A federal program created in 1965 under Title XIX—Medical Assistance of the Social Security Act. The program is administered and operated individually by participating state and local governments providing medical benefits and services to eligible persons who meet income or medical need criteria. The federal and state governments share Medicaid program costs.

Medical Management: The Healthfirst Medical Management department whose function it is to promote the efficient use of healthcare services and quality of care.

Medical Management Program: The program of utilization management, clinical review, and quality improvement established by Healthfirst to assure that the proper level and quality of care is provided to members.

Medical Record: A complete record that documents care received by the member, including inpatient, outpatient, and emergency care, in accordance with all applicable laws, rules, and regulations, which is signed by the medical professional rendering the services.

Medically Necessary – PHSP: Applies to health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury or disability.

Medically Necessary: Medical or hospital services which are determined by Healthfirst to be 1) rendered for the treatment or diagnosis of an illness or injury; 2) are appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; 3) are not furnished primarily for the convenience of the member, the attending physician, or other provider of service; and 4) are furnished in the most economically efficient manner which may be provided safely and effectively to the member.

Medical Staff: A hospital’s or ambulatory surgery center’s medical staff, as that term is defined in the bylaws of the hospital or ambulatory surgery center.

Medicare: The federal government health insurance program established by Title XVIII of the Social Security Act.

- **Medicare Part A:** Hospital insurance benefits, including inpatient hospital care, Skilled Nursing Facility Care, Home Health Agency Care, and Hospice care offered through Medicare.
- **Medicare Part B:** Medical insurance benefits that are optional and require the payment of a premium. Covers provider and certain non-provider services.
- **Medicare Part D:** Prescription drug insurance available to everyone with Medicare and provided by private companies.
- **Original Medicare:** The payment system by which doctors, hospitals, and other providers are paid a specific amount for each service performed as it is rendered and identified by a claim for payment.

Medicare Basic Benefits: All healthcare services that are covered under Medicare Part A and Part B programs (except hospice services), additional services that are covered by Medicare funds, and other services for which a member is required to pay a premium.

Medicare Benefit Period: A period beginning with the first day of a Medicare-covered inpatient hospital stay and ending with the close of a period of 60 consecutive days during which the member was neither an inpatient of a hospital nor of a SNF.

Member: An individual who is covered by Healthfirst, including newborn children of persons who have enrolled in benefit programs offered by Healthfirst.

Noncontracting Medical Provider or Facility: Any professional, organization, or health facility licensed and/or certified by the state or Medicare to deliver or furnish healthcare services but not under contract with Healthfirst to provide such services.

Nonparticipating Provider: A provider of medical care and/or services with which the health plan has no provider agreement.

Nonprescription/Over-the-Counter (OTC) Drugs and Medical/Surgical Supplies: Nonprescription drugs and supplies listed on the New York State Fee schedule as listed in the MMIS pharmacy Provider Manual.

Notice of Discharge and Medicare Appeal Rights (NODMAR): A notice issued to Healthfirst Medicare Plan members receiving inpatient hospital care or to their representative when it is determined that the current care is no longer medically necessary or is custodial in nature.

Obstetric and Gynecologic (OB/GYN) Providers: A group of providers including obstetricians, gynecologists, certified nurse midwives, and nurse practitioners with training in obstetrics and/or gynecology that provide women's healthcare services to Healthfirst members.

Optional Supplemental Benefits: Services not covered by Medicare that a member must purchase as a part of a Medicare Advantage plan that are paid for directly or on behalf of a member in the form of premiums or cost-sharing.

Organizational Determination: A decision whether or not coverage is necessary and appropriate.

Participating Provider: A hospital, physician, ambulatory surgical center, home healthcare agency, pharmacy, multispecialty group practice, or other healthcare provider that has entered into an agreement to provide services covered under benefit plans marketed by Healthfirst.

Peer Review Organization (PRO): An independent contractor paid by CMS to review medical necessity, appropriateness, and quality of medical care and services provided to Medicare beneficiaries.

Premium: The amount that must be paid for your health insurance or plan on a monthly, quarterly, or yearly basis.

Prior Authorization: The process whereby a provider must receive approval from the Medical Management department prior to rendering services. Services are authorized in accordance with nationally recognized standards of medical care.

Prepaid Health Services Plan (PHSP): A public or private organization organized under the laws of the State of New York and certified by the State Department of Health under Section 4403-A of the New York State Public Health Law.

Prescription Drugs: Those drugs that are listed on the New York State List of Medicaid Reimbursable Drugs.

Primary Care Covered Services: Those provider services covered by Healthfirst as described in the PCP agreement.

Primary Care Provider (PCP): A qualified physician or nurse practitioner or team of no more than four (4) qualified physicians/nurse practitioners who provide all required primary care services contained in the benefit package to members. Medical residents may be used as part of the PCP delivery system under the supervision of a qualified attending physician. PCPs specialize in internal medicine, family practice, pediatrics, or general practice. For the Medicare and commercial programs, geriatricians may participate as PCPs.

Provider Agreement: Any written contract between the health plan and a participating provider to provide medical care and/or services under this agreement.

Prepaid Capitation Plan Roster: The monthly reporting mechanism by which all Medicaid Managed Care Plans currently enrolling recipients in New York State (and any county within which these plans operate) are informed of specifically which recipients a managed care plan will be servicing for the coming month.

Provider's Members: Those members who have been assigned by Healthfirst to the provider, including newborn children of members who have been assigned to the provider, for the provision of medically necessary covered services. These members comprise the participating provider's panel.

Provider Network: The providers with whom Healthfirst contracts or makes arrangements to furnish covered healthcare services to Healthfirst members.

Qualified Health Plan (QHP): An insurance plan that is certified by the Federal or State Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements established by the Marketplace in which it is sold. Qualified health plans began coverage in 2014 under the Affordable Care Act. The QHPs offered by Healthfirst on the NY State of Health website are known as the Healthfirst Leaf Plans and Leaf Premier Plans.

Quality Improvement Organization (QIO): An independent organization under contract with the Centers for Medicare and Medicaid Services (CMS) for the purpose of improving the quality of care for Medicare beneficiaries, protecting the integrity of the Medicare Trust Fund, and protecting Medicare beneficiaries by addressing individual cases such as beneficiary complaints.

Quality Improvement Program (QIP): A program for reviewing, assessing, ensuring, and making determinations regarding the quality of the healthcare delivery system serving Healthfirst members. This includes review of the timeliness, quality, and appropriateness of medical care by the Health Care Quality Council and external peer review bodies.

Reconsideration: An appeal of an initial determination that was not favorable.

Referrals: A health plan–approved recommendation given to one participating provider from another participating provider (usually from a PCP to a participating specialist) in order to arrange for certain medical services for a Member within the health plan's active provider network. A referral facilitates a provider's effort in coordinating a member's healthcare needs. Leaf Plan and Leaf Premier Plan members must obtain referrals from their PCPs to arrange for certain specialist services in order to ensure the plan will cover these services.

Service Area: The specific geographic area where members reside and the health plan is authorized to operate. A geographic area approved by New York State and CMS within which an eligible individual may enroll in Healthfirst.

Skilled Nursing Care: Services that can only be performed by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility (SNF): A facility that provides inpatient Skilled Nursing Care, rehabilitation services, or other related health services. This term does not apply to convalescent nursing homes, rest homes, or facilities for the aged that primarily furnish custodial care including training in routines of daily living.

Specialty Care Provider: A physician or other provider in a medical specialty (e.g., cardiology, dermatology, or orthopedics) who provides clinical services to a Healthfirst member upon referral by the member's primary care provider.

Sterilization: Any medical procedure, treatment or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

Urgent Medical Condition – PHSP: A medical condition manifesting itself by acute symptoms of sufficient severity that, in the assessment of a prudent layperson possessing an average knowledge of medicine and health, could reasonably be expected to result in serious impairment of bodily functions, serious dysfunction of a bodily organ, body part, or mental ability, or any other condition that would place the health or safety of that person or another individual in serious jeopardy in the absence of medical or behavioral treatment within 24 hours.

Urgently Needed Services: Covered services provided when a member is temporarily absent from the plan's service area (or, under unusual and extraordinary circumstances, provided when the member is in the service area but the plan's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and

immediately required as a result of an unforeseen illness, injury, or condition and it is not reasonable, given the circumstances, to obtain the services through the member's PCP.

19 Appendices

Appendix I – Appointment Availability and 24-Hour Access Standards

Healthfirst maintains provider access, visit scheduling, and waiting time standards that comply with New YorkState regulations. Healthfirst and the NYSDOH actively monitor adherence to these standards. Healthfirst conducts audits of provider appointment availability, office waiting times, and 24-hour access and coverage. All participating providers are expected to provide care for their Healthfirst members within these access guidelines.

Description of Level of Care or Type of Service	Standards
Emergency Care: An emergency condition is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing the health of the person afflicted with such condition in: **a)** serious jeopardy, impairment, dysfunction, or disfigurement, or **b)** placing the health of others in serious jeopardy, in the case of a behavioral condition.	Care must be provided **immediately** upon presentation at the service delivery site.
Urgent Care: Urgent conditions are defined as those illnesses and injuries, of a less serious nature than emergencies, that require services to prevent a serious deterioration of a member's health and which cannot be delayed without imposing undue risk to the patient's well-being, until the patient either returns to the Plan's service area or until the patient can secure services from his or her primary care physician.	Urgent medical or behavioral problems must be seen within **24 hours** of request.
Non-urgent "Sick" Visits: These are visits for symptomatic conditions which are neither an emergency nor of an urgent nature.	Visit must be scheduled within **48-72 hours** of request as indicated by the nature of the clinical problem.
Routine Care: These visits are for routine management of clinical conditions or other follow-upcare as is clinically appropriate.	Appointment must be scheduled within **4 weeks** of request.
Adult Baseline and Routine Physicals	Appointment must be scheduled within **12 weeks** of enrollment.
Well-Child Care Visits	Appointment must be scheduled within **4 weeks** of request.
Initial Prenatal Visits: First Trimester	Appointment must be scheduled within **3 weeks** of request.
Initial Prenatal Visits: Second Trimester	Appointment must be scheduled within **2 weeks** of request.
Initial Prenatal Visits: Third Trimester	Appointment must be scheduled within **1 week** of request.
Newborn Visits: Initial Visit to the PCP	Appointment must be scheduled within **2 weeks** of hospital discharge.
Initial Family Planning Visits	Appointment must be scheduled within **2 weeks** of request.
Non-urgent Referred Specialist Visits	Appointment must be scheduled within **4 to 6 weeks** of request.
In-Plan Behavioral Health or Substance Abuse Follow-up Visits (subsequent to an emergency or inpatient stay)	Appointment must be scheduled within **5 days** or as clinically indicated.
In-Plan, Non-urgent Behavioral Health or Substance Abuse Visits	Appointment must be scheduled within **2 weeks** of request.

Appendix II – Credentialing

II.A Credentialing Requirements

All providers must meet the specific core criteria listed below as a condition for their participation in any of the Healthfirst provider networks.

1. A valid, current, unencumbered, and registered license for the state(s) in which the applicant will provide care. A license is “unencumbered” if it has not been the subject of any adverse action, including, but not limited to, probation, suspension, revocation, or imposition of conditions such as periodic reporting, restrictions on nature or scope of practice, or public or private censure.
2. Professional liability insurance in the amount of $1 million per incident/$3 million aggregate, per annum. The practitioner must maintain continuous malpractice coverage and must have no history of denial or cancellation of professional liability insurance, or exclusion of any specific procedures from coverage or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard performance.
3. No history of professional liability claims, including, but not limited to, lawsuits, arbitration, settlements, or judgments paid by, for, or on behalf of the practitioner or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard professional performance.
4. Valid, current, unencumbered, and unrestricted participation in the Medicaid and Medicare programs or other government program or, in the case of a provider who does not participate in these programs, proof that such nonparticipation is entirely voluntary and not due to current or past debarment or disbarment from the programs
5. No physical or mental impairment/condition, including, but not limited to, a communicable disease that makes the provider unable to perform the essential functions of a practitioner in the same area of practice or unable to perform such functions without causing a threat to the health or safety of others, except where the provider has submitted adequate evidence that a physical or mental impairment/condition does not render the provider unable to perform the essential functions of a practitioner in the same practice area or unable to perform such functions without causing a threat to the health or safety of others
6. No present or past chemical dependency or substance abuse problem that might adversely affect the provider’s ability to perform the essential functions of a practitioner competently and safely in the same area of practice, except where the provider has submitted adequate evidence that a chemical dependency or substance abuse problem does not adversely affect the provider’s ability to perform the essential functions of a practitioner competently and safely in the same practice area
7. No history of professional disciplinary actions or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard professional performance
8. No history of involuntary termination (including resignation to avoid dismissal) of professional employment or of a contract
9. No history of felony criminal conviction or indictment or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard professional performance.
10. No information to indicate a pattern of inappropriate utilization of medical resources
11. No other information that might indicate provider is engaged in conduct unbecoming to a professional in any jurisdiction. “Conduct unbecoming” can be defined as, but not limited to, sexual misconduct (e.g., with patients), tax evasion, sexual harassment of his/her patients, fraudulent billing practices, etc.
12. No falsification of the credentialing application requested documents, or material omission of information requested in the application
13. No report history to the National Practitioner Data Bank
14. No verified adverse reports from member satisfaction surveys or, in the case of an applicant with this history, evidence that this history does not indicate probable future substandard professional performance
15. Absence of inclusion on the Medicare Opt-Out List
16. Specially Designated Nationals List (SDN)
17. Absence of inclusion on the Office of the Inspector General (OIG) Exclusions List
18. Absence of inclusion on the New York Office of the Medicaid Inspector General (OMIG) Database

19. Absence of inclusion on the U.S. Department of Justice, Drug Enforcement Administration (DEA),Case Against Doctors Listing
20. Absence of inclusion on the CMS Preclusion List
21. For Medicaid only, providers that are sanctioned by the NYS DOH's Medicaid Program will be excluded from participation in the HMO's Medicaid panel
22. Enrolled in the New York State's Medicaid FFS Program if in the Medicaid Line of Business.

Information collected must be no more than 180 days old at the time of the Credentialing Committee decision.

Additional Requirements for MDs, DDSs, DMDs, DPMs, and Doctors of Osteopathy (DOs)

1. Graduation from an accredited medical school, dental school, college of osteopathy, or a foreign medical school recognized by the World Health Organization, and completion of a residency program
2. Evidence of a minimum of five (5) years of work history. If provider does not have five (5) years of work history, the time spent after in training will be included in the five-year minimum
3. Valid, current DEA registration (where applicable)
4. A review of the practitioner's site of practice that meets Healthfirst standards for office environment assessments is required (where applicable).

Additional Requirements for HIV Specialist Providers

1. Direct clinical ambulatory care of HIV-infected persons, including management of antiretroviral therapy, in at least 20 patients during the past year AND ten (10) hours annually of continuing medical education (CME), including information on the use of antiretroviral therapy in the ambulatory care setting. Practitioners who have been accorded HIV Specialist status by the American Academy of HIV Medicine (AAHIVM) or who have met the HIV Medicine Association's(HIVMA) definition of an HIV- experienced provider are eligible for designation as an HIV Specialist in New York State, provided that the requirements for management of antiretroviral therapy in HIV- infected patients have been fulfilled in the ambulatory care setting
2. Nurse practitioners and licensed midwives who provide clinical care to HIV-infected individuals in collaboration with a physician may be considered HIV Specialists, provided that all other practice agreements are met (8 NYCRR 79-5.1; 10 NYCRR 85.36; 8 NYCRR 139-6900). Physician assistants who provide clinical care to HIV-infected individuals under the supervision of an HIV Specialist physician may also be considered HIV Specialists (10 NYCRR 94.2)
3. A PCP must practice a minimum of 16 hours a week at each primary care site
4. A provider must have appropriate on-call designees (covering providers) who are in compliance with the requirements of these credentialing criteria.

Additional Requirements for Behavioral Health/Nurse Practitioner/Nurse Midwife/Allied Health Providers

1. Nurse Practitioners that have more than 3,600 hours of practices as a licensed or Certified NP may practice more autonomously by having a Collaborative Relationship with a Physician qualified to collaborate in the specialty, he/she is involved in. The NP must sign the Collaborative Relationship Attestation Form; this form will be accepted in lieu of the Collaborative Agreement.
2. Completion of an accredited education program registered with the State Education Department or program determined by the State Education Department to be equivalent to such a registered program which is designed to prepare graduates to practice in the specialty in which the applicant will provide care.
3. Valid, current DEA registration (where applicable)
4. Evidence of a minimum of five (5) years of work history. If provider does not have five (5) years of work history, the time spent after in training will be included in the five-year minimum.
5. A review of the practitioner's site of practice that meets Healthfirst's standards for office environment assessments is required (where applicable)
6. Nurse Practitioners: Execution of a collaborative agreement and practice protocols with a physician, in accordance with the requirements of the New York State Department of Education. The collaborating physician must be a member of the Healthfirst provider network

7. Nurse Midwives: A collaborative relationship with a physician in accordance with the requirements of the New York State Department of Education. The collaborative relationship must be with an OB/GYN provider in the Healthfirst network.

II.B Healthfirst Office Site Evaluation Form

PROVIDER NAME: _____
SPECIALTY: _____
ADDRESS: _____
PROVIDER ID: _____

Office Hours

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Reason for Visit

□ Initial Site Visit □ Recredentialing Visit □ Routine Visit □ Other_____

PHYSICAL ACCESSIBILITY	YES	NO	N/A	COMMENTS
Clearly marked office sign				
Handicapped parking available				
Entrance to facility handicapped accessible				
Exam rooms handicapped accessible				
Patient restrooms properly equipped and handicapped accessible				

PHYSICAL APPEARANCE	YES	NO	N/A	COMMENTS
Facility is clean and well maintained				
Restrooms AND exam rooms clean				
Provider hand washing area available				
Adequate patient seating available				
Adequate number of exam rooms				

FIRE AND SAFETY ISSUES	YES	NO	N/A	COMMENTS
Exits are clearly marked and accessible				
Fire safety equipment present (alarm/detector AND extinguisher)				
Hazardous waste disposal process in place (“Red bag system”)				
Impervious container for needle/syringe disposal				
Emergency kit available and includes Ambu bag/mask – Emergency drugs				

X-RAY / LABORATORY / PHARMACEUTICALS	YES	NO	N/A	COMMENTS
Current X-Ray/Radiological Equipment inspection certificate				
Current CLIA certificate or certificate of waiver				
Medication accessible only to authorized personnel				
Prescription pad, needles and syringes are inaccessible to patients				

MEDICAL RECORDKEEPING/CONFIDENTIALITY	YES	NO	N/A	COMMENTS
Current medical records are accessible only to authorized staff				
Medical records are kept in a secured location after hours				
Private consultation space available				
Use of Mental Health Assessment Tool *				
Standardized medical record format				

PROVIDER AVAILABILTY	YES	NO	N/A	COMMENTS
Maximum wait time for appointments – 1 hour for a scheduled visit *Medicare patients only* – 30 minute or less wait-time				
Maximum wait time for appointments – 2 hours for a walk-in (non-emergent condition)				
Emergency Care: Immediately upon presentation				
Urgent medical care appointment within 48 hours				
Non-urgent “sick visits” within 48-72 hours				
New patient appointments within 12 weeks (4 weeks for HIV positive members) Pediatrics – well child care 4 weeks				
Routine appointments within 4 weeks				
24 hour coverage available/7 days a week (list method)				
Physician **MUST** be available minimum of 16 hours/week at each site (Medicare and Commercial only minimum of 10 hours/ 2 days)				

Name and address of practitioner(s) providing coverage:

_____

_____

_____

_____

Is the practitioner providing coverage a Healthfirst provider? ☐ Yes ☐ No

Comments:

_____
_____
_____
_____
_____

Score:_____

Healthfirst Representative: _____ **Date: _____**

I acknowledge that the above review has taken place and that I am not necessarily in agreement with the above listed responses.

Provider / Staff Acknowledgment Signature: _____ **Date**: _____

II.C Interpretative Guidelines for the Office Site Evaluation Form

Physical Accessibility

- Clearly marked office sign: Sign identifying the practitioner/practice should be prominent and easy to read from the street or easy to find if the practitioner is housed in a building with other tenants.
- Handicapped parking available: This standard is met if there are designated parking spaces available for the handicapped (exceptions are made for urban areas; i.e., Manhattan).
- Entrance to facility is handicapped accessible: There must be an appropriate ramp for the building; an entrance large enough to accommodate a wheelchair or person using crutches; no barriers (i.e., curbsides).
- Exam rooms are handicapped accessible: The entrance must be large enough to accommodate a wheelchair or person using crutches; no barriers.
- Patient restrooms are properly equipped and handicapped accessible: At least one stall is equipped with a grab bar; no barriers; entrance is large enough to accommodate a wheelchair.

Physical Appearance

- Facility is clean and well maintained: Reception, waiting area, and hallways are orderly, uncluttered, and clean. The carpet/floor is in good condition. There are clean wall coverings and furniture. Overall appearance is acceptable.
- Restrooms and exam rooms are clean: There is no paper on the floor of the restroom; exam room is neat; proper care is taken to ensure that items used for a particular patient—such as gowns, instruments, and paper exam table covers—are not reused.
- Practitioner hand washing area is available: There should be a sink, soap, and paper towels available in each exam room for practitioner use.
- Adequate patient seating is available: There should be two (2) to three (3) chairs for patient seating foreach practitioner in the office.
- Adequate number of exam rooms: There should be two (2) exam rooms available per practitioner on duty.

Fire and Safety Issues

- Exits must be clearly marked and accessible: Lighted exit signs should be posted on the doors.
- Fire safety equipment must be present: This standard is met if there are both a working smoke alarm/smoke detector and fire extinguisher.
- Hazardous waste disposal process is in place: The practitioner must have a mechanism in place for the proper disposal of body fluids and any other materials that may be soiled and/or considered hazardous.
- Disposable equipment is readily available when necessary: There are disposable gloves within reach of the examination table and disposable masks and table covers inside the exam room.
- Impervious container available for needle/syringe disposal: The standard is met if there is an impenetrable container for sharp objects located within reach of the point where the sharp object is being used.
- Emergency kit available: This kit must include Ambu bag/mask and epinephrine; a crash cart should be accessible and conveniently located.

X-Ray/Laboratory/Pharmaceuticals

- Current X-Ray and Radiology Equipment Inspection Certificate is available: A current or recently reviewed inspection certificate and performance summary-testing sheet must be on file.
- Current CLIA Certificate: If laboratory services are performed in the provider's office, the site must have a current CLIA (Clinical Laboratory Improvement Act) certificate or certificate of waiver.
- Laboratory specimen storage: Laboratory specimens must be stored/shipped in puncture-proof containers.
- Accessibility of medication: Medication is accessible only to authorized personnel; narcotics are kept in a locked and secure area.
- Prescription pads, needles, syringes must not be accessible to patients: These supplies are to be kept in a secure location.

Medical Recordkeeping/Confidentiality - The site reviewer must physically examine at least one (1) actual medical record.

- Current medical records should be accessible only to authorized staff: Medical records being utilized for the day must be inaccessible to patients.
- Medical records are kept in a secured location after hours: Medical records should be kept in a locked cabinet or a locked file room after business hours.
- Private consultation space is available: This standard is met if there is space available away from other patients and office staff to discuss patient information privately with the patient or with other clinical staff.
- Standardized formats: There should be templates established and followed by the office staff regarding the order of each medical record for consistency. Templates must meet the medical records standards set by Healthfirst, as adopted from NCQA.

Provider Availability

- Emergency Care: Patients presenting with an emergency condition such as severe chest pains must be seen immediately.
- The maximum waiting time in the office for scheduled appointments is one (1) hour. Provider offices should not overbook appointments. The standard is met if the waiting time for a scheduled appointment is zero (0) to one (1) hour. For Medicare patients, the maximum waiting time for scheduled appointments is 30 minutes or less.
- The maximum waiting time for a non-emergent walk-in patient (if the provider accepts walk-in patients) is two (2) hours. The standard is met if the waiting time to be seen is between zero (0) to two (2) hours.
- Appointments for urgent medical care: Appointments for urgently required medical care must be scheduled to take place within 48 hours of request. Potentially life-threatening conditions require immediate attention.
- Appointments for non-urgent “sick visits”: These appointments must be scheduled to take place within forty-eight (48) to seventy-two (72) hours of request.
- Well-care appointments: Adult baseline physicals/new patient appointments are scheduled within twelve (12) weeks; well-child/preventive care appointments are scheduled within four (4) weeks.
- Physician coverage: The provider maintains coverage of the practice twenty-four (24) hours a day, seven (7) days a week. Reviewer must document (1) the type of coverage provided—live voice answering service, answering machine, or direct phone number—and (2) the coverage arrangements in place (e.g., shared coverage with other participating providers).
- Physician hours: Providers must practice a minimum of sixteen (16) hours per week. To qualify as a primary care provider, the practitioner must be available a minimum of two (2) days or sixteen (16) hours per week at each practice site. For Medicare and commercial programs, the minimum is two (2) days or ten (10) hours per week at each practice site.

Appendix III - Healthfirst Commercial Plans and Medicaid Managed Care Exclusions and Exemptions

Medicaid Exclusions

The following persons are excluded from joining a managed care plan:

- Medicare/Medicaid Dual Eligible
- Individuals who became eligible for Medicaid only after spending down a portion of their income
- Residents of State psychiatric facilities and residential treatment facilities for children and youth
- Residents of residential healthcare facilities at the time of enrollment and persons who enter a residential healthcare facility subsequent to enrollment, except for short-term rehabilitative stays anticipated to be less than thirty (30) days
- Participants in capitated long-term care demonstration projects, including beneficiaries with Medicare
- Medicaid-eligible infants living with incarcerated mothers
- Comprehensive private health insurance consumers if cost is lower than the State's
- All children in foster care. (Noninstitutional foster care children and institutional foster care children, children enrolled in Brides to Health waiver program – not excluded as of April 1,2013)
- Certified blind or disabled children living or expected to live separate from their parents for thirty (30) days or more. (No longer excluded as of April 1, 2013.) certified blind or disabled children living or expected to live separate from their parents for thirty (30) days or more. (No longer excluded as of April 1, 2013.)
- Individuals expected to be Medicaid eligible for less than six (6) months (except for pregnant women)
- Individuals receiving (at the time of enrollment) institutional long-term care services through long-term home healthcare programs, or childcare facilities (except ICF Services for the Developmentally Disabled).
- Individuals eligible for medical assistance benefits only with respect to tuberculosis-related services.
- Individuals placed in OMH licensed family care homes.
- Individuals enrolled in the Restricted Recipient Program. (No longer excluded as of August 1, 2012.)
- Individuals with a "County of Fiscal Responsibility" Code of 99, Code of 97 (OMH in MMIS), or Code of 98 (OMRDD in MMIS)
- Individuals receiving family planning services who are not otherwise eligible for medical assistance and whose net available income is 200% or less of the federal poverty line
- Individuals receiving hospice services (at time of enrollment)
- Individuals eligible for Medicaid pursuant to the terms of the "Medicaid buy-in for the working disabled." (No longer excluded as of April 1, 2013.)
- Individuals who are eligible for medical assistance.

Medicaid Exemptions

The following persons may voluntarily enroll, but are not required to enroll, in a Medicaid managed care plan.

- Individuals with chronic medical conditions who have been under active treatment for at least six (6) months with a subspecialist who is not a network provider for any Medicaid managed care plan in the service area, or whose request has not been approved by the SDOH medical director because of unusually severe chronic care needs.
- Residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR). (No longer exempt as of April 1, 2013.)
- Individuals with characteristics and needs similar to those who are residents of an ICF/MR. (No longer exempt as of April 1, 2013.)
- Individuals previously scheduled for a major surgical procedure (within thirty [30]) days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid managed care plan in the service area.
- Persons with developmental or physical disability receiving services through a Medicaid Home- and Community-Based Services Waiver. (No longer excluded as of April 1, 2013.)

- Individuals whose needs are similar to participants receiving services through a Medicaid Home- and Community-Based Services Waiver.
- Participants in the Medicaid Model Waiver (Care-At-Home) Program. (No longer excluded as of April1, 2013.)
- Individuals whose needs are similar to participants receiving services through the Medicaid Model Waiver (Care-At-Home) Programs. (No longer excluded as of April 1, 2013.)
- Residents of Alcohol/Substance Abuse Long-Term Residential Treatment Programs.
- Native Americans.
- Recipients with a “County of Fiscal Responsibility” Code of 98 (OMRDD in MMIS).
- Individuals eligible for Medicaid pursuant to the terms of the “Medicaid buy-in for the working disabled.” (No longer excluded as of April 1, 2013.)

Healthfirst Commercial Plan Exclusions

The following persons are excluded from joining a Healthfirst Commercial plan:

- Individuals over 65 who are eligible for Medicare.
- Individuals who are eligible for Medicaid.
- Individuals who live outside of Bronx, New York, Queens, Kings, Richmond, Suffolk, and Nassau counties.
- Individuals who are already insured through an employer or through a spouse’s employer.
- Individuals who are incarcerated.

Appendix IV - Marketing Guidelines

IV.A Medicaid Marketing Guidelines for Medical Service Providers

Definitions

"**Providers**" shall mean all physicians or medical facilities (hospitals, clinics, diagnostic and treatment centers, and physician group practices) that contract with one or more Medicaid managed care organizations.

"**Marketing**" shall mean all forms of communication, written or oral, used to encourage or induce Medicaid recipients to enroll in a managed care plan.

Appropriateness of Advertising and Outreach Materials

- Advertising and outreach materials must be pre-approved by the State Department of Health or the Local Department of Social Services (LDSS) prior to distribution.
- Providers shall not engage in marketing practices, nor distribute any advertising and outreach materials, that mislead, confuse, or defraud eligible persons, the public, or any government agency. Providers may not misrepresent the Medicaid program, the Medicaid managed care program, or the program or policy requirements of the LDSS or the State Department of Health.
    - **Reminder: Medicaid recipients may never be told by their providers that they have to join a plan now—they will never have to make a selection until they receive their official notices.**
- Advertising and outreach materials must accurately reflect general information which is applicable to the average consumer of Medicaid managed care. Advertising and outreach materials must provide as much information as possible to allow consumers to choose the plan that best meets their needs.
- Providers may not use any federal, state, or local government logos in their materials. Care should be taken to avoid the format and colors used in informational materials by these entities to ensure that there is no confusion about their sources.

Permitted/Impermissible Advertising and Outreach Activities

- Advertising and outreach activities may not discriminate on the basis of a potential member's health status, prior health service use, or need for future healthcare services.
- Providers may not conduct "cold call" telephone solicitations.
- Providers may not provide mailing lists of their patients to managed care organizations (MCO).
- Providers may give permission to MCO marketing representatives to conduct advertising and outreach activities at their facility. If the providers are in multiple plans and allow one (1) plan to market in their facilities or want to let their patients know of their affiliation with one (1) or more MCOs, they must prominently display a list of all other managed care plans operating in the county or borough with which they are contracted.
- Physicians may speak to their patients about their MCO affiliation and should encourage the patient to make their choice of plan based on the health needs of the patient and his/her family. Such advice, whether presented verbally or in writing, must be individually based and not merely a promotion of one (1) plan over another.
- Neither the provider nor MCO-facilitated enrollment representatives may market in emergency room facilities, treatment rooms, or hospital patient rooms. MCOs may not require providers to distribute plan-prepared communications to their patients.
- In the event a provider is no longer affiliated with a particular MCO but remains affiliated with other participant MCOs, the provider may notify his/her patients of the new status and the impact of such change on the patient.
- All advertising and outreach activities shall be conducted in an orderly, nondisruptive manner and shall not interfere with the privacy of potential members or the general community.
- Providers shall not target individuals and families who are already enrolled in other managed care plans.

Inducements to Enroll

Providers may not offer material or financial gain to Medicaid beneficiaries as an inducement to enroll. Specifically, providers may only:

- Make reference in advertising and outreach materials and activities to benefits/services offered under the program; and
- offer only nominal gifts, with a fair market value of no more than $5, with such gifts being offered regardless of the beneficiary's intent to enroll.

Providers shall not pay any individual, or accept payment from a Medicaid MCO, any commission, bonus, or similar compensation that uses numbers of Medicaid-eligible persons enrolled in the managed care plan as a factor in determining compensation.

IV.B Medicare Marketing Guidelines

The term provider means all Medicare health plan-contracting healthcare delivery network members (e.g., physicians, hospitals, etc.) The purpose of this section is to specify what marketing practices in this area meet both CMS requirements and the needs of the Medicare health plans with respect to entities considered providers by Medicare health plans.

CMS holds health plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. Therefore, Healthfirst must ensure that any providers contracted (and its subcontractors, including providers or agents) comply with the CMS marketing requirements.

Healthfirst and its subcontractors, including contracted providers or agents, are prohibited from steering, or attempting to steer an undecided potential enrollee toward a particular provider, or limited number of providers, based on the financial interest of the provider or agent (or their subcontractors or agents).

Providers must remain neutral when assisting beneficiaries with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their healthcare options.

Providers may conduct the following activities:

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare.
- Be listed in the Plan Finder, "Medicare & You" handbook, or "Medicare Options Compare" (from **https://www.medicare.gov**), including in areas where care is delivered.
- Provide the names of Plans/Part D sponsors with which they contract and/or participate.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered);
- Refer patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, Healthfirst plan marketing representatives, State Medicaid Office, local Social Security Office, CMS' website at **https://www.medicare.gov**, or 1 (800) MEDICARE.
- Refer patients to Healthfirst plan marketing materials available in common areas.
- Provide information and assistance in applying for the LIS;
- Make available, distribute, and display communication materials, including in areas where care is being delivered; and
- Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms).

Providers must not do the following:

- Accept/collect scope of appointment forms;
- Accept Medicare enrollment applications;

- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider;
- Mail marketing materials on behalf of Plans/Part D sponsors;
- Offer inducements to persuade their patients to enroll in a particular plan or organization;
- Conduct health screenings as a marketing activity;
- Distribute marketing materials/applications in areas where care is being delivered;
- Offer anything of value to induce enrollees to select them as their provider; or
- Accept compensation from any plan for any marketing or enrollment activities.

A full copy of the most current Medicare Marketing Guidelines is available on the Centers for Medicare &Medicaid Services (CMS) website at www.cms.gov/Medicare/Health-lans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html.

Appendix V – Medical Record Standards

Healthfirst providers are required to maintain member medical records in a manner that is current, detailed, organized, and comprehensive and that permits effective patient care and quality review. All medical records MUST include the following:

1. Patient's name and ID number on each page
2. Personal biographical data, including the patient's date of birth, address, employer, home and work telephone numbers, and marital status
3. A Problem List that is updated regularly to reflect current medications, significant illnesses, surgeries, and medical conditions
4. Medication/food allergies and adverse reactions must be prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this must be appropriately noted in the record
5. Patient's medical history (for patients seen three (3) or more times) must be easily identifiable and include serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), medical history relates to prenatal care, birth, operations, and childhood illnesses
6. For patients 13 years and older, an appropriate notation concerning the use of cigarettes, alcohol, and illegal substances and a substance abuse history
7. The history and physical exam identify appropriate subjective and objective information pertinent to the patient's presenting complaints and must be updated annually
8. Laboratory and other studies are ordered as appropriate and results are included with the chart
9. Working diagnoses are consistent with findings, and treatment plans are consistent with diagnoses
10. Encounter forms or notes have a notation regarding follow-up care, calls, or visits. The specific time of the return is noted in weeks, months, or as needed
11. Unresolved problems from previous office visits are addressed in subsequent visits
12. If a consultation is requested, there is a note or letter from the consultant in the medical record
13. Consultation, lab, and imaging reports filed in the chart must be initialed by a physician to signify review. Review and signature by a professional other than a physician, such as a nurse or physician assistant (PA), does not meet this requirement. If the reports are presented electronically or by some other method, there must also be indication of physician review. Consultations, abnormal lab, and imaging study results must have an explanation in the record of follow-up plans
14. There is an up-to-date immunization record for children (a note stating "immunizations up to date" is not acceptable). For adults, an appropriate history notation must be made in the medical record
15. There is evidence that preventive services and risk screening are offered, in accordance with Healthfirst's practice guidelines
16. Evidence of reporting of public health cases (e.g., STDs, TB, lead poisoning, domestic violence, etc.) to appropriate public health agencies is documented in the record
17. A record of all emergency room (ER) visits and hospitalizations should be maintained in the medical record. If the provider receives a written notice regarding a member's ER visit/hospitalization from a Medical Management Care Manager, a copy of such notice should be made part of the member's medical record and a note documenting the member's present condition relative to the ER visit/hospitalization must be included on the Progress Note
18. All entries are signed, stamped, or otherwise indicate the author's identity. All entries by a resident or PA are cosigned by an attending physician
19. All entries are dated.
20. The record is legible to someone other than the writer. (A second reviewer will examine any record judged to be illegible by the first reviewer.)
21. A Behavioral Health Screening Tool must be used to assess the mental health of PHSP Medicaid members, as appropriate
22. The member's written consent to disclose personal health information (PHI) to Healthfirst
23. Documentation of the risks of treatment versus no treatment for specific problems has been explained to the member
24. Evidence of continuity and coordination of care between primary and specialty providers
25. Documentation of prescriptions given, including drug name, dose, and date of initial and refill prescription

26. Documentation of a discussion about Advance Directives for HFHP Medicare members.

Appendix VI – Preventive Care

VI.A Preventive Care Standards and Required Documentation

Preventive Service Care	Standard	Required Documentation
Adolescent Screening & Counseling	Adolescents 12–17 years old who receive a comprehensive well-care visit with a PCP or OB/GYN should have the following seven components of preventive care during the measurement year: 1. BMI screening/percentile 2. Nutrition 3. Physical activity/exercise 4. Sexual activity & preventive actions 5. Depression 6. Risks of tobacco usage 7. Risks of substance abuse (including alcohol and drugs)	• BMI calculation/percentile or graph (BMI percentile is required for 3–15 years old; BMI value is acceptable for 16–17 years old) • Notation of assessment, counseling, or education on both nutrition & exercise • Notation of assessment, counseling, or education on physical activity/exercise • Notation of assessment, counseling, or education on preventive actions and risk behaviors associated with sexual activity • Notation of an assessment for depression • Notation of assessment, counseling, or education about the risks of tobacco use • Notation of assessment, counseling, or education about the risks of substance abuse (including alcohol and drugs)
Adolescent Well-Care Visits	At least one (1) comprehensive well-care visit with a PCP or OB/GYN for all patients 12–21 years old by December 31 of the measurement year.	• A note by the PCP or OB/GYN • Date of the well-care visit • A health history • A physical developmental history • A mental developmental history • A physical exam • Health education/anticipatory guidance
Annual Dental Visit	Children 2–21 years of age should have at least one dental visit during the measurement year 2.	• Oral health risk assessments to identify known risk factors
Antidepressant Medication Management	Patients 18 years of age and older with a diagnosis of major depression must remain on medication for a minimum of 84 days and optimally at least 180 days.	• Date of follow-up visit to a mental health provider • Name and dose of the prescribed antidepressant
Appropriate Testing for Pharyngitis	For patients 3 years of age and older, a strep test/throat culture should be performed when a diagnosis of pharyngitis is made, and antibiotics are prescribed.	• Date the strep test/throat culture was performed and the result • Additional diagnosis (if any) during the same date of service
Appropriate Treatment for URI	Antibiotics should not be prescribed for patients 3 months of age or older with a diagnosis of URI.	• Documentation in the medical record must include additional diagnosis (if any) during the same date of service
Avoidance of Antibiotic in Acute Bronchitis	Antibiotics should not be prescribed for patients 3 months of age and older with a diagnosis of acute bronchitis.	• Documentation in the medical record must include additional diagnosis or comorbidities (if any) during the same date of service
	Women 50–74 years of age should have a	• Date the mammogram was performed

Preventive Service Care	Standard	Required Documentation
Breast Cancer Screening	mammogram at least once every two years.	• Results of procedure
Care for Older Adults	Patients 65 years of age and older should receive the following: 1. Advance care planning 2. Medication review 3. Functional status assessment 4. Pain assessment	• Advance care planning • Medication list and review • Functional status assessment • Pain assessment
Cervical Cancer Screening	For women 21–64 years of age – 1 or more cervical cytology tests at least once every 3 years. Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years For women 30–64 years of age – 1 or more cervical cytology/high-risk human papillomavirus (hrHPV) co-testing at least once every five years.	• Date cervical cytology and hrHPV test were performed • Result of test(s)
Childhood and Adolescent Immunizations	Complete immunizations on or before the child's 2nd birthday: • 4 – DTaP/DTP • 3 – IPV • 3 – Hib • 3 – Hep B • 4 – PCV • 1 – MMR • 1 – VZV • 2 or 3 – Rotavirus • 1 – Hep A • 2 – Influenza Complete immunizations on or before child's 13th birthday: • 1 – Meningococcal ACWY vaccine (on or between 11th and 13th birthdays) • 1 – Tdap (on or between 10th and 13th birthdays) Complete immunizations on or between the female adolescent's 9th and 13th birthdays: • 2 or 3 – HPV vaccinations	• Dated immunization history OR note indicating name of specific antigen and date of immunization When entries are made at the time of the immunization, documentation must include: • Name of specific antigen • Date of immunization(s) • A certificate of immunization from an authorized provider or agency must include: • Specific date of immunization(s) • Type of immunization(s) given All entries must be dated by the child's 2nd birthday. • A note that the patient is up to date with all immunizations is not sufficient documentation.
Chlamydia Screening in Women	Sexually active women 16–24 years of age should be screened for chlamydia annually.	• Date the test was performed • Result of test
Colorectal Screening	Patients 50–75 years of age should have 1 or more screening(s) done:	• A note indicating the date the colorectal cancer

Preventive Service Care	Standard	Required Documentation
	1. Fecal occult blood (FOB) in the year 2. Flexible sigmoidoscopy in the last 5 years 3. Colonoscopy in the last 10 years 4. CT colonography in the last 5 years 5. FIT-DNA test in the last 3 years	screening was performed • The results or finding
Comprehensive Diabetes Care	For patients 18–75 years of age with diabetes: 1. 1 or more HbA1c test(s) in the year. Result should be < 8 % 2. A screening for diabetic retinal disease in the year for members with diabetic retinopathy and every 2 years for members without diabetic retinopathy by an optometrist or ophthalmologist 3. Annual nephropathy screening: a. Therapy with ACE inhibitor/ARB b. A test for microalbuminuria or documentation of existing macroalbuminuria or nephropathy 4. Blood pressure control (< 140/90 mm/Hg)	• Note that the HbA1c, nephropathy screening, dilated retinal eye exam, and BP checks were performed • Date performed • Results of the tests
Controlling High Blood Pressure	Document BP reading every visit for patients 18 years of age and over. BP reading is considered controlled: 18–85 years of age whose BP was < 140/90 mm Hg.	• Date the visit occurred • BP reading
DMARD for Rheumatoid Arthritis	Members who with a diagnosis of rheumatoid arthritis need to be on a disease-modifying anti-rheumatic drug (DMARD).	Medical record documentation must include name of prescription to treat rheumatoid arthritis
Follow-up Care for Children Prescribed ADHD Medication	Children 6–12 years of age who are prescribed ADHD medications should have at least 3 outpatient follow-up visits after the initial prescription: • 1 follow-up visit within 30 days • 2 follow-up visits within 2 to 9 months after the initial prescription (one can be a telephone visit)	Documentation in the medical record must include the date on which the follow-up care occurred
Follow-up after Hospitalization for Mental Illness	Patients 6 years of age and older who were hospitalized during the year for mental health disorders should have follow-up visits by a mental health	• Date of follow-up visit • Documentation that visit was with a mental health provider

Preventive Service Care	Standard	Required Documentation
	provider within 7 and 30 days of hospital discharge.	
Influenza Vaccine	Patients 18 years of age and older or those with chronic illnesses or weak immune systems should receive an annual flu vaccine during the months of July to December.	• Date of administration • Specific antigen OR documentation of contraindication or patient refusal
Lead Screening	All children should have at least one lead capillary or venous blood test on or before the child's second birthday.	Any medical record documentation, including lab slips, must include all the following: • Child's name • Child's date of birth (age is not sufficient) • Date blood test was performed • Result of test • Results of erythrocyte protoporphyrin testing is unacceptable
Medication Reconciliation	Patients 65 years of age and older should have medication reconciled within 30 days of discharge.	• Documentation in the medical record must include medications prescribed at discharge or a notation that no medications were prescribed
Osteoporosis Management in Women	Women 67–85 years of age who suffered a fracture and who had either a bone mineral density test or prescription for a drug to treat osteoporosis in the six months after the fracture.	• Date of test and result • Name of prescription to treat osteoporosis
Prenatal and Postpartum Care	**Prenatal Care**: initial visit must be within first trimester or within 42 days of enrollment. **Postpartum Care:** must occur between 7 and 84 days (1 and 12 weeks) after delivery.	• Documentation in the medical record must include a note indicating the date on which the prenatal or postpartum visit occurred
Pneumococcal Vaccine	Patients 65 years of age and older or those with chronic illnesses or weak immune systems should receive a pneumococcal vaccine at least once in their lifetime.	• Date of administration • Specific antigen OR documentation of contraindication or patient refusal
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received spirometry testing to confirm the diagnosis.	• Date of test • Result of test
Well-Child Visits in the first 15 Months of Life	Patients who turned 15 months during the reporting year should have at least six (6) well-child visits conducted during the first 15 months of life.	Documentation must include a note indicating a visit with a PCP, the date on which the well-child visit occurred, and evidence of all the following: • A health history • A physical developmental history • A mental developmental history • A physical exam • Health education/anticipatory

Preventive Service Care	Standard	Required Documentation
		guidance
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	At least one (1) well-child visit with a PCP during the measurement year for all patients who were 3–6 years of age as of December 31 of the measurement year.	• A note by the PCP • Date of the well-child visit • Health history • A physical developmental history • A mental developmental history • A physical exam • Health education/anticipatory guidance
Weight Assessment and Counseling for Nutrition & Physical Activity for Children and Adolescents	Children 3–17 years of age who had an outpatient visit with a PCP or OB/GYN should have evidence of the following: 1. BMI screening/percentile 2. Nutrition counseling 3. Physical activity counseling	• BMI percentile documentation (BMI percentile is required for 3–15 years old; BMI value is acceptable for 16–17 years old) • Notation of counseling on nutrition • Notation of counseling on physical activity

*Please refer to NYSDOH website for further info/additional requirements.

VI.B Child/Teen Health Plan (C/THP) Guidelines and Immunization Schedule

The matrix displayed below generally follows recommendations of the Committee on Standards of Child Healthcare of the American Academy of Pediatrics. The contents of each exam are the recommended standards for the specific age of the child/teenager and do not preclude providers from performing additional tests if indicated. A star indicates the age at which each component of the exam should be performed.

	2–4 wks	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	24 mos	3 yrs
HISTORY – Initial/Interval	*	*	*	*	*	*	*	*	*	*
MEASUREMENTS										
Length/Height and Weight	*	*	*	*	*	*	*	*	*	*
BMI Screening									*	
Head Circumference	*	*	*	*	*	*	*	*	*	
Weight for Length	*	*	*	*	*	*	*	*		
Blood Pressure	+	+	+	+	+	+	+	+	+	*
PHYSICAL EXAMINATION	*	*	*	*	*	*	*	*	*	*
SENSORY SCREENING – Sight and Hearing	+	+	+	+	+	+	+	+	+	*
DEVELOPMENTAL and BEHAVIORAL ASSESSMENT	*	*	*	*	*	*	*	*	*	*
DENTAL CARE (1)				*	*	*		*	*	*
COUNSELING and EDUCATION	*	*	*	*	*	*	*	*	*	*
IMMUNIZATIONS (See Guidelines) (2)	*	*	*	*	*	*	*	*	*	*
SCREENING – GENERAL										
Hereditary/Metabolic Screening (3)	*									
Hemoglobin and Hematocrit (4)			*			+	*	*	*	*
SCREENING PATIENTS at RISK										
Tuberculosis (5)	*			*		*			*	*
Lead Screening (6)				*	*	*		*	*	
Cholesterol Screening (7)									*	

	2–4 wks	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	24 mos	3 yrs
*** = to be performed** **+ = risk assessment to be performed with appropriate action to follow, if positive**										

	4y	5y	6y	8y	10y	11y–14y	15y–17y	18y–21y
HISTORY – Initial/Interval	*	*	*	*	*	*	*	*
MEASUREMENTS								
Height and Weight	*	*	*	*	*	*	*	*
BMI Screening	*	*	*	*	*	*	*	*
Head Circumference								
Blood Pressure	*	*	*	*	*	*	*	*
PHYSICAL EXAMINATION	*	*	*	*	*	*	*	*
SENSORY SCREENING – Sight and Hearing	*	*	*	*	*	*	*	*
DEVELOPMENTAL and BEHAVIORAL ASSESSMENT	*	*	*	*	*	*	*	*
DENTAL CARE	*	*	*	*	*	*	*	*
COUNSELING and EDUCATION	*	*	*	*	*	*	*	*
IMMUNIZATION (See Guidelines)	*	*	*	*	*	*	*	*
SCREENING – GENERAL								
Hemoglobin and Hematocrit	+	+	+	+	+	+	+	+
		*						
SCREENING PATIENTS at RISK								
Tuberculosis	+	+	+	+	+	+	+	+
Lead Screening	+	+	+					
Cholesterol Screening	*	*	*	*	*	*	*	*
STI (including chlamydia) (10)						*	*	*
HIV (11)						*	*	*
Pelvic Exam. (Pap smear) (12)						*	*	*
Testicular/Breast Examination (13)							*	*
*** = to be performed** **+ = risk assessment to be performed with appropriate action to follow, if positive**								

At each visit, a complete physical exam is essential, with infants totally unclothed and older children undressed or suitably dressed.

1. Scheduling a visit to the dentist is recommended within six (6) months of the eruption of the first tooth and no later than the child's first (1st) birthday, then twice a year thereafter.
2. See guidelines for immunization.
3. At first encounter, obtain results of newborn screening tests for all children born in New York State.
4. Performed during the 9th- to 10th-month visit and then repeated during the 23rd- to 25th-month visit (two tests by age two). All menstruating adolescents should be screened annually.
5. Testing should be done upon recognition of high-risk factors.
6. Regardless of exposure risk, all children must be screened with a blood lead test at or around 12 months and 24 months of age. Elevated blood lead levels require evaluation and/or referral for appropriate follow-up services.
7. Performed if family history is positive for early cardiovascular disease or hyperlipidemia.
8. Screen at least annually if sexually active.

9. Screen if at high risk for infection. Provide age and developmentally appropriate education/prevention, as well as confidential HIV counseling, testing, and supportive services.
10. Screen females annually if sexually active or if 18 years or older.
11. Should have physician exam with periodic health exam and be taught to do monthly breast self-examinations.

Sources: NYS Chapter 6 – Operational Protocol (Child/Teen Health Plan), Guidelines for Adolescent Preventive Services.

The U.S. Preventive Services Task Force, American Academy of Pediatrics and American Dental Association, Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents. 3rd ed.

VI.C Guidelines for Adolescent Preventive Services (GAPS)

The recommendations for GAPS emphasize annual clinical preventive services visits that address both the developmental and psychosocial aspects of adolescent health, in addition to traditional biomedical conditions. These recommendations were developed by the AMA, with contributions from a Scientific Advisory Panel comprising national experts, as well as representatives of primary care medical organizations and the health insurance industry. The body of scientific evidence indicated that the periodicity and content of preventive services can be important in promoting the health and well-being of adolescents.

Preventive Health Service by Age and Procedure

Age of Adolescent	**Early**				**Middle**			**Late**			
Procedure	11	12	13	14	15	16	17	18	19	20	21
Health Guidance											
Parenting****			*			*					
Development	*	*	*	*	*	*	*	*	*	*	*
Diet and physical activity	*	*	*	*	*	*	*	*	*	*	*
Healthy lifestyles**	*	*	*	*	*	*	*	*	*	*	*
Injury prevention	*	*	*	*	*	*	*	*	*	*	*
Screening History											
Eating disorders	*	*	*	*	*	*	*	*	*	*	*
Sexual activity***	*	*	*	*	*	*	*	*	*	*	*
Alcohol and other drug use	*	*	*	*	*	*	*	*	*	*	*
Tobacco use	*	*	*	*	*	*	*	*	*	*	*
Abuse	*	*	*	*	*	*	*	*	*	*	*
School performance	*	*	*	*	*	*	*	*	*	*	*
Depression	*	*	*	*	*	*	*	*	*	*	*
Risk for suicide	*	*	*	*	*	*	*	*	*	*	*
Physical Assessment											
Blood pressure	*	*	*	*	*	*	*	*	*	*	*
BMI	*	*	*	*	*	*	*	*	*	*	*
Comprehensive exam	*				*			*			
Tests											
Cholesterol	1				1			1			
TB	2				2			2			
GC, Chlamydia, Syphilis. and HPV	3				3			3			
HIV	4				4			4			
Pap smear	5				5			5			
Immunizations											
MMR	*										
Td	*				+						
Hep B	*				6			6			
Hep A	7				7			7			
Varicella	8				8			8			

1) Screening test performed once if family history is positive for early cardiovascular disease or hyperlipidemia
2) Screen if positive for exposure to active TB or lives/works in high-risk situation (e.g., homeless shelter, healthcare facility)
3) Screen at least annually if sexually active
4) Screen if high risk for infection
5) Screen annually if sexually active or if 18 years or older.
6) Vaccinate if high risk for hepatitis B infection.
7) Vaccinate if at risk for hepatitis A infection.
8) Vaccinate if no reliable history of chicken pox.
9) * Adolescents should have a complete physical examination during three of these preventive services visits. One should be performed during early adolescence (age 11-14), one during middle adolescence (age 15- 17), and one during late adolescence (age 18-21), unless clinical signs or symptoms warrant more frequent examinations
10) ** Includes counseling regarding sexual behavior and avoidance of tobacco, alcohol, and other drug use.
11) *** Includes history of unintended pregnancy and STD.
12) **** A parent health guidance visit is recommended during early and middle adolescence.
13) -+- Do not give if administered in last five years.

VI.D Primary Care Provider Behavioral Health Screening Tool

This questionnaire is intended exclusively as a screening device and is NOT a substitute for a complete Behavioral Health evaluation and assessment. All answers will remain confidential.

	QUESTION	YES	NO
I	Over the past month, have you had decreased interest or pleasure in doing things that you usually enjoy?		
	Over the past month, have you been feeling down or depressed?		
	If yes, rate your mood most of the time over the past month, on a scale of 1 to 10 (1 =worst, 10 = best mood)		
	Over the past month, has there been a change in your sleeping or eating habits or energylevel, without any obvious explanation?		
	Do you ever think about harming yourself or feel you might be better off dead?		
	Over the past month, have you experienced feelings of helplessness, hopelessness, orworthlessness?		
II	Over the past month, have you often felt very nervous or anxious, or have you beenworrying about things for no good reason?		
	If yes, rate how anxious or nervous you felt most of the time, on a scale of 1 to 10 (1 =highly anxious, 10 = relaxed).		
	In the past month, have you had an anxiety attack (suddenly felt fear or panic)?		
	Over the past month, have you ever had recurrent thoughts or rituals that interfere withyour daily activities or make them difficult to complete?		
III	Have you ever felt you ought to cut down on your drinking?		
	Have people annoyed you by criticizing your drinking?		
	Have you ever felt bad or guilty about your drinking?		
	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of ahangover (eye opener)?		
	10A. Do you ever use illegal drugs?		
	10B. Approximately how often?		
	10C. What kind of drugs do you use?		
	Has drinking or drug use ever interfered with work, home, school, or family responsibilities?		
IV	12A. In the last three months, have you done any of the following to avoid gaining weight?		
	12B. Intentionally made yourself vomit?		
	12C. Taken laxatives regularly or excessively?		
	12D. Fasted for over 24 hours, for no other reason?		
	12E. Exercised excessively, for more than an hour at a time?		
	13A. In the past three months, have you ever had an episode of binge eating?		
	13B. If yes, approximately how many episodes have you had?		
	13C. Approximately how often have you had them?		
V	Over the past month, has there ever been a time when you heard voices when no oneelse was around, or seen things that no one else saw?		
	During the past month, have you ever had thoughts or feelings that someone wanted tohurt you or is out to get you?		
	Do you believe that you have any special powers?		

Patient's Name:

DOB:

Today's Date:

Primary Care Provider Behavioral Health Screening Tool Scoring Guide

Questions 4 and 14, if answered in the affirmative, require the patient's immediate referral for urgent or emergent evaluation.

Section I Depression questions 1–5: Any three (3) or more questions answered in the affirmative, or any two (2) or more questions answered in the affirmative with a mood severity rating of < 4, require the patient's referral for further evaluation.

Section II Anxiety/Panic/OCD questions 6–8: Any two (2) or more questions answered in the affirmative, or any one (1) question answered in the affirmative with an anxiety severity rating of < 4, require the patient's referral for further evaluation.

Section III Substance & Alcohol Use/Abuse questions 9–11: Any two (2) or more questions answered in the affirmative require the patient's referral for further evaluation. Referral should also be made based on the severity assessment screening questions.

Section IV Eating Disorders questions 12–13: Any three (3) or more questions (question 12 counts as 4 questions) answered in the affirmative require the patient's referral for further evaluation. Referral should also be made based on the severity assessment screening questions.

Section V Perceptual Abnormalities/Psychotic Symptoms questions 14–16: Any two (2) or more questions answered in the affirmative require the patient's referral for further evaluation.

If the total number of questions answered in the affirmative is equal to or greater than 10, regardless of the distribution/specific question answered or the severity reported the patient should be referred for further evaluation.

VI.E Healthfirst Wellness Reward Card – PHSP

Healthfirst Medicaid, Child Health Plus, Essential Plan and Personal Wellness Plan members can earn rewards for completing healthy activities such as accessing well-child visits, postpartum care, immunizations, taking asthma controller medication and colorectal cancer screenings. To qualify, members can fill out a reward form and mail or fax the reward form back to Healthfirst. The reward form can also be completed in the Member Portal. The correct coding information for relevant claims can be found in the HEDIS Code Book.

For the latest Rewards Card, please go to the Provider Portal by visiting **https://hfproviderportal.org**. Enter your username and password at the top of the page and then go to the Provider Resource Center tab, located at the top of the screen.

Once there, please go to the Top section for information on the Rewards Card.

VI.F Healthfirst Wellness Reward Card – Medicare

Healthfirst Medicare Advantage Plan and CompleteCare members who meet program eligibility criteria can earn rewards for completing healthy activities. These activities include preventive screening and chronic-condition management, such as completion of a health risk assessment, a diabetic retinal exam, a mammogram, a colorectal cancer screening, and many more. To qualify, members can fill out a reward form and mail or fax the reward form back to Healthfirst or let us know they completed any eligible preventive screenings/health initiatives through the Healthfirst mobile app (coming soon!). The correct claims can be found in the HEDIS Code Book.

For the latest reward form, please go to the Provider Portal by visiting **https:/hfproviderportal.org**. Enter your username and password at the top of the page and then go to the Provider Resource Center tab at the top of the screen. Once there, please go to the Top Quality section for information on the rewards.

Appendix VII – Description of Skilled Nursing Services

Units = 15 min

	Level of Care/Bill Codes	Skilled Nursing	Rehabilitation
1	A. Level 1 **Skilled Nursing Care** Bill Code: 191	1–4 hours skilled nursing per day	Up to 1.5 hrs. multidiscipline therapies per day; min. 5 days per week
2	B. Level 2 **Rehabilitation Therapy** Bill Code: 192	Over 4 and up to 6 hours skilled nursing per day	Between 1.5 and 3 hrs. multidiscipline therapies per day; min. 5 days per week
3	C. Level 3 **Subacute Skilled Care Non-weanable Ventilator Management** Bill Code: 193	More than 6 hours skilled nursing per day	Between 3 and 6 hrs. multidiscipline therapies per day; min. 5 days per week
4	D. Level 4 **Weanable Ventilator Management** Bill Code: 194	3–6 hours skilled nursing per day	More than 6 hrs. multidiscipline therapies per day; min. 5 days per week

Inclusions	Exclusions

• Semi-private room
• Administration of drugs and biologicals
• Routine medications, including intramuscular (IM) medications and supplies (see exclusions)
• Nutrition services, including enteral and parental supplies
• Registered nurse onsite availability 24 hours a day
• Nursing and personal care, including assistance in activities of daily living
• Rehabilitation services: physical, speech, and occupational therapy
• Attending physician services
• Routine admission diagnostic radiology
• Lab services based on medical necessity or diagnosis/physician plan care
• Basis equipment, medical supplies, and appliances
• Supervision of the use of durable medical equipment, assistive devices, and prescribed therapies
• Recreational therapies
• Social work and psychological services
• Routine dental services
• Maintenance of patient room cleanliness
• Other services or furnishings related to the basic room, board, and care of the patient
• Discharge planning
	• Specialty consults (except when consult is included in specific level of care)
	• Hemo and peritoneal dialysis
	• Blood and blood products
	• Enteral and TPN solutions
	• Transportation
	• Specialty equipment, supplies, wheelchairs, appliances, and beds
	  • Nonroutine radiology (including MRI, CT scan, PET scan)
	  • All of the foregoing excluded services must be pre-certified by a case manager or designated representative. In the event that a question arises concerning the need for treatment, the matter shall be referred to the Managed Care Organization (MCO)
	  • Drugs exceeding $50 per day on average are excluded from the per diem and must be purchased through the MCO's designated pharmacy network or contracted provider(s) of infusion therapy services

Appendix VIII – Medicare Member Reimbursement Form

Healthfirst Medicare Plan Member Reimbursement Form

healthfirst

Here are some helpful hints on how to complete this form:

Section 1 Member Information

- Write your member ID# found on your ID card.
- Write your name as shown on your ID card (First Name, Last Name).
- Write your mailing address.
- Write your telephone number in case we need to reach you to verify any information you have provided.

Section 2 Reimbursement Information

- Write the amount to be reimbursed.

Section 3 Reason for Reimbursement Request

- Select the reason for your reimbursement request. You may submit only one reimbursement request at a time.
- If you do not see your type of request listed, please give us a detailed description in the box listed as "Other".

Section 4 Attached Supporting Documentation

- Check the type of supporting documentation (receipt) you will be attaching with your form.

Section 5 Member Attestation

- Sign and date your form to certify that the information on the form and that the documents attached are accurate and complete.
- If you are not the member and are signing this form, we may request that you send us your contact information.

Don't forget to attach your receipt when you submit this form. If you have any questions or need additional help with filling this form, please call our Member Services department at **1-888-260-1010**, Monday–Sunday, 8:00am–8:00pm. If you need an interpreter, please call our Member Services department at **1-888-260-1010**, Monday–Sunday, 8:00am–8:00pm, TDD/TTY English 1-888-542-3821, TDD/TTY Español 1-888-867-4132. If you require in-person assistance with filling out this form, you may contact Member Services for the nearest Community Office location.

 NYMED00950 H3359_MSD16_03 Accepted 09282015

Find this form at *HFMedicareMaterials.org* under the "Member Resources" tab

Appendix IX – Preauthorization Guidelines by Service Type

IX.A Preauthorization Guidelines for Healthfirst Medicaid, Child Health Plus, Medicare, and CompleteCare Plans

Preauthorization is not a guarantee of payment. The member's eligibility determines benefits. Policies are subject to change. Written formal referrals are not required for all Healthfirst plan in-network providers.

Members should always be referred to, and receive care from, in-network specialists.

Please contact Utilization Management for prior authorization questions at the number in the grid.

The following table includes a representative list of services requiring preauthorization as of 9/19/22 and is subject to change. Authorization requests and inquiries should be made directly to Healthfirst Medical Management at 1 (888) 394-4327.

To see current prior authorization requirements for all services, including delegated vendors, see the Procedure Code Lookup Tool in the Online Authorization section on the Healthfirst Provider Portal (https://hfproviderportal.org).

Services That Require Prior Authorization	Medicaid	CHPlus	65 Plus Plan	Increased Benefits Plan	Life Improvement Plan	Signature (HMO)	Signature (PPO) in-network	Connection	CompleteCare	SHP	EP	QHP	HFIC
ABA Treatment for Autism Spectrum Disorder	✓	✓	NC	NC	NC	NC	NC	NC	NC	NC	✓	✓	✓
Acute Rehabilitation Admissions	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Adult Day Health Care	✓	NC	NC	NC	NC	NC	NC	✓	✓	✓	NC	NC	NC
Adult Behavioral Health Home and Community Based Services (BH HCBS)	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
AIDS Adult Day Health Care	✓	NC	NC	NC	NC	NC	NC	✓	✓	✓	NC	NC	NC
Air Ambulance	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓

Services That Require Prior Authorization	Medicaid	CHPlus	65 Plus Plan	Increased Benefits Plan	Life Improvement Plan	Signature (HMO)	Signature (PPO) in-network	Connection	CompleteCare	SHP	EP	QHP	HFIC
Ambulatory Surgery Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Audiology, Hearing Aid Services and Products	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bariatric Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Community Oriented Recovery and Empowerment (CORE)	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
Cardiac Rehabilitation	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Children's Home and Community Based Services (HCBS)	✓	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
Cognitive Skills Development Testing	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Comprehensive Emergency Psychiatric Programs (CPEPs)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NC	NA	NA	NA
Consumer-Directed Personal Assistance Services	✓	NC	NC	NC	NC	NC	NC	✓	✓	✓	NC	NC	NC
Continuing Day Treatment	✓	✓	NC	NC	NC	NC	NC	✓	✓	NC*	NC	NC	NC

Services That Require Prior Authorization	Medicaid	CHPlus	65 Plus Plan	Increased Benefits Plan	Life Improvement Plan	Signature (HMO)	Signature (PPO) in-network	Connection	CompleteCare	SHP	EP	QHP	HFIC
Cosmetic Surgery (not covered; however, codes may require review in non-elective instances)	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Durable Medical Equipment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Elective Admissions to a Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Electroconvulsive Therapy (ECT) – Outpatient	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
EMG/Nerve Conduction Studies	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Enteral Formula	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Experimental and/or Investigational Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Foot Inserts	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Home Health Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Home-Delivered and Congregate Meals	✓	NC	NC	NC	NC	NC	NC	✓	✓	✓	NC	NC	NC

Services That Require Prior Authorization	Medicaid	CHPlus	65 Plus Plan	Increased Benefits Plan	Life Improvement Plan	Signature (HMO)	Signature (PPO) in-network	Connection	CompleteCare	SHP	EP	QHP	HFIC
Hospice Care	✓	✓	NC	NC	NC	NC	NC	NC	NC**	NC**	✓	✓	✓
Infertility Services	✓	NC	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Inpatient Substance Use Disorder (SUD) Services (Detoxification, Rehabilitation)	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Medical Social Services	✓	✓	NC	NC	NC	NC	NC	✓	✓	✓	NC	NC	NC
Neuropsychological Testing	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Orthopedic Footwear	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Orthotics	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Out-of-Network Services (except anesthesia)	✓	NC	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓
Outpatient Medically Supervised Withdrawal	NA	NA	NA	NA	NA	NA	NA	NA	NA	NC	NA	NA	NA
Outpatient Mental Health (Routine in-network outpatient, i.e., psychotherapy)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NC	NA	NA	NA

Services That Require Prior Authorization	Medicaid	CHPlus	65 Plus Plan	Increased Benefits Plan	Life Improvement Plan	Signature (HMO)	Signature (PPO) in-network	Connection	CompleteCare	SHP	EP	QHP	HFIC
Outpatient Program Substance Use Disorder (Routine in-network outpatient SUD treatment)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Pain Management Services	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Partial Hospitalization Program (PHP)	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Personal Care Assistance Services	✓	NC	NC	NC	NC	NC	NC	✓	✓	✓	NC	NC	NC
Personal Emergency Response System (PERS)	✓	NC	NC	NC	NC	NC	NC	✓	✓	✓	NC	NC	NC
Post-Discharge Meal	NC	NC	✓	✓	✓	✓	✓	✓	NC	NC	NC	NC	NC
Private Duty Nursing	✓	NC	NC	NC	NC	NC	NC	✓	✓	✓	NC	NC	NC
Procedures and Equipment for Erectile Dysfunction	NC	NC	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Prosthetics	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Psychological Testing	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓

Services That Require Prior Authorization	Medicaid	CHPlus	65 Plus Plan	Increased Benefits Plan	Life Improvement Plan	Signature (HMO)	Signature (PPO) in-network	Connection	CompleteCare	SHP	EP	QHP	HFIC
Pulmonary Rehabilitation	✓	✓	✓	✓	✓	✓	✓	✓	✓	NC	✓	✓	✓
Rehabilitation Services – Physical Therapy, Occupational Therapy, and/or Speech Therapy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Residential Rehabilitation Services for Youth (RRSY)	NC	NA	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
Skilled Nursing Facility Admissions	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Social Day Care	✓	NC	NC	NC	NC	NC	NC	✓	✓	✓	NC	NC	NC
Transplants (must be performed in a Medicare-certified facility for Medicare members)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

- ✓ = Prior Authorization Required NC = Not Covered
- NA = Not Applicable/No Authorization Required
- *Carved out to Fee-for-Service Medicaid
- **Only room and board covered
- Preauthorization is not a guarantee of payment. Payment by Healthfirst for services provided is contingent upon the member's active membership in Healthfirst at the time of service or when treatment was rendered. Policies are subject to change.
- For preauthorization for the services listed above or to notify Healthfirst of an admission, contact the Medical Management department at 1-888-394-4327.
- For advance imaging, radiology, radiation oncology, Medical Oncology and genetic testing preauthorization, please contact eviCore at 1-877-773-6964.
- For preauthorization of surgical procedures of the eye, please contact Superior Vision at 1 (888) 273-2121.

- For information on chiropractic services, please contact ASH at 1-800-972-4226.
- For pharmacy authorizations, please contact CVS Caremark at 1-800-294-5979.
- QHP/EP/HFIC: 1-855-582-2022
- Medicaid/PWP/CHPlus: 1-877-433-7643
- SGM: 1-866-814-5506
- For back pain management and spinal surgery, please contact Orthonet at 1 (844) 504-8091

IX.B Preauthorization Guidelines – Leaf Plan

ABA Treatment for Autism Spectrum Disorder	Preauthorization Required
Assistive Device for Autism Spectrum Disorder	Preauthorization Required
Advanced Imaging Services – Freestanding/Outpatient	CareCore Preauthorization Required
All Out-of-Network Services	Preauthorization Required
Ambulatory Surgery Services	Preauthorization Required
Cardiac and Pulmonary Rehabilitation	Preauthorization Required
Chiropractic Services	Please refer to ASH
Cosmetic Services	Preauthorization Required
Dialysis	Preauthorization Required
DME and Breast Pump Rental	Preauthorization Required
EMG/Nerve Conduction Study	Preauthorization Required
Habilitation Services – Physical, Occupational, and Speech Therapy	Preauthorization Required
Hearing Aid and Cochlear Implants	Preauthorization Required
Home Health Care	Preauthorization Required
Hospice Care – Inpatient and Outpatient	Preauthorization Required
Infertility Services	Preauthorization Required
Inpatient Hospital Services and Facility	Preauthorization Required
Rehabilitation Services (Physical, Occupational, and Speech Therapy) – Inpatient and Outpatient	Preauthorization Required
Insulin Pump	Preauthorization Required
Interruption of Pregnancy (Abortion)	Preauthorization Required
Mental Health and Substance Use Services – Admissions and the following outpatient services: ECT, Neuropsychological Testing, Partial Hospital Program, Intensive Outpatient Treatment, and Day Treatment require preauthorization. *Authorization for traditional in-network outpatient behavioral health services provided by Healthfirst providers is not required.*	Preauthorization Required
Non-emergency Ambulance Services	Preauthorization Required
Outpatient Hospital Services and Surgery	Preauthorization Required
Prosthetic (External and Internal)	Preauthorization Required
Skilled Nursing Facility	Preauthorization Required
Transplant	Preauthorization Required

Preauthorization is not a guarantee of payment. Payment by Healthfirst for services provided is contingent upon the member's active membership in Healthfirst at the time of service or when treatment was rendered. Policies are subject to change.

- For preauthorization for the services listed above or to notify Healthfirst of an admission, please contact the Medical Management department at 1-888-394-4327.

- For advance imaging, radiology, radiation oncology, Medical Oncology, and genetic testing preauthorization, please contact eviCore at 1-877-773-6964.
- For preauthorization of surgical procedures of the eye, please contact Superior Vision at 1-888-273-2121.
- For information on chiropractic services, please contact ASH at 1 (800) 972-4226.
- For pharmacy authorizations, please contact CVS Caremark at 1 (800) 294-5979.
- QHP/EP/HFIC: 1 (855) 582-2022
- Medicaid/PWP/CHP: 1 (877) 433-7643
- SGM: 1 (866) 814-5506
- For back pain management and spinal surgery, please contact Orthonet at 1 (844)504-8091

Appendix X – Clinical Practice Guidelines

2022 Clinical Practice Guidelines and Protocols

Conditions	Clinical Practice Guideline	Source
Sickle Cell Disease		
Sickle Cell Disease (SCD)	2019 sickle cell disease guidelines by the American Society of Hematology: methodology, challenges, and innovations • Cardiopulmonary and Kidney Disease • Transfusion Support • Cerebrovascular Disease • Management of Acute and Chronic Pain	**American Society of Hematology** https://ashpublications.org/bloodadvances/article/3/23/3945 /429212/2019-sickle-cell-disease-guidelines-by-the?utm_source=TrendMD&utm_medium=cpc&utm_campa ign=Blood_Advances_TrendMD_0
Respiratory		
Asthma	2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2020.	National Heart, Lung, and Blood Institute/National Institutes of Health https://www.nhlbi.nih.gov/health-topics/all-publications-and- resources/2020-focused-updates-asthma-management- guidelines Global Strategy for Asthma Management and Prevention https://ginasthma.org/gina-reports/
Chronic Obstructive Pulmonary Disease (COPD)	Global strategy for prevention, diagnosis and management of copd: 2022	Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) https://goldcopd.org/2022-gold-reports-2/
Treating Tobacco Use & Dependence	Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons, January 19, 2021 US Preventive Services Task Force Recommendation Statement - US Preventive Services Task Force	AMA Network US Preventive Services Task Force https://jamanetwork.com/journals/jama/fullarticle/2775287
Cardiovascular		
Congestive Heart Failure (CHF)	2021 Update to the 2017 ACC Expert Consensus Decision Pathway for Optimization of Heart Failure Treatment: Answers to 10 Pivotal Issues About Heart Failure With Reduced Ejection Fraction: A Report of the American College of Cardiology Solution Set Oversight Committee	JACC https://www.jacc.org/doi/10.1016/j.jacc.2021.06.011
Coronary Heart Disease (CHD)	2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR Guideline for the Evaluation and Diagnosis of Chest Pain: A Report of the American College of Cardiology/American Heart	**JACC** 2021 ACC Expert Consensus Decision Pathway on the Management of ASCVD Risk Reduction in Patients With Persistent Hypertriglyceridemia: A Report of the American College of Cardiology Solution Set Oversight Committee | Journal of the American College of Cardiology (jacc.org)

Conditions	Clinical Practice Guideline	Source
	Association Joint Committee on Clinical Practice Guidelines AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update A Guideline From the American Heart Association and American College of Cardiology Foundation	https://www.jacc.org/doi/10.1016/j.jacc.2021.06.011 **American Heart Association** http://circ.ahajournals.org/content/early/2011/11/01/CIR.0b0 13e318235eb4d.full.pdf
Hyperlipidemia	2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol. J Am Coll Cardiol. 2019 Jun, 73 (24) e285-e350. 2021 ACC Expert Consensus Decision Pathway on the Management of ASCVD Risk Reduction in Patients With Persistent Hypertriglyceridemia: A Report of the American College of Cardiology Solution Set Oversight Committee	**JACC** https://www.onlinejacc.org/content/73/24/e285 https://www.jacc.org/doi/10.1016/j.jacc.2021.06.011
Hypertension	2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines New Guidance on Blood Pressure Management in Low-Risk Adults with Stage 1 Hypertension	**American Heart Association** http://hyper.ahajournals.org/content/early/2017/11/10/HYP. 0000000000000065 **Journal of the American College of Cardiology** http://www.onlinejacc.org/ https://www.acc.org/latest-in-cardiology/articles/2021/06/21/13/05/new-guidance-on-bp- management-in-low-risk-adults-with-stage-1-htn
Diabetes	American Diabetes Association Standards of Medical Care in Diabetes - 2022. Diabetes Care Volume 45, Supplement 1, January 2022.	**American Diabetes Association** SJ-DC_Edbd 1.2 (silverchair-cdn.com)
Prevention of Cardiovascular Disease	2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines 2019 ACC/AHA guideline on the primary prevention of cardiovascular disease: a report of the American College of Cardiology/American Heart Association Task Force on Clinical	**ASPC** https://www.aspconline.org/?s=2019+ACC%2FAHA+Guidelines+on+the+Primary+Prevention+of+Cardiovascular+Disease **JACC** https://www.onlinejacc.org/content/74/10/1376?_ga=2.3877 9683.1432197343.1591652628-1558476331.1591652628

Conditions	Clinical Practice Guideline	Source
	Practice Guidelines. J Am Coll Cardiol 2019;74:e177–232	
Mental Health		
Attention Deficit Hyperactivity Disorder (ADHD)	American Academy of Pediatrics - Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents	**American Academy of Pediatrics** https://pediatrics.aappublications.org/content/144/4/e20192 528
Depression	Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts The 2019 guideline recommends interventions for the treatment of depression in children and adolescents, adults, and older adults.	**American Psychological Association** https://www.apa.org/depression-guideline
Use of Buprenorphine in the Treatment of Opioid Addiction	Treatment of Opioid Use Disorder – 2020 Focused Update The National Practice Guideline is intended to inform and empower clinicians, health system administrators, criminal justice system administrators, and policymakers who are interested in implementing evidence-based practices to improve outcomes for individuals with OUD. This is especially critical in the context of the ongoing COVID-19 emergency, which threatens to curtail patient access to evidence-based treatment.	The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder – 2020 Focused Update
Psychiatric Disorders	American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders APA's practice guidelines focus on a set of discrete clinical questions of relevance to an overarching subject area. A systematic review of evidence is conducted to address these clinical questions and involves a detailed assessment of individual studies.	**American Psychiatric Association Practice Guidelines** http://psychiatryonline.org/guidelines.aspx
Preventive and Screening Guidelines		
Pediatric Care	The **Screening Technical Assistance & Resource Center (STAR Center**) seeks to improve the health, wellness, and development of children through practice and system-based interventions to increase rates of • early childhood developmental screening, counseling, referral, and follow-up • perinatal depression, and • social determinants of health.	**American Academy of Pediatrics / STAR** https://www.aap.org/en-us/advocacy-and-policy/aap-health- initiatives/Screening/Pages/default.aspx **American Academy of Pediatrics/Bright Futures** http://brightfutures.aap.org/clinical_practice.html

Conditions	Clinical Practice Guideline	Source
	Clinical Practice - Preventive Pediatric Health Care Bright Futures/American Academy of Pediatrics	
Adult and Children	Introducing a One-Page Adult Preventive Health Care Schedule: USPSTF Recommendations at a Glance - Editorials - American Family Physician (aafp.org) U.S. Preventive Services Task Force (USPSTF) Search: Clinical Preventive Services	**American Family Physician Journal** https://www.aafp.org/afp/2016/0501/p738.html **U.S. Preventive Task Force** Search Results | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Child and Adolescent	Focus on Children and Adolescents. U.S. Preventive Services Task Force 2019	**U.S. Preventive Task Force** https://scholar.google.com/scholar?q=Focus+on+Children+ and+Adolescents.+U.S.+Preventive+Services+Task+Force +2019&hl=en&as_sdt=0&as_vis=1&oi=scholar
Immunization Schedule	Birth -18 Years & "Catch-up Immunization Schedules"	**Centers For Disease Control and Prevention** http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
Lead Screening	Prevention of Childhood Lead Toxicity policy statement Information for Health Care Providers on Lead Poisoning Prevention and Management (ny.gov)	**AAP** https://www.aap.org/en/patient-care/lead-exposure/lead-exposure-policy/
EPSDT/CTHP	EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid) New York State Department of Health Office of Medicaid Management 2019	New York State Department of Health Information for Health Care Providers on Lead Poisoning Prevention and Management http://www.emedny.org/ProviderManuals/EPSDTCTHP/PDFS/EPSDT-CTHP.pdf
Injury Prevention Program	Healthy Children Safety and Prevention © Copyright 2022 American Academy of Pediatrics	**American Academy of Pediatrics** http://www.healthychildren.org/english/safety-prevention/Pages/default.aspx
Eye Examination	American Optometric Association Comprehensive Eye and Vision Examination © Copyright 2019 American Optometric Association Clinical Guidelines – Recommended Eye Examination Frequency for Pediatric Patients and Adults	**American Optometric Association** https://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines http://www.aoa.org/patients-and-public/caring-for-your-vision/comprehensive-eye-and-vision-examination/recommended-examination-frequency-for- pediatric-patients-and-adults?sso=y
Well Woman Care including Prenatal, Postpartum and Interpartum Care	ACOG Women's Preventive Services Initiative New York State Department of Health Medicaid Prenatal Care Standard, Revised: July 2022 Guidelines for Perinatal Care, 8th Edition By AAP Committee on Fetus	**American College of Obstetricians and Gynecologists** https://www.womenspreventivehealth.org/wellwomanchart/#interactive **New York State Department of Health** https://www.health.ny.gov/health_care/medicaid/standards/perinatal_care

Conditions	Clinical Practice Guideline	Source
	and Newborn and ACOG Committee on Obstetric Practice, Published in 2017 Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e140–50 Racial and ethnic disparities in obstetrics and gynecology. Committee Opinion No. 649. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;126:e130–4 Interpregnancy care. Obstetric Care Consensus No. 8. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e51–72.	American Academy of Pediatrics https://ebooks.aappublications.org/content/guidelines-for-perinatal-care-8th-edition. Accessed June 5, 2020. **ACOG** https://www.acog.org/search#q=Racial%20and%20ethnic%20disparities%20in%20obstetrics%20and%20gynecology.%20Committee%20Opinion%20No.%20649&sort=relevancy https://www.acog.org/search#q=Interpregnancy%20care.%20Obstetric%20Care%20Consensus%20No.%208.%20&sort=relevancy https://www.acog.org/search#q=Interpregnancy%20care.%20Obstetric%20Care%20Consensus%20No.%208.%20&sort=relevancy
Antibiotic Use		
	CDC. Antibiotic Use in the United States, 2020 Update: Progress and Opportunities. Atlanta, GA:	**Centers for Disease Control** https://www.cdc.gov/antibiotic-use/pdfs/stewardship-report-2020-H.pdf
Sexually Transmitted Diseases		
STD	Sexually Transmitted Infections Treatment Guidelines, 2021	
HIV	Primary Care Approach To The HIV-Infected Patient; Accessed March 4, 2021. Clinical Guidelines The federally approved medical practice guidelines for HIV/AIDS are developed by panels of experts in HIV care. Pre-Exposure Prophylaxis (PrEP) and Post- Exposure Prophylaxis (PEP)	**New York State Department of Health AIDS Institute** http://www.hivguidelines.org/?s=Primary+Care+http://www.hivguidelines.org/?s=Primary%2BCare%2BApproach%2BTo%2BThe%2B%2BHIV-Infected%2BPatient **HIV/AIDS Treatment Guidelines | NIH** https://clinicalinfo.hiv.gov/en/guidelines **Centers For Disease Control and Prevention** https://www.cdc.gov/hiv/clinicians/prevention/prep-and-pep.html
Obesity		
Children	AAP Obesity Guidelines Algorithm for the Assessment and Management for Childhood Obesity 2016 NICHQ Childhood Obesity Implementation Guide: Best Practices and Tools	**American Academy of Pediatrics** https://ihcw.aap.org/Pages/policy.aspx https://ihcw.aap.org/Documents/Assessment%20%20and%20Management%20of%20Childhood%20Obesity%20Algorit hm_FINAL.pdf **Institute for Healthcare Improvement** http://www.ihi.org/resources/Pages/Tools/NICHQChildhood ObesityImplementationGuide.aspx
Adult	Clinical Guidelines On The Identification, Evaluation, And Treatment Of Overweight And Obesity In Adults Management of Adult Overweight and Obesity (OBE) (2020)	**National Institutes Of Health National Heart, Lung, And Blood Institute** https://www.nhlbi.nih.gov/files/docs/guidelines/ob_gdlns.pdf **Department of Veterans Affairs Department of Defense**

Conditions	Clinical Practice Guideline	Source
	The guideline describes the critical decision points in the Management of Adult Overweight and Obesity and provides clear and comprehensive evidence-based recommendations incorporating current information and practices for practitioners throughout the DoD and VA Health Care systems. Comprehensive Clinical Practice Guidelines for Medical Care of Patients with Obesity © 2016 Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians | Annals of Internal Medicine (acpjournals.org)	https://www.healthquality.va.gov/guidelines/CD/obesity/VADoDObesityCPGFinal5087242020.pdf **AACE** https://pro.aace.com/disease-state-resources/nutrition-and-obesity/guidelines **American College of Physicians** https://www.acpjournals.org/doi/10.7326/M16-2367
Rheumatology		
Rheumatology	ACR Clinical Practice Guidelines	**American College of Rheumatology** https://www.rheumatology.org/Practice-Quality/Clinical-Support/Clinical-Practice-Guidelines
Long Term Care		
Transitions of Care	ACR Clinical Practice Guidelines	**American Medical Directors Association** https://paltc.org/product-store/transitions-care-cpg
Oral Health		
Children	Maintaining and Improving the Oral Health of Young Children. American Academy of Pediatrics Policy Statement, December 2014. Accessed March 4, 2022 Reference Manual for Pediatric Dentistry – 2021-2022	**American Academy of Pediatrics** http://pediatrics.aappublications.org/content/134/6/1224 AAPD Reference Manual 2021-2022 (walsworth.com)
Advanced Care Planning		
Advanced Care Planning	Advanced Care Planning	**American College of Physicians** https://search.acponline.org/s/search.html?collection=acp-meta&profile=_default&query=Advanced+Care+Planning+
Behavioral Health		
Serving Justice-Involved Individuals	Principles of Community -based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide, 2019	**SAMHSA** https://store.samhsa.gov/sites/default/files/d7/priv/sma19- 5097.pdf

Appendix XI – Notice of Medicare Noncoverage

XI.A Notice of Medicare Noncoverage

The Effective Date Coverage of Your Current Services Will End:

- Your Medicare health plan and/or provider have determined that Medicare probably will not pay foryour current services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above; Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). AQIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: Livanta, 1 (866) 815-5440, TTD/TTY: 1 (866) 868-2289 to appeal, or if you have questions.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below
  Telephone: 1-877-779-2959
  TDD/TTY: 1-888-542-3821
- Plan contact information:
  Healthfirst Medicare Plan Appeals & Grievances Unit
  P.O. Box 5166
  New York, NY 10274-5166T
- Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Name of Patient: _____ Signature:_____ **Date:** _____

XI.B Important Information for Healthfirst Medicare Plan Members' Appeal Rights

Healthfirst Medicare Plan
100 Church Street
New York, NY 10007

If a member disagrees with a decision made by Healthfirst Medicare Plan, the member or the member's representative has the right to request a reconsideration. Generally, service-related appeals are processed under the standard 30-day appeal timeframe. If the member believes that his/her health or ability to function could be seriously harmed or jeopardized by waiting 30 days for a service-related standard appeal, he/she may request an expedited 72-hour appeal. Healthfirst will decide if your request for an expedited appeal meets the requirements under Medicare guidelines. If not, the appeal will be processed under the standard 30-day appeal process.

To request an expedited 72-hour appeal (does not apply to denials of payment):

Telephone	**1-877-779-2959**	**Fax**	**1-646-313-4618**
Mail	**Healthfirst** **Appeals Unit** **P.O. Box 5166** **New York, NY 10274**	**Visit**	**Healthfirst** **100 Church Street** **New York, NY 10007**

To request a 30-day service-related appeal or a 60-day payment-related appeal:

A member can file a service-related appeal, which will be processed within 30 days, or a payment-related appeal, which will be processed within 60 days. The appeal can be submitted verbally or in writing.

In addition, the member may also file such appeal with the Department of Health and Human Services or the Railroad Retirement Board if the member is a railroad annuitant. Your request will be transferred to Healthfirst for processing.

14-Day Extension

An extension up to 14 calendar days is permissible for both 30-day and 72-hour appeals if the extension of time benefits the member; for example, if the member needs time to provide Healthfirst with additional information or if Healthfirst needs to have additional diagnostic tests completed.

Healthfirst will make a decision and notify the member within the timeframes specified by the Centers for Medicare & Medicaid Services (CMS), and the New York State Department of Health (DOH), if applicable.

XI.C Standard Description and Instructions for Healthcare Consumers to Request an External Appeal

New York State law ensures you the right to an external appeal when healthcare services are denied by your HMO or insurer (health plan) on the basis that the services are not medically necessary or that the services are experimental or still under investigation by the AMA.

To request an external appeal you must complete the application form and send it to the Department of Financial Services within four (4) months of receipt of said notice of final adverse determination from your health plan in the first level of the plan's internal appeal process or within four (4) months of receiving written confirmation from your health plan that the internal appeal process has been waived. If all applicable items have not been completed, your request will not be accepted.

Understanding External Appeals

- An external appeal is a request that you make to the state for an independent review of a denial of services by your health plan

- Reviews are conducted by external appeal agents who are certified by the state and have a network of medical experts to review your health plan's denial of services.
- You must complete this application and submit it to the Department of Financial Services to request an external appeal. The application is also available at the end of this appendix.

Eligibility for an External Appeal

To be eligible for an external appeal, you must have received a final adverse determination as a result of your health plan's internal utilization review appeal process, or you and your health plan must have agreed to waive that appeal process. A final adverse determination is written notification from your health plan that your healthcare service has been denied through the plan's appeal process.

- If you and your health plan agree to waive the internal appeal process, the health plan must confirm the agreement in writing. You must submit a request for an external appeal to the state within four (4) months from receipt of a notice of final adverse determination from your health plan or within four (4) months of receiving written confirmation from your health plan that the internal appeal process has been waived. If your plan had two (2) levels of internal appeals, you must file a request for an external appeal within four (4) months of your receipt of the notice of final determination from the plan's first- level appeal process to be eligible for an external appeal.
- If services are denied as experimental or investigational, you must have a life-threatening or disabling condition or disease to be eligible for an external appeal, and your attending physician must complete the attached Attending Physician Attestation form and send the form to the Department of Financial Services
- You may only appeal a service or procedure that is a covered benefit under your contract. The external appeal process may not be used to expand the coverage of your contract.
- Your health plan cannot be a self-insured plan. The state does not have jurisdiction over self-insured plans. Your employer can tell you if your plan is self-insured. The appeal cannot be for workers' compensation claims or for claims under no-fault auto coverage.

Am I Eligible for an External Appeal if I am Covered by Medicare or Medicaid?

- You are not eligible for this external appeal process when Medicare is your only source of health services. If you have coverage under Medicare, you must file a complaint with the federal government for denials of services. Questions concerning Medicare coverage should be directed to the Centers for Medicare & Medicaid Services at 1-800-MEDICARE (1-800-633-4227).
- If you have coverage under Medicare and Medicaid, this external appeal process may be used solely to appeal denials of services or treatments covered by Medicaid.
- If you have Medicaid coverage you may also request a fair hearing. If you have requested an external appeal and a fair hearing, the determination in the fair hearing process will be the one that applies. If you have questions about the fair hearing process, you should contact the New York State Department of Health at 1 (800) 774-4241.

Eligibility for an Expedited (fast-tracked) External Appeal

If your attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to your health, you may request an expedited appeal. When requesting an expedited appeal, make sure you give the attending physician an attestation from your primary care doctor to complete. Your appeal will not be forwarded to the external appeal agent until your physician sends this attestation to the Department of Financial Services.

External Appeal Timeline

- **Expedited appeals:** The external appeal agent must make a determination within three (3) days of receiving your request for an external review from the state
- **Standard appeals:** When your appeal is not expedited, the external appeals agent must make a determination within 30 (thirty) days of receiving your request for an external review from the state. If

additional information is requested, the external appeal agent has five (5) additional business days to make a determination

The Cost of an External Appeal

Your health plan may charge you a fee of up to $50 for an external appeal.

If you have coverage under Medicaid or Child Health Plus, or your health plan determines that the fee will pose a hardship, you will not be required to pay a fee.

If your health plan does require a fee, you must submit the fee with your application for an external appeal. If you fax your application to the Department of Financial Services, you must send the fee within three (3) business days to the Department of Financial Services. If the fee is not sent to the Department of Financial Services within this time frame, the external appeals agent will suspend review of your appeal until payment is received.

Only checks or money orders, made payable to your health plan, will be accepted.

If the external appeal agent overturns your health plan's determination, the fee will be refunded to you.

When to Submit Information to the External Appeals Agent

If your case is determined to be eligible for external review, you and your health plan will be notified of the certified external appeals agent assigned to review your case.

Your health plan must send your medical and treatment records to the external appeals agent.

When the external appeals agent reviews your case, the agent may request additional information from you or your doctor. This information should be sent to the external appeals agent immediately.

You and your doctor can submit information even when the external appeals agent has not requested specific information. You must submit this information within 45 days from when your health plan made a final adverse determination or from when you and your health plan agreed to waive the internal appeal process.

It is important to send this information immediately. Once the external appeals agent makes a determination or once your 45-day time period ends, you will be unable to submit additional information.

When an External Appeals Agent Makes a Decision

- **Expedited appeals:** If your appeal was expedited, you and your health plan will be notified immediately by telephone or fax of the external appeals agent's decision. Written notification will follow.
- **Standard appeals:** If your appeal was not expedited, you and your health plan will be notified in writing within two business days of the external appeals agent's decision.

The decision of the external appeals agent is binding on you and your health plan.

If you have any questions, please contact the Department of Financial Services at 1-800-400-8882 or the New York State Department of Health at 1-800-774-4241, or visit http://www.dfs.ny.gov/insurance or www.health.state.ny.us.

NEW YORK STATE EXTERNAL APPEAL

You have the right to appeal to the Department of Financial Services (DFS) when your insurer or HMO denies health care services as not medically necessary, experimental/investigational or out-of-network. This appeal is known as an external appeal. Health care providers also have the right to an external appeal when health care services are denied (concurrently or retrospectively).

Deadlines

Consumers must send an external appeal application to DFS within 4 months from the date of the final adverse determination from the first level of appeal with the health plan or the waiver of the internal appeal process. If your health plan offers a second-level internal appeal, you do not have to file one, but if you do, you must still submit an external appeal to DFS within 4 months of the first appeal decision. If DFS does not receive your application within 4 months, you will not be eligible for an external appeal. Providers appealing on their own behalf must submit an external appeal within 60 days of the final adverse determination.

Fees

Health plans may charge a $25.00 fee to patients or their designees, not to exceed $75.00 in a single plan year. The fee is waived for patients who are covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee will pose a hardship. Health plans may charge providers a $50.00 fee per appeal. This fee will be returned if the external appeal agent overturns the denial.

Expedited (Fast-Tracked) External Appeals

For an external appeal to be expedited, the denial must concern an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized; or the patient's physician must attest that the patient has not received the treatment and a 30-day timeframe would seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health. A patient may request an expedited internal and external appeal at the same time. A decision on an expedited external appeal will be made within 72 hours, even if all of the patient's medical information has not yet been submitted.

Submit an External Appeal

Complete the **New York State External Appeal Application** and send it by fax to (800) 332-2729 or by certified or registered mail to the Department of Financial Services, PO Box 7209, Albany NY, 12224. If eligible, DFS will have the appeal reviewed by an independent external appeal agent that will either overturn (in whole or part) or uphold the denial.

Experimental/Investigational Denial (including Clinical Trial and Rare Disease)

The patient's physician (for rare diseases this cannot be the treating physician) must complete pages 4-7 of the application and send to DFS.

Out-of-Network Denials

There are two types of out-of-network denials that are eligible for external appeal. The first is an out-of-network service denial. For these, the patient must have a pre-authorization request denied because the service is not available in-network and the health plan recommends an alternate in-network service that it believes is not materially different from the out-of-network service. The second is an out-of-network referral denial. For these, the patient's out-of-network referral request must be denied because the health plan has an in-network provider with appropriate training and experience to meet the particular health care needs of the patient. For an out-of-network service denial or referral denial, the patient's physician must complete pages 4 – 7 of the application and send to DFS.

The External Appeal Agent

You will be notified when your appeal is assigned to an external appeal agent, who will request supporting documents. You should respond immediately to that request. Once the agent makes a decision, additional information will not be considered. The agent will make a decision within 72 hours for expedited appeals or 30 days for standard appeals. The external appeal agent's decision is binding on the patient and the patient's health plan.

Patients covered under Medicare are not eligible for an external appeal and should call (800) MEDICARE or visit www.medicare.gov. Patients covered under regular Medicaid are not eligible for an external appeal; however, patients covered under a Medicaid Managed Care Plan are eligible. All Medicaid patients may also request a fair hearing, and the fair hearing decision will be the one that applies. Call (800) 342-3334 or visit www.otda.state.ny.us/oah for fair hearing information.

For questions or help with an application visit www.dfs.ny.gov/ExternalAppeal, call (800) 400-8882 or email externalappealquestions@dfs.ny.gov. If you are faxing an expedited appeal call (888) 990-3991.

HELPFUL HINTS FOR COMPLETING THE EXTERNAL APPEAL APPLICATION

Some sections of the application can be confusing. This will help explain what is expected for those sections.

Application

- The Type of Review must be completed if an expedited appeal is being requested. External Appeals can only be expedited if the denial falls into one of these categories. If you already received the services your appeal cannot be expedited.
- Number 11 indicates the reason the health plan denied the service. This information is found on the Final Adverse Determination (denial letter) from the health plan.
- Number 12 is to be used to describe the services requested. You can attach a separate document with this information.
- Number 14 relates to the fee that a health plan may charge for the external appeal. The final adverse determination will indicate if the health plan charges a fee.
- Number 15 is required if the provider is submitting the application on their own behalf or behalf of the patient.
- Number 16 is only required if the patient has designated someone other than the provider to act on their behalf.
- Patient Consent to the Release of Records for NYS External Appeal – this document must be signed by the patient or their authorized representative. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Physician's Attestation

- The first section is required if the attending physician is requesting an expedited appeal because the standard 30-day timeframe would jeopardize the patient's life, health or ability to regain maximum function, or the delay would pose an imminent or serious threat to the patient's health. The attending physician must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination within 72 hours of receipt. The decision must be issued even in the event of incomplete medical information or unanswered questions due to the inability to reach the attending physician.
- Number 10 is required for Experimental/Investigational and Out-of-Network Service denials (where the health plan offers an alternate in-network service that is not materially different from the out-of-network service). Subsections a, c and d are required when appealing an experimental/investigational denial.

  Subsections b, c and d are required for Out-of-Network Service denials.

  Subsection c. must include information on the medical and scientific evidence (clinical peer reviewed literature) that supports the service requested for the patient's condition. Two articles are required. This section MUST be completed in full, "See attached" will not suffice. The documents that are acceptable for submission are described in subsection d. There is no requirement that the two documents be from different categories.
- Number 11 is required for coverage in a clinical trial. Please note, the Affordable Care Act requires coverage of routine patient costs associated with approved clinical trials. This requirement does NOT apply to grandfathered health plans.
- Number 12 is required for the Experimental/Investigational denials for treatment of a rare disease. The physician signing the attestation for treatment of a rare disease cannot be the patient's attending physician. They must disclose any relationship with the patient's attending physician and indicate which definition of "rare disease" applies to the patient's condition.
- Number 13 must be completed for out-of-network referral denials (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient). The name and address of the out-of-network provider must be included as well as their training and experience. The information provided will be used by the clinical peer reviewer when comparing the qualifications of the in-network provider(s) to the out-of-network provider. Information such as the out-of-network provider's curriculum vitae, Board certification, number of years of experience treating the condition, the number of times the out-of-network provider has performed the requested procedure and the outcomes of those procedures, and any other relevant information should be provided. This information may be provided in an attachment to the application.
- Number 14 must be signed by a Physician. Physician is defined in NYS Education law as an MD or DO. Attestations signed by any other provider will not be accepted.

NEW YORK STATE EXTERNAL APPEAL APPLICATION

Complete and send this application within 4 months of the plan's final adverse determination if you are the patient or the patient's designee, or within 60 days if you are a provider appealing on your own behalf to DFS.

Mail to: New York State Department of Financial Services, PO Box 7209, Albany NY, 12224-0209
or Fax to: (800) 332-2729. If an appeal is expedited, you must call (888) 990-3991 to tell us.

If the patient has not received the service, this appeal may be expedited. Expedited decisions are made within 72 hours, even if the patient or physician does not provide needed medical information to the external appeal agent.

Type of Review Requested:	☐ Standard Appeal (30 days)	☐ Expedited Appeal (72 hours)
If Expedited (check one):	☐ Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.	
	☐ 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health, and patient's physician will complete the Physician Attestation and send it to the Department of Financial Services.	

TO BE COMPLETED BY ALL APPLICANTS: (Print legibly)				
1. Applicant Name:				
2. Patient Name:				
3. Patient Address:				
4. Patient Phone Number:	Primary: ( )	Secondary: ( )		
5. Patient Email Address:				
6. Patient Health Plan:				
7. Patient's Physician:				
8. Physician Address:				
9. Physician Phone Number:	( )	Fax:	( )	
10. If the patient has a Medicaid Managed Care Plan, has patient requested a fair hearing through Medicaid or received a fair hearing determination?	☐ Yes	☐ No	☐ Don't know	

11. Reason for Health Plan Denial (check only one and **attach** a completed physician's attestation for all denial reasons except for Not Medically Necessary):		
	☐ Not medically necessary	☐ Experimental/investigational for a clinical trial
	☐ Experimental/ investigational	☐ Experimental/investigational for a rare disease
	☐ Out-of-network and the health plan proposed an alternate in-network service	☐ Out-of-network referral

12. Description and date(s) of Service: (Attach any additional information you want considered):

13. External Appeal Eligibility (Check one):	
	☐ Attached is final adverse determination from first level appeal with health plan.
	☐ Attached is the health plan's letter waiving an internal appeal.
	☐ Patient requests expedited internal appeal at same time as the external appeal.
	☐ Health plan did not comply with internal appeal requirements for patient appeal.

For help call (800) 400-8882 or email externalappealquestions@dfs.ny.gov

14. EXTERNAL APPEAL FEE	
You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you.	
Please check one:	☐ Enclosed is a check or money order made out to the health plan.
	☐ Application was faxed and fee will be mailed to the Department within 3 days.
	☐ Patient is covered under Medicaid, Child Health Plus or Family Health Plus.
	☐ Patient requests fee waiver for hardship and will provide documentation to the health plan.
	☐ Health plan does not charge a fee for an external appeal or fee is not required.

15. TO BE COMPLETED IF APPLICANT IS PATIENT'S PROVIDER			
Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. This section should be completed by providers appealing on their own behalf or appealing as a patient's designee. The initial denial and final adverse determination from the first level of appeal must be attached.			
☐ Provider filing own behalf	☐ Provider filing as designee on behalf of patient		
Provider Name:			
Person or Firm Representing Provider (if applicable):			
Contact Person for Correspondence:			
Address for Correspondence:			
Phone Number:	( )	Fax Number:	( )
Email Address:			
I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.			
Provider Signature:			

16. TO BE COMPLETED IF APPLICANT IS PATIENT'S DESIGNEE			
Complete this section only if a designee is submitting this appeal on a patient's behalf.			
Name of Designee:			
Relationship to Patient:			
Address:			
Phone Number:	( )	Fax Number:	( )
Designee Email Address:			

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental/investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately.

Mail to: New York State Department of Financial Services, PO Box 7209, Albany NY, 12224-0209
or Fax to: (800) 332-2729.

If the patient has **not yet received the treatment,** and **the 30-day timeframe will seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health,** the patient's physician may request the appeal be expedited.

The external appeal agent must make an expedited decision within 72 hours, instead of 30 days, whether you provide all necessary medical information or records to the agent or not. **You must send information to the agent immediately in order for it to be considered.**

- For an **expedited appeal**, the patient's physician must complete the box below and item **14**.

Type of Review Requested:	☐ Standard Appeal (30 days)	☐ Expedited Appeal (72 hours)
If Expedited:	☐ I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.	
	During non-business days, I can be reached at: ( )	

- For an **experimental/investigational** denial (other than a clinical trial or rare disease treatment) the patient's physician must complete items **1-10 and 14**.
- For a **clinical trial** denial, the patient's physician must complete items **1-9, 11 and 14**.
- For an **out-of-network service** denial (the health plan offers an alternate in-network service that is not materially different from the out-of-network service), the patient's physician must complete items **1-10 and 14**.
- For an **out-of-network referral denial** (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient), the patient's physician must complete items **1 - 9, 13 and 14**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 12 and 14**.

1. Name of Physician completing this form:	
To appeal an experimental/investigational, clinical trial, out-of-network service or out-of-network referral denial, the physician must be licensed and board-certified or board-eligible and qualified to practice in the area of practice appropriate to treat the patient. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.	
2. Physician Address:	
3. Contact Person:	

For help call (800) 400-8882 or email externalappealquestions@dfs.ny.gov

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PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans.

When an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Signature:			
Print Name:			
Date: (required)			
On behalf of (if applicable):		Age:	
Patient's Health Plan ID#:			

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental/investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately.

Mail to: New York State Department of Financial Services, PO Box 7209, Albany NY, 12224-0209
or Fax to: (800) 332-2729.

If the patient has **not yet received the treatment,** and **the 30-day timeframe will seriously jeopardize the patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to the patient's health,** the patient's physician may request the appeal be expedited.

The external appeal agent must make an expedited decision within 72 hours, instead of 30 days, whether you provide all necessary medical information or records to the agent or not. **You must send information to the agent immediately in order for it to be considered.**

- For an **expedited appeal**, the patient's physician must complete the box below and item **14**.

Type of Review Requested:	☐ Standard Appeal (30 days)	☐ Expedited Appeal (72 hours)
If Expedited:	☐ I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.	
	During non-business days, I can be reached at: ( )	

- For an **experimental/investigational** denial (other than a clinical trial or rare disease treatment) the patient's physician must complete items **1-10 and 14**.
- For a **clinical trial** denial, the patient's physician must complete items **1-9, 11 and 14**.
- For an **out-of-network service** denial (the health plan offers an alternate in-network service that is not materially different from the out-of-network service), the patient's physician must complete items **1-10 and 14**.
- For an **out-of-network referral denial** (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient), the patient's physician must complete items **1 - 9, 13 and 14**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 12 and 14**.

1. Name of Physician completing this form:	
To appeal an experimental/investigational, clinical trial, out-of-network service or out-of-network referral denial, the physician must be licensed and board-certified or board-eligible and qualified to practice in the area of practice appropriate to treat the patient. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.	
2. Physician Address:	
3. Contact Person:	

For help call (800) 400-8882 or email externalappealquestions@dfs.ny.gov

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4. Phone Number:	( )	Fax Number:	( )
5. Physician Email (if you want contact by e-mail):			
6. Name of Patient:			
7. Patient Address:			
8. Patient Phone Number:			
9. Patient Health Plan Name and ID Number:			

10. Experimental/Investigational Denial or Out-of-Network Service Denial
(Complete this section for experimental/investigational denial or an out-of-network service denial only. DO NOT complete this item for appeal of clinical trial participation, rare disease, or an out-of-network referral denial.)

a. For an Experimental/Investigational Denial:

As the patient's physician I attest that (select one without altering):

	☐ Standard health services or procedures have been ineffective or would be medically inappropriate.
OR	☐ There does not exist a more beneficial standard health service or procedure covered by the health plan.
AND	☐ I recommended a health service or pharmaceutical product that, based on the documents of medical and scientific evidence **outlined in c and d below**, is likely to be more beneficial to the patient than any covered standard health service.

b. For an Out-of-Network Service Denial

☐ As the patient's physician I attest that the following out-of-network health service (identify service):

is materially different from the alternate in-network health service recommended by the health plan and (based on the following **two** documents of medical and scientific evidence) is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

c. List the documents relied upon and attach a copy of the documents:

Document #1 Title:					
Publication Name:		Issue Number:		Date:	
Document #2 Title:					
Publication Name		Issue Number:		Date:	

d. Supporting Documents

The medical and scientific evidence listed above meets one of the following criteria (Note: peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.)		Check the applicable documents:
☐	Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;	☐ Document #1 ☐ Document #2

☐	Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;	☐ Document #1 ☐ Document #2
☐	Peer-reviewed abstracts accepted for presentation at major medical association meetings;	☐ Document #1 ☐ Document #2
☐	Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;	☐ Document #1 ☐ Document #2
☐	The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the National Comprehensive Cancer Network's Drugs and Biological Compendium; (iii) the American Dental Association Accepted Dental Therapeutics; (iv) Thomson Micromedex DrugDex; or (v) Elsevier Gold Standard's Clinical Pharmacology; or other compendia as identified by the Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal;	☐ Document #1 ☐ Document #2
☐	Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.	☐ Document #1 ☐ Document #2

11. Clinical Trial Denial

☐	There exists a clinical trial which is open and for which the patient is eligible and has been or will likely be accepted.

Although not required, it is recommended you enclose clinical trial protocols and related information. The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified non-governmental research entity as identified in guidelines issued by individual NIH Institutes for Center Support Grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

12. Rare Disease Treatment Denial

If provision of the service requires approval of an Institutional Review Board, include or attach the approval.

☐	As a physician, other than the patient's treating physician, I attest the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service. The requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service.

☐ I do ☐ I do not have a material financial or professional relationship with the provider of the service (check one).

Check one:	☐ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.
	☐ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

13. Out-of-Network Referral Denial	
As the patient's attending physician, I certify that the in-network health care provider(s) recommended by the health plan do not have the appropriate training and experience to meet the particular health care needs of the patient. I recommend the out-of-network provider indicated below, who has the appropriate training and experience to meet the particular health care needs of the patient and is able to provide the requested health service.	
Name of out-of-network provider:	
Address of out-of-network provider:	
Training and experience of out-of-network provider: (e.g.,. board certification, years treating the condition, # of procedures performed and outcome, any other pertinent information).	

14. Physician Signature			
I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.			
Signature of Physician:		Date:	
Physician Name: (Print Clearly):			

XI.D Appointment of Representative Statement and Form

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB no. 0938-0950

APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an_____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE

Form CMS-1696 (07/05) EF (07/05)

CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Form CMS-1696 (07/05) EF (07/05)

Find this form at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.

XI.E Detailed Notice of Discharge

DETAILED NOTICE OF DISCHARGE
OMB Approval No. 0938-1019

Patient Name:
Patient ID Number:
Date Issued:
Physician:

DETAILED NOTICE OF DISCHARGE

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hiredby Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on . This is based on Medicare coverage policies listed below and your medical condition. This is not an official Medicare decision. The decision onyour appeal will come from your QIO.

Medicare Coverage Policies:

Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k).)

Medicare Managed Care policies, if applicable (check below):

- In response to your diagnosis, your physician developed a comprehensive care plan designed to specifically address your medical condition. Based on your progress and recovery thus far, your physician is confident that a sufficient level of inpatient services has been provided and has not requested additional inpatient days be added to your care plan.
- Per Medicare guidelines, any additional inpatient days would need to be outlined under a plan of care and approved by a physician. As there is no current physician order for additional inpatient days, no additional services will be covered.
- Other

Specific information about your current medical condition. Some or all of the following factors no longer exist:

- Severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for inpatient diagnostic studies;
- Diagnostic and therapeutic services for medical diagnosis, treatment, and care are no longer medically necessary.

If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, or if you need help understanding the content of this notice, please call our Medical Management department at 1-888-394-4327 (TTY: 1-800-662-1220), Monday to Friday, 8am–6pm.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CMS 10066 (approved 5/2007) H3359 UMD07_11 12/07

XI.F Important Message from Medicare About Your Rights

Department of Health & Human Services
Centers for Medicare & Medicaid Services OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

As a Hospital Inpatient, you have the right to:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will be responsible for paying for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here {Insert Name and Telephone Number of the QIO}.

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- Talk to the hospital staff, your doctor, and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
    - If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
    - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step-by-step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call_____

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative _____ Date _____

CMS-R-193 (approved 07/10)
1 of 3

Steps to Appeal Your Discharge

- **Step 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

  Here is the contact information for the QIO:
  - QIO Name:
  - Phone Number:

  You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun. Ask the hospital if you need help contacting the QIO. The name of this hospital is:

  Hospital Name:
  Provider ID Number:

- **Step 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **Step 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

- **Step 4:** The QIO will review your medical records and other important information about your case.

- **Step 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon (12pm) of the day after the QIO notifies you of its decision.

If you miss the deadline to appeal, you have other appeal rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
- If you have Original Medicare: Call the QIO listed above.
- If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048.

Additional Information:

Notice Instructions: The Important Message From Medicare
Completing the Notice
Page 1 of the Important Message from Medicare

Header:

Hospitals must display “Department of Health & Human Services, Centers for Medicare & Medicaid Services “and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:Patient Name: Fill in the patient’s full name.

Patient ID Number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the patient’s social security number.

Physician: Fill in the name of the patient’s physician.

Body of the Notice

Bullet # 3. Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here .

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet – Insert name and telephone number of QIO in bold: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date and time to document delivery of the follow-up copy of the IM, or documentation of refusals.

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Appendix XII – Codes, Claims and Reimbursable Services

XII.A Appropriate Codes for Claims/Encounter Data

Reminder ICD10 is here and should be used for all dates of service from October 1, 2015 forward. Visit www.healthfirst.org/ICD10 for resources to ensure your practice is using the correct ICD-10 codes.

Providers should follow all guidelines outlined in Provider Manual Section 16 – Provider Compensation and the Billing and Reimbursement Policies. Adhering to these guidelines ensures prompt and accurate claims payments.

Obstetrical Care: Healthfirst reimburses for obstetrical care on a fee-for-service basis or based on specific contractual arrangements. In all cases, the provider must submit claims for each service rendered. Claims should be submitted for payment of prenatal and postpartum visits, as well as for delivery. The following CPT-4 codes should be used:

- 59409 – Vaginal Delivery Only
- 59514 – Cesarean Delivery Only
- 59612 – Vaginal Delivery after Previous Cesarean Delivery
- 59620 – Cesarean Delivery after Previous Cesarean Delivery
- 59430 – Postpartum Care (in conjunction with the appropriate pregnancy diagnosis ICD10 code; e.g.,Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2)

Cases requiring more than seven (7) prenatal visits or more than one (1) postpartum visit may be subject to retrospective medical record review by the Healthfirst Medical Management department

Type of Care	Appropriate CPT-4 Codes	Appropriate ICD-10 Codes
PRENATAL CARE (Initial visit must be made in the 1st trimester or within 42 days of enrollment with Healthfirst)	59425 and 59426 (itemize each date of service), 99201–99205, 99211–99215, 99241–99245 with a pregnancy-related diagnosis code	Series 009-016, Series 020-026, Series 020-030, Series 040-048Z codes-Z33.2-Z34.93
POSTPARTUM VISITS (Visit must be made between 21to 56 days after delivery)	59430	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39

Please verify that the codes you are currently using match those shown above. If you have a billing service, please make them aware that they should use these codes to report prenatal and postpartum services. To report gestational diabetes, use the appropriate ICD10 codes O24.011- O24.919

Family Planning Services: Healthfirst reimburses for family planning services provided to Healthfirst members.

- The following CPT/HCPCS/ICD9CM codes are acceptable for billing family planning services: A4260, 11975, 11976, 11977, 55450, 56301, 56302, 57170, 58300, 58301, 58600, 58605, 58611, 58700, 58770, 81025, 84703, 86406, Z30.02, Z31.61, J1050, J1055, J7300.
- The following codes are likely to be deemed unacceptable according to New York State's definition of family planning services: 84235, 89310, 54900, 54901, 55250, 55400, 57700, 57720, 58760, 58321, 58322, 58345, 58740, 58750, 58752, 59000, 59012, 59015, 59320, 59325, 74740, 74742, 76857, 84165 V26.0–V26.9.

Please note:

- Healthfirst's Medicaid members may obtain family planning and reproductive services without a PCP referral from either in-network or out-of-network Medicaid providers.
- Healthfirst's CHPlus and members may obtain family planning and reproductive health services through any in-network CHPlus provider without approval from or notification to Healthfirst or their PCP.
- Healthfirst will not pay claims for Healthfirst CHPlus members seeking family planning and reproductive health services from out-of-network providers.

Chlamydia Testing: In accordance with the requirements of the NYSDOH, tests for chlamydia must be coded according to the DNA tests specific for chlamydia. Healthfirst will deny all claims coded with -ICD 10 CM diagnostic code 87797 – DETECT AGENT NOS, DNA, DIR when used for chlamydia testing. Use CPT4 code 87491 for chlamydia screening using urine specimen.

Providers must use these codes for chlamydia testing:

- 87110 – Chlamydia culture Chlamydia trachomatis detection by:
- 87270 – immunofluorescence microscopy
- 87320 – enzyme immunoassay technique Chlamydia trachomatis detection by nucleic acid:
- 87490 – direct probe technique
- 87491 – amplified probe technique
- 87492 – quantification
- 87810 – Chlamydia trachomatis detection by immunoassay with direct optical observation

Venipuncture: Venipuncture for the collection of specimens is considered a bundled service and is NOT separately reimbursable. Venipuncture is the insertion of a needle into a vein in order to obtain a blood sample, start an intravenous infusion, or to give medication. A bundled service is any service essential to the primary procedure and is included in the fee for the primary procedure. Bundled services are not reimbursed separately.

Venipuncture for the collection of specimens shall NOT be reimbursed separately if submitted with a charge for an office visit, hospital or emergency room visit, or in addition to a laboratory test. The reimbursement is considered included in the office visit, or the surgical or laboratory procedure. Healthfirst will automatically deny payment for the venipuncture procedure codes listed below. “ZE”-“Procedure Rebundled” will appear on the EOP.

Procdure Code	Desciption
36400	Venipuncture, under age 3 years, necessitating physician’s skill, not to be used for routine venipuncture; femoral or jugular vein
36405	Venipuncture, under age 3 years, necessitating physician’s skill, not to be used for routine venipuncture; scalp vein
36406	Venipuncture, under age 3 years, necessitating physician’s skill, not to be used for routine venipuncture; other vein
36410	Venipuncture, age 3 years or older, necessitating physician’s skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415	Collection of venous blood by venipuncture
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)
36420	Venipuncture, cutdown; under age 1 year
36425	Venipuncture, cutdown; age 1 or over
G0001	Routine venipuncture for collection of specimen(s)

Modifier – 25: Modifier – 25 indicates that on the day a procedure or service was performed, the patient required a significant, separately identifiable evaluation and management (E&M) service. The service must have been above and beyond the initial service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

In these instances, the provider should bill the E&M code with Modifier – 25. E&M codes should not be billed separately in addition to a CPT-4 procedure code that has been assigned a global period. Medical records should support the use of Modifier – 25. Healthfirst will review E&M codes and will deny such codes billed in addition to procedure codes assigned a global period.

ICD-10: The ICD-10-CM code set has expanded the length of characters (formerly referred to as “digits”) to a maximum of seven (7) characters, as opposed to five characters (digits) in ICD-9-CM. The code structure contains categories, subcategories, and codes. All categories are three characters, and the first character of a category is a letter. The second and third characters may be either numbers or alpha categories. A three character category that has no further subdivision is equivalent to a code (I10 – Essential [primary] hypertension). Subcategories are either four (4) or five (5) characters. Subcategory characters may be either letters or numbers. Codes are four, five or six characters and the final character may be either a letter or number. The four (4) character subcategory further defines the site, etiology, and manifestation(s) or state (s)of the disease or condition. The fifth (5th) or sixth (6th) character

sub-classification represents the most precise level of specificity. Certain ICD-10-CM categories have applicable seven (7) characters. The seventh (7th) character must always be the 7th character in the data field.

Example: T50.B96A – Underdosing of other viral vaccines, initial encounter

If a code that requires a 7th character is not 6 characters, a placeholder X (dummy placeholder) must be used to fill in the empty characters. Example: T15.12XS Foreign body in conjunctival sac, left eye, sequela.

As mentioned above, medical records must contain information to substantiate and support the reported codes.

Sexually Transmitted Diseases

STD	Minimum Required Visits	Appropriate CPT-4 Codes	Appropriate ICD-10 Codes
Chlamydia	Once per year	87110, 87270, 87320, 87490–87492, 87810	Z00.00, **Z11.3**, **Z11.8**, Z11.9, Z20.2
Gonorrhea	Once per year	87590–87592, 87850	Z00.00, **Z11.3**, **Z11.8**, Z11.9, Z20.2
Syphilis	Once per year	86592, 86593	Z11.3
Trichomoniasis	Once per year	88141–88158, 87177, 87210, 87211	Z00.00, **Z11.3**, **Z11.8**, Z11.9, Z20.2

Well-Child/Adolescent Care

Member's Age	Minimum Required Visits	Appropriate CPT-4 Codes	Appropriate ICD-10 Codes
0 to 15 months	6 or more	99381, 99382, 99391, 99392, 99432, 99461, and one of the ICD-9codes listed in the next column	Z00.00-Z02.9
3 to 6 years old	Once per year	99382, 99383, 99392, 99393, and one of the ICD-9 codes listed in the next column	Z00.00-Z02.9
12 to 21 years old	Once per year	99383–99385, 99393–99395, and one of the ICD-9 codes listed in the next column	Z00.00-Z02.9

Childhood and Adolescent Immunizations

Required Service	CPT Codes
DTaP (4)	90700
Diphtheria and tetanus	90702
Diphtheria	90719
Tdap	90715
Td	90714, 90718
Tetanus	90703
IPV (3)	90713
DTaP-Hib-IPV	90698
DtaP-HepB-IPV	90723
DtaP-Hib	90721
MMR (1)	90707
Measles	90705
Measles & Rubella	90708
Mumps	90704
Rubella	90706
MMRV (Measles/Mumps/Rubella/Varicella)	90710
HiB (3)	90645, 90646, 90647, 90648

Required Service	CPT Codes
Hepatitis A	90633
Hepatitis B	90740, 90744, 90747
HepB-Hib	90748
VZV (1)	90716
Rotavirus (2 doses)	90681
Rotavirus	90680
Human Papillomavirus Vaccine (HPV)	90650
PCV Pneumococcal (4)	90669
Meningococcal	90733, 90734
Influenza	90655, 90657, 90661, 90662

Please click here for a complete list of HEDIS eligible codes

XII.B Reimbursable Services

In Scope – Effective 05/01/2021.

The following table lists the CPT-4 Codes and service descriptions that are reimbursable to Healthfirst NY PCPs/FPs and clarifies the reimbursement methodology for each code.

This list of service codes may change from time to time

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
10060	S	Y	FFS
10061	S	Y	FFS
10080	S	Y	FFS
10081	S	Y	FFS
10120	S	Y	FFS
10121	S	Y	FFS
11000	S	Y	FFS
11042	S	Y	FFS
11043	S	Y	FFS
11045	M	Y	FFS
11046	M	Y	FFS
11200	S	Y	FFS
11201	M	Y	FFS
11300	S	Y	FFS
11301	S	N	FFS
11305	S	Y	FFS
11400	M	Y	FFS
11401	M	Y	FFS
11976	S	Y	FFS
11981	S	N	FFS
12001	S	Y	FFS
12002	S	Y	FFS
12004	S	Y	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
12011	S	Y	FFS
12020	S	Y	FFS
12021	S	Y	FFS
12031	S	Y	FFS
15730	S	N	FFS
15733	S	N	FFS
16000	S	Y	FFS
16020	S	Y	FFS
16025	S	Y	FFS
16030	M	Y	FFS
17000	S	Y	FFS
17003	M	Y	FFS
17004	S	Y	FFS
17110	S	Y	FFS
17250	S	Y	FFS
19294	S	N	FFS
20550	M	Y	FFS
20551	M	Y	FFS
20552	M	Y	FFS
20553	S	Y	FFS
20600	S	Y	FFS
20605	S	Y	FFS
20610	S	Y	FFS
20939	S	N	FFS
24640	S	Y	FFS
26010	M	Y	FFS
26011	S	Y	FFS
29130	S	Y	FFS
29131	S	Y	FFS
29550	S	Y	FFS
29580	S	Y	FFS
30300	S	Y	CAP
30901	S	Y	FFS
31241	S	N	FFS
31253	S	N	FFS
31257	S	N	FFS
31259	S	N	FFS
31298	S	N	FFS
32994	S	N	FFS
33927	S	N	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
34701	S	N	FFS
34702	S	N	FFS
34703	S	N	FFS
34704	S	N	FFS
34705	S	N	FFS
34706	S	N	FFS
34707	S	N	FFS
34708	S	N	FFS
34709	S	N	FFS
34710	S	N	FFS
34711	S	N	FFS
34712	S	N	FFS
34713	S	N	FFS
34714	S	N	FFS
34715	S	N	FFS
34716	S	N	FFS
36405	S	N	CAP
36406	S	N	CAP
36410	S	N	CAP
36420	S	N	CAP
36425	S	N	CAP
36465	S	N	FFS
36466	S	N	FFS
36482	S	N	FFS
36483	S	N	FFS
37225	S	N	FFS
37226	S	N	FFS
37227	S	N	FFS
37229	S	N	FFS
37230	S	N	FFS
37231	S	N	FFS
38222	S	N	FFS
38573	S	N	FFS
43286	S	N	FFS
43287	S	N	FFS
43288	S	N	FFS
44381	S	N	FFS
44384	S	N	FFS
44401	S	N	FFS
44402	S	N	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
44403	S	N	FFS
44404	S	N	FFS
44405	S	N	FFS
44406	S	N	FFS
44407	S	N	FFS
44408	S	N	FFS
45330	S	Y	FFS
45346	S	N	FFS
45347	S	N	FFS
45349	S	N	FFS
45350	S	N	FFS
45388	S	N	FFS
45389	S	N	FFS
45390	S	N	FFS
45393	S	N	FFS
45398	S	N	FFS
46600	S	Y	FFS
46601	S	N	FFS
46607	S	N	FFS
54150	S	Y	FFS
55874	M	N	FFS
57420	S	N	FFS
57421	S	N	FFS
57452	S	N	FFS
57454	S	N	FFS
57455	S	N	FFS
57456	S	N	FFS
57500	S	N	FFS
57510	S	N	FFS
57511	S	N	FFS
58300	S	Y	FFS
58301	S	Y	FFS
58555	S	N	FFS
58558	S	N	FFS
58575	S	N	FFS
59020	S	N	FFS
59025	M	N	FFS
59160	S	N	FFS
59200	S	N	FFS
59300	S	N	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
59350	S	N	FFS
59400	S	N	FFS
59409	S	N	FFS
59410	S	N	FFS
59412	S	N	FFS
59414	S	N	FFS
59425	S	N	FFS
59426	S	N	FFS
59430	S	N	FFS
59510	S	N	FFS
59514	S	N	FFS
59515	S	N	FFS
59610	S	N	FFS
59612	S	N	FFS
59614	S	N	FFS
59618	S	N	FFS
59620	S	N	FFS
59622	S	N	FFS
59812	S	N	FFS
59820	M	N	FFS
59821	S	N	FFS
59830	S	N	FFS
59840	S	N	FFS
59841	S	N	FFS
59850	S	N	FFS
59851	S	N	FFS
59852	S	N	FFS
59855	S	N	FFS
59856	S	N	FFS
59857	S	N	FFS
62270	S	Y	FFS
64912	S	N	FFS
64913	S	N	FFS
69200	S	Y	FFS
71010	S	Y	CAP
71020	S	Y	CAP
71045	S	N	FFS
71046	S	Y	CAP
71047	S	N	FFS
71048	S	N	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
74018	S	N	FFS
74019	S	N	FFS
74021	S	N	FFS
76801	S	N	FFS
76802	M	N	FFS
76805	S	N	FFS
76810	S	N	FFS
76815	S	N	FFS
76818	M	N	FFS
76819	S	N	FFS
76830	S	N	FFS
76856	S	N	FFS
76857	S	N	FFS
77080	S	Y	FFS
77081	S	Y	FFS
78491	S	N	FFS
78492	S	N	FFS
78608	S	N	FFS
78609	S	N	FFS
80061	S	N	CAP
81000	S	Y	CAP
81001	S	Y	CAP
81002	M	Y	CAP
81003	S	Y	FFS
81005	S	Y	FFS
81007	S	Y	FFS
81025	S	Y	CAP
81099	S	N	FFS
82270	S	Y	CAP
82271	S	Y	CAP
82272	S	Y	CAP
82272	M	Y	CAP
82274	S	Y	FFS
82465	S	Y	CAP
82947	M	Y	FFS
82948	S	Y	CAP
82962	S	Y	CAP
83013	S	Y	FFS
83014	M	Y	FFS
83036	S	Y	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
83655	S	Y	FFS
83876	S	N	FFS
83987	S	N	FFS
84145	S	N	FFS
84431	S	N	FFS
85004	S	N	FFS
85007	S	N	FFS
85009	S	N	FFS
85013	S	Y	FFS
85014	S	Y	FFS
85018	S	Y	FFS
85025	S	Y	FFS
85027	S	N	FFS
85032	S	N	FFS
85041	S	N	FFS
85610	M	Y	FFS
85651	M	N	FFS
85660	S	N	FFS
85999	S	N	FFS
86305	S	N	FFS
86317	S	Y	FFS
86318	S	N	FFS
86352	S	N	FFS
86403	S	Y	FFS
86480	S	N	CAP
86580	S	Y	FFS
86701	S	N	FFS
86780	S	N	FFS
86825	S	N	FFS
86826	S	N	FFS
86850	M	N	FFS
86860	M	N	FFS
86870	M	N	FFS
87070	M	N	FFS
87075	S	N	FFS
87076	S	N	FFS
87077	M	N	FFS
87084	S	N	FFS
87086	M	N	FFS
87088	M	N	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
87110	S	Y	FFS
87150	M	N	FFS
87153	M	N	FFS
87181	S	N	FFS
87210	S	Y	FFS
87220	S	Y	FFS
87426	M	Y	FFS
87428	M	Y	FFS
87493	S	N	FFS
87811	M	Y	FFS
87880	M	Y	FFS
88199	S	N	FFS
88299	M	N	FFS
90460	M	Y	CAP
90461	M	Y	CAP
90471	S	Y	CAP
90472	M	Y	CAP
90473	S	Y	FFS
90474	S	Y	FFS
90785	S	Y	CAP
90791	S	Y	CAP
90792	S	Y	CAP
90832	S	Y	CAP
90833	S	Y	CAP
90834	S	Y	CAP
90836	S	Y	CAP
90837	S	Y	CAP
90838	S	Y	CAP
90839	S	Y	CAP
90840	S	Y	CAP
90845	S	Y	CAP
90846	S	Y	CAP
90847	S	Y	CAP
90951	M	N	CAP
90954	M	N	CAP
90955	M	N	CAP
90957	M	N	CAP
90958	M	N	CAP
90960	M	N	CAP
90961	M	N	CAP

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
90963	M	N	CAP
90964	M	N	CAP
90965	M	N	CAP
90966	M	N	CAP
90967	M	N	CAP
90968	M	N	CAP
90969	M	N	CAP
90970	M	N	CAP
92081	S	N	CAP
92540	S	N	CAP
92550	S	N	CAP
92551	S	Y	CAP
92552	S	Y	CAP
92553	S	Y	CAP
92555	S	N	CAP
92557	S	N	CAP
92567	S	Y	CAP
92568	S	Y	CAP
92570	S	N	CAP
92585	S	N	CAP
92586	S	N	CAP
92587	S	Y	CAP
93000	S	Y	CAP
93005	M	Y	FFS
93010	M	Y	CAP
93040	S	Y	FFS
93224	S	N	FFS
93792	S	N	FFS
93793	S	N	FFS
94010	S	Y	CAP
94011	S	Y	CAP
94012	S	Y	CAP
94013	S	N	CAP
94014	S	N	CAP
94015	S	N	CAP
94016	S	N	CAP
94060	S	Y	CAP
94375	S	Y	FFS
94617	S	N	FFS
94618	S	N	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
94640	M	Y	FFS
94664	S	Y	CAP
94760	S	N	CAP
95115	S	N	CAP
95117	S	N	CAP
95249	S	N	FFS
95905	M	N	CAP
96116	M	N	CAP
96150	M	N	CAP
96151	M	N	CAP
96152	M	N	CAP
96153	M	N	CAP
96154	M	N	CAP
96160	S	N	CAP
96161	S	N	CAP
96372	M	Y	CAP
96377	S	N	FFS
96573	S	N	FFS
96574	S	N	FFS
97607	S	N	FFS
97608	S	N	FFS
97763	S	N	FFS
97802	M	N	CAP
97803	M	N	CAP
97804	M	N	CAP
97810	M	N	FFS
97811	M	N	FFS
97813	M	N	FFS
97814	M	N	FFS
98925	S	Y	FFS
98926	S	Y	FFS
98927	S	Y	FFS
98928	S	Y	FFS
98929	S	Y	FFS
99195	S	N	CAP
99201	S	Y	CAP
99202	S	Y	CAP
99203	S	Y	CAP
99204	S	Y	CAP
99205	S	Y	CAP

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
99211	S	Y	CAP
99212	S	Y	CAP
99213	S	Y	CAP
99214	S	Y	CAP
99215	S	Y	CAP
99217	S	Y	FFS
99218	S	Y	FFS
99219	S	Y	FFS
99220	S	Y	FFS
99221	S	Y	FFS
99222	S	Y	FFS
99223	S	Y	FFS
99224	M	Y	FFS
99225	M	Y	FFS
99226	M	Y	FFS
99231	M	Y	FFS
99232	M	Y	FFS
99233	M	Y	FFS
99234	S	Y	FFS
99235	S	Y	FFS
99236	S	Y	FFS
99238	S	Y	FFS
99239	S	Y	FFS
99241	S	Y	CAP
99242	S	Y	CAP
99243	S	Y	CAP
99251	S	Y	FFS
99252	S	Y	FFS
99253	S	Y	FFS
99254	S	Y	FFS
99255	S	Y	FFS
99281	S	Y	FFS
99282	S	Y	FFS
99283	S	Y	FFS
99284	S	Y	FFS
99285	S	Y	FFS
99291	S	N	FFS
99292	M	N	FFS
99304	S	Y	FFS
99305	S	Y	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
99306	S	Y	FFS
99307	S	Y	FFS
99308	S	Y	FFS
99309	S	Y	FFS
99310	S	Y	FFS
99315	S	Y	FFS
99316	S	Y	FFS
99318	S	Y	FFS
99324	S	Y	FFS
99325	S	Y	FFS
99326	S	Y	FFS
99327	S	Y	FFS
99328	S	Y	FFS
99334	S	Y	FFS
99335	S	Y	FFS
99336	S	Y	FFS
99337	S	Y	FFS
99341	S	Y	CAP
99342	S	Y	CAP
99343	S	Y	CAP
99344	S	Y	CAP
99345	S	Y	CAP
99347	S	Y	CAP
99348	S	Y	CAP
99349	S	Y	CAP
99350	S	Y	CAP
99356	S	N	CAP
99357	M	N	CAP
99375	S	N	FFS
99381	S	Y	CAP
99382	S	Y	CAP
99383	S	Y	CAP
99384	S	Y	CAP
99385	S	Y	CAP
99386	S	Y	CAP
99387	S	Y	CAP
99391	S	Y	CAP
99392	S	Y	CAP
99393	S	Y	CAP
99394	S	Y	CAP

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
99395	S	Y	CAP
99396	S	Y	CAP
99397	S	Y	CAP
99401	S	Y	CAP
99402	S	Y	CAP
99403	S	Y	CAP
99404	S	Y	CAP
99406	S	Y	FFS
99407	S	Y	FFS
99411	S	Y	CAP
99412	S	Y	CAP
99415	S	N	CAP
99416	M	N	CAP
99420	S	Y	CAP
99441	S	Y	CAP
99442	S	Y	CAP
99443	S	Y	CAP
99460	M	Y	FFS
99461	M	Y	FFS
99462	M	Y	FFS
99463	M	Y	FFS
99464	S	Y	FFS
99465	S	Y	FFS
99466	S	N	FFS
99467	M	N	FFS
99468	M	Y	FFS
99469	M	Y	FFS
99471	M	Y	FFS
99472	M	Y	FFS
99475	M	Y	FFS
99476	S	Y	FFS
99477	S	Y	FFS
99478	M	Y	FFS
99479	M	Y	FFS
99480	M	Y	FFS
99483	M	N	FFS
99484	M	N	FFS
99487	M	N	CAP
99488	M	N	CAP
99489	M	N	CAP

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
99492	M	N	FFS
99493	M	N	FFS
99494	M	N	FFS
99497	S	Y	FFS
99498	S	Y	FFS
99605	M	N	FFS
99606	M	N	FFS
99607	M	N	FFS
0001A	S	Y	FFS
0002A	S	Y	FFS
0011A	S	Y	FFS
0012A	S	Y	FFS
0031A	S	Y	FFS
1111F*	S	N	FFS
1125F***	S	N	FFS
1126F***	S	N	FFS
1159F***	S	N	FFS
1160F***	S	N	FFS
1170F***	S	N	FFS
3074F**	S	N	FFS
3075F**	S	N	FFS
3077F**	S	N	FFS
3078F**	S	N	FFS
3079F**	S	N	FFS
3080F**	S	N	FFS
99495*	S	Y	FFS
99496*	S	Y	FFS
D1206	S	Y	FFS
G0008	M	Y	CAP
G0009	M	Y	FFS
G0010	M	Y	CAP
G0071	S	N	FFS
G0101	S	Y	FFS
G0108	M	Y	CAP
G0109	M	Y	CAP
G0179	M	Y	FFS
G0180	M	Y	FFS
G0182	M	Y	FFS
G0250	S	N	FFS
G0270	M	N	FFS

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
G0271	S	N	FFS
G0296	M	Y	FFS
G0297	M	N	FFS
G0396	S	Y	FFS
G0397	S	Y	FFS
G0402	S	N	CAP
G0403	S	N	CAP
G0404	S	N	CAP
G0405	S	N	CAP
G0438	S	Y	CAP
G0439	S	Y	CAP
G0442	S	Y	FFS
G0443	S	Y	FFS
G0444	S	Y	FFS
G0445	M	N	CAP
G0446	M	N	FFS
G0447	S	Y	FFS
G0459	M	Y	CAP
G0506	S	N	CAP
G0508	S	N	CAP
G0509	S	N	CAP
G0511	M	N	FFS
G0512	M	N	FFS
G0513	M	N	FFS
G0514	M	N	FFS
G0515	M	N	FFS
G0516	M	N	FFS
G0517	M	N	FFS
G0518	M	N	FFS
G2012	S	N	CAP
G2061	M	N	CAP
G2062	M	N	CAP
G2063	M	N	CAP
G9141	M	Y	CAP
G9685	S	N	FFS
G9686	S	N	FFS
M0239	S	N	FFS
M0243	S	N	FFS
M0245	S	N	FFS
T1013	M	Y	CAP

Service Code	Units Single (S)/Multiple (M)	In PCP Scope Yes (Y)/No (N)	Capitated Coverage Payable Fee For Service (FFS) or Capitated (CAP)
U0002	S	Y	FFS

***Only reimbursable for ages 18 years old +**

****Only reimbursable for ages 18-85 years old**

*****Only reimbursable for ages 66 years old +**

The following table shows the reimbursement detail for all vaccines that are covered by the VFC program or otherwise included in the Healthfirst Incentive Program.

Vaccine Code	Description	MUE	Children's Vaccine	Capitated Providers	FFS
90281	Immune globulin (ig), human, for intramuscular use	S			X
90283	Immune globulin (igiv), human, for intravenous use	S			X
90284	Immune globulin (scig), human, for use in subcutaneous infusions, 100 mg, each	M			X
90291	Cytomegalovirus immune globulin (cmv-igiv), human,for intravenous u	S			X
90371	Hepatitis b immune globulin (hbig), human, fo r intramuscular use	M			X
90375	Rabies immune globulin (rig), human, for intramuscular and/or subcutaneous use	S			X
90376	Rabies immune globulin, heat-treated (rig-ht), human, for intramuscu and/or subcutaneous use	S			X
90378	Respiratory syncytial virus immune globulin (rsv-igim), for intramuscular use, 50 mg, each	M			X
90384	Rho(d) immune globulin (rhig), human, full-dose, for intramuscular use	S			X
90385	Rho(d) immune globulin (rhig), human, mini-dose, for intramuscular use	S			X
90386	Rho(d) immune globulin (rhigiv), human, for intravenous use	S			X
90389	Tetanus immune globulin (tig), human, for intramuscular use	S			X
90396	Varicella-zoster immune globulin, human, for intramuscular use	S			X
90476	Adenovirus vaccine, type 4, live, for oral use	S		Included in Capitation	X
90477	Adenovirus vaccine, type 7, live, for oral use	S		Included in Capitation	X
90581	Anthrax vaccine, for subcutaneous use	S		Included in Capitation	X

Vaccine Code	Description	MUE	Children's Vaccine	Capitated Providers	FFS
90585	Bacillus calmette-guerin vaccine (bcg) for tuberculosis, live, for percutaneous use	S		Included in Capitation	X
90586	Bacillus calmette-guerin vaccine (bcg) for bladdercancer, live, for intravesical use	S		Included in Capitation	X
90620	Meningococcal recombinant protein and outer m embrane vesicle vaccine, serogroup b (menb-4c), 2 dose schedule, for intramuscular use	M	X	Included in Capitation	X
90621	Meningococcal recombinant lipoprotein vaccine , serogroup b (menb-fhbp), 2 or 3 dose schedu le, for intramuscular use	M	X	Included in Capitation	X
90625	Cholera vaccine, live, adult dosage, 1 dose s chedule, for oral use	S			X
90630	Influenza virus vaccine, quadrivalent (iiv4), split virus, preservative free, for intrader mal use	S		Included in Capitation	X
90632	Hepatitis a vaccine, adult dosage, for intram uscular use	S		Included in Capitation	X
90633	Hepatitis a vaccine, pediatric/adolescent dos age-2dose schedule, fo intramuscular use	S	X	Included in Capitation	X
90634	Hepatitis a vaccine, pediatric/adolescent dos age-3dose schedule, fo intramuscular use	S		Included in Capitation	X
90636	Hepatitis a and hepatitis b vaccine (hepa-hep b), adult dosage, for intramuscular use	S	X	Included in Capitation	X
90644	Meningococcal conjugate vaccine, serogroups c & y and hemophilus influenza b vaccine, teta nus toxoidconjugate (hib-mency-tt), 4-dose sc hedul e, when a dministered to children 2-15 months of a	S		Included in Capitation	X
90645	Hemophilus influenza b vaccine (hib), hboc co njugate (4 dose schedul for intramuscular use	S		Included in Capitation	X
90646	Hemophilus influenza b vaccine (hib), prp-d c onjugate, for booster u only, intramuscular u se	S		Included in Capitation	X
90647	Hemophilus influenza b vaccine (hib), prp-omp conjugate (3 dose schedule), for intramuscul ar use	S	X	Included in Capitation	X
90648	Hemophilus influenza b vaccine (hib), prp-t conjugate (4 dose schedule for intramuscular use	S	X	Included in Capitation	X
90649	Human papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivale 3 dose schedule, for	S		Included in Capitation	X

Vaccine Code	Description	MUE	Children's Vaccine	Capitated Providers	FFS
	intramuscular use				
90650	Human papillomavirus (HPV) vaccine, types 16 and 18, bivalent, 3 dose schedule, for intramuscular usse (vaccine is pending FDA approval)	S		Included in Capitation	X
90651	Human papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, Nonavalent (9vhpv), 2 or 3 dose schedule, for intramuscular use	S	X	Included in Capitation	X
90653	Influenza vaccine, inactivated(iiv), subunit , adjuvanted, for intramuscular use	S		Included in Capitation	X
90654	Influenza virus vaccine, trivalent (iiv3), split virus, preservative-free, for Intradermal use	S		Included in Capitation	X
90655	Influenza virus vaccine, trivalent (iiv3), split virus, preservative free, 0.25 ml dosage , for intramuscular use	S		Included in Capitation	X
90656	Influenza virus vaccine, trivalent (iiv3), split virus, preservative free, 0.5 ml dosage, for intramuscular use	S		Included in Capitation	X
90657	Influenza virus vaccine, trivalent (iiv3), split virus, 0.25 ml dosage, for intramuscular use	S		Included in Capitation	X
90658	Influenza virus vaccine, trivalent (iiv3), split virus, 0.5 ml dosage, for intramuscular use	S		Included in Capitation	X
90660	Influenza virus vaccine, trivalent, live, for intranasal use	S		Included in Capitation	X
90661	Influenza virus vaccine, trivalent (cciiv3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 ml dosage, for Intramuscular use	S		Included in Capitation	X
90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	S		Included in Capitation	X
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use (vaccine pending FDA approval)	S		Included in Capitation	X
90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use(vaccine pending FDA approval)	S		Included in Capitation	X
90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use (vaccine pending FDA	S		Included in Capitation	X

Vaccine Code	Description	MUE	Children's Vaccine	Capitated Providers	FFS
	approval)				
90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use (vaccine pending FDA approval)	S		Included in Capitation	X
90669	Pneumococcal conjugate vaccine, polyvalent, f or Children under 5 yea for intramuscular use	S		Included in Capitation	X
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	S	X	Included in Capitation	X
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use	S	X	Included in Capitation	X
90673	Influenza virus vaccine, trivalent, derived f rom recombinant DNA (riv3), hemagglutinin (ha) protein only, preservative and Antibiotic free, for intramuscular use	S			X
90674	Influenza virus vaccine, quadrivalent (cciiv4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 ml dosage, for intramuscular use	S		Included in Capitation	X
90675	Rabies vaccine, for intramuscular use	S		Included in Capitation	X
90676	Rabies vaccine, for intradermal use	S		Included in Capitation	X
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral Use	S	X	Included in Capitation	X
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	S	X	Included in Capitation	X
90682	Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use	S			X
90685	Influenza virus vaccine, quadrivalent (iiv4), split virus, preservative free, 0.25 ml, for intramuscular use	S	X	Included in Capitation	X
90686	Influenza virus vaccine, quadrivalent (iiv4), split virus, preservative free, 0.5 ml dosage, for intramuscular use	S	X	Included in Capitation	X
90687	Influenza virus vaccine, quadrivalent (iiv4), split virus, 0.25 ml dosage, for intramuscular use	S	X	Included in Capitation	X

Vaccine Code	Description	MUE	Children's Vaccine	Capitated Providers	FFS
90688	Influenza virus vaccine, quadrivalent (iiv4), split virus, 0.5 ml dosage, for intramuscular use	S	X	Included in Capitation	X
90690	Typhoid vaccine, live, oral	S		Included in Capitation	X
90691	Typhoid vaccine, vi capsular polysaccharide (vicps), for intramuscular use	S		Included in Capitation	X
90692	Typhoid vaccine, heat- and phenol-inactivated (h-p), for subcutaneous intradermal use	S		Included in Capitation	X
90693	Typhoid vaccine, acetone-killed, dried (akd), for subcutaneous use (military)	S		Included in Capitation	X
90694	Influenza virus vaccine, quadrivalent (aiiv4) , inactivated, adjuvanted, preservative free , 0.5 ml dosage, for intramuscular use	S		Included in Capitation	X
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (dtap-ipv), when administered to children 4 ye Ars through 6 years of age, for intramuscular use	S	X	Included in Capitation	X
90698	Diphtheria, tetanus toxoids, acellular pertus sis vaccine, haemophilus influenzae type b, and inactivated poliovirus vaccine, (dtap-ip v/ hib), for intramuscular use	S	X	Included in Capitation	X
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (dtap), when administered to individuals younger than 7 years, for intramuscular use	S	X	Included in Capitation	X
90702	Diphtheria and tetanus toxoids (dt) adsorbed when administered to individuals Younger than 7 years, for intramuscular use	S		Included in Capitation	X
90703	Tetanus toxoid adsorbed, for intramuscular us e	S		Included in Capitation	X
90704	Mumps virus vaccine, live, for subcutaneous u se	S		Included in Capitation	X
90705	Measles virus vaccine, live, for subcutaneous use	S		Included in Capitation	X
90706	Rubella virus vaccine, live, for subcutaneous use	S		Included in Capitation	X
90707	MEASLES, MUMPS AND RUBELLA VIRUS VACCINE (MMR), LIVE, FOR subcutaneos USE	S	X	Included in Capitation	X

Vaccine Code	Description	MUE	Children's Vaccine	Capitated Providers	FFS
90708	Measles and rubella virus vaccine, live, for subcutaneous use	S		Included in Capitation	X
90710	Measles, mumps, rubella, and varicella vaccin e (mmrv), live, for subcutaneous use	S	X	Included in Capitation	X
90712	Poliovirus vaccine, (any type(s)) (opv), live , fororal use	S		Included in Capitation	X
90713	Poliovirus vaccine, inactivated, (ipv), for subcutaneous or intramuscular use	S	X	Included in Capitation	X
90714	Tetanus and diphtheria toxoids (td) adsorbed, preservative free, when administered to indi viduals 7 years or older, for intramuscular use	S	X	Included in Capitation	X
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (tdap), when administered to individuals7 years or older, for intramuscular use	S	X	Included in Capitation	X
90716	Varicella virus vaccine, live, for subcutaneous use	S	X	Included in Capitation	X
90717	Yellow fever vaccine, live, for subcutaneous use	S		Included in Capitation	X
90719	Diphtheria toxoid, for intramuscular use	S		Included in Capitation	X
90720	Diphtheria, tetanus toxoids, and whole cell p ertussis vaccine and hemophilus influenza b v accine (dtp-hib), for intramuscular use	S		Included in Capitation	X
90721	Diphtheria, tetanus toxoids, and acellular pe rtussis vaccine and hemophilus influenza b v a ccine (dtap/hib), for Intramuscular use	S		Included in Capitation	X
90723	Diphtheria, tetanus toxoids, acellular pertus sis vaccine, hepatitis b, and inactivated po l iovirus vaccine (dtap-hepb-ipv), for intram us cular use	S	X	Included in Capitation	X
90725	Cholera vaccine for injectable use	S		Included in Capitation	X
90727	Plague vaccine, for intramuscular use	S		Included in Capitation	X
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	S	X	Included in Capitation	X
90733	Meningococcal polysaccharide vaccine (any gro up(s)), for subcutaneou use	S		Included in Capitation	X

Vaccine Code	Description	MUE	Children's Vaccine	Capitated Providers	FFS
90734	Meningococcal conjugate vaccine, serogroups a , c, w, y, quadrivalent, diphtheria toxoid ca rrier (menacwy-d) or crm197 carrier (menacwy- crm), for intramuscular use	S	X	Included in Capitation	X
90735	Japanese encephalitis virus vaccine, for subc utaneous use	S		Included in Capitation	X
90736	Zoster (shingles) vaccine, live, for subcutan eous injection	S		Included in Capitation	X
90738	Japanese encephalitis virus vaccine, inactivated, for intramuscular use	M		Included in Capitation	X
90739	Hepatitis b vaccine (hepb), adult dosage, 2 d ose schedule, for intramuscular use	S		Included in Capitation	X
90740	Hepatitis b vaccine, dialysis or immunosuppressed patient dosage (3 schedule), for intramuscular use	S		Included in Capitation	X
90743	Hepatitis b vaccine, adolescent (2 dose sched ule),for intramuscular	S		Included in Capitation	X
90744	Hepatitis b vaccine, pediatric/adolescent dos age (3 dose schedule), intramuscular use	S	X	Included in Capitation	X
90746	Hepatitis b vaccine, adult dosage (3 dose sch edule), for intramuscular use	S		Included in Capitation	X
90747	Hepatitis b vaccine, dialysis or immunosuppressed patient dosage (4 schedule), for intramuscular use	S		Included in Capitation	X
90748	Hepatitis b and hemophilus influenza b vaccine (hepb-hib), for intramuscular use	S		Included in Capitation	X
90749	Unlisted vaccine/toxoid	S		Included in Capitation	X
90750	Zoster (shingles) vaccine (hzv), recombinant, sub-unit, adjuvanted, for intramuscular injection	S			X
90756	Influenza virus vaccine, quadrivalent (cciiv4), derived from cell cultures, subunit, antib iotic free, 0.5ml dosage, for intramuscular use	M		Included in Capitation	X

XII.C Glossary of EOP Code Messages

Use the following glossary as a guide to understand the most common payment determination messages found in the EOP.

EOP Message	Explanation of Message
Authorization Required, not Found	Prior authorization for service was not obtained or referral form not submitted. This includes authorizations that do not matchthe services billed.
Require medical record	Healthfirst requires the complete medical record for claim review.
Service Included in Case Rate	Payment for this service is included in the reimbursement for another service.
Service Capitated to Hospital	Monthly payment was made to the hospital for this service.
Denied: Medical Chart not Received Within 45 Days	Service denied: provider did not submit records within 45 days of date of request
Denied: Information (INF) not Received Within 60 Days of Request	Service denied: requested information (INF) was not received within 60 days of original request.
Denied-INF/Appeal not Received Within 60 Days	Service denied: request for appeal/review or submission of additional information was not received within 60 days of original EOP denial.
Failure to Comply with Healthfirst Notification Policy	Healthfirst requires notification of emergency room care within 48 hours and notification of inpatient admission by the next business day. Notification was not received.
Provider Not Eligible for Service	Service rendered is not covered under the provider's contract/specialty. Usually applies when PCP performs nonprimary care service.
Exact Duplicate of Closed Claim	Healthfirst has already received and processed a claim for these services.
Denied: Failure to Preauthorize	Service denied: required authorization from Medical Management department was not obtained.
Emergency room record required	Healthfirst requires submission of complete emergency room medical record to process claim.
Failure to Provide Clinical Information/Review	Medical Management department did not receive clinical information during inpatient stay.
Admission not medically necessary	Services denied: based on information provided, healthfirst determined that services were not medically necessary.
Member Not Enrolled on Date of Service	Service denied: patient not a Healthfirst member on the date service was provided.
Claim exceeds filing date	Service denied: claim was not received within 180 days of date of service.
Xn	Intranet work provider – not member's pcp

Appendix XIII – New York State Communicable Disease Reporting Requirements

NEW YORK STATE DEPARTMENT OF HEALTH

Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

Anaplasmosis
Amebiasis
C Animal bites for which rabies prophylaxis is given[1]
C Anthrax[2]
C Arboviral infection[3]
Babesiosis
C Botulism[2]
C Brucellosis[2]
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
C Cholera
Cryptosporidiosis
Cyclosporiasis
C Diphtheria
E.coli O157:H7 infection[4]
Ehrlichiosis
C Encephalitis
C Foodborne illness
Giardiasis
C Glanders[2]
Gonococcal infection
Haemophilus influenzae[5] (invasive disease)
C Hantavirus disease
Hemolytic uremic syndrome
Hepatitis A
C Hepatitis A in a food handler
Hepatitis B (specify acute or chronic)
Hepatitis C (specify acute or chronic)
Pregnant hepatitis B carrier
Herpes infection, infants aged 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory-confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
C Measles
C Melioidosis[2]
Meningitis
Aseptic or viral
C Haemophilus
C Meningococcal
Other (specify type)
C Meningococcemia
C Monkeypox
Mumps
Pertussis
C Plague[2]
C Poliomyelitis
Psittacosis
C Q Fever[2]
C Rabies[1]
Rocky Mountain spotted fever
C Rubella (including congenital rubella syndrome)
Salmonellosis
C Severe Acute Respiratory Syndrome (SARS)
Shigatoxin-producing E.coli[4] (STEC)
Shigellosis[4]
C Smallpox[2]
Staphylococcus aureus[6] (due to strains showing reduced susceptibility or resistance to vancomycin)
C Staphylococcal enterotoxin B poisoning[2]
Streptococcal infection (invasive disease)[5]
Group A beta-hemolytic strep
Group B strep
Streptococcus pneumoniae
C Syphilis, specify stage[7]
Tetanus
Toxic shock syndrome
Transmissable spongiform encephalopathies[8] (TSE)
Trichinosis
C Tuberculosis current disease (specify site)
C Tularemia[2]
C Typhoid
C Vaccinia disease[9]
Vibriosis[4]
C Viral hemorrhagic fever[2]
Yersiniosis

WHO SHOULD REPORT?

Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

WHERE SHOULD REPORT BE MADE?

Report to local health department where patient resides.

Contact Person _____

Name _____

Address _____

_____

Phone _____ Fax _____

WHEN SHOULD REPORT BE MADE?

Within 24 hours of diagnosis:

- Phone diseases in bold type.
- Mail case report, DOH-389, for all other diseases.
- In New York City use form PD-16.

SPECIAL NOTES

- Diseases listed in **bold type** **C** warrant prompt action and should be reported **immediately** to local health departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- **Cases of HIV infection, HIV-related illness and AIDS are reportable on form DOH-4189 which may be obtained by contacting:**

  Division of Epidemiology, Evaluation and Research
  P.O. Box 2073, ESP Station
  Albany, NY 12220-2073
  (518) 474-4284

  In NYC: New York City Department of Health and Mental Hygiene
  For HIV/AIDS reporting, call:
  (212) 442-3388

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1. Local health department must be notified prior to initiating rabies prophylaxis.
2. Diseases that are possible indicators of bioterrorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nile virus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatoxin test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test ≥1:16 or any positive prenatal or delivery test regardless of titer or any primary or secondary stage disease, should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, cases should also be reported to the NYCDOHMH.
9. Persons with vaccinia infection due to contact transmission and persons with the following complications from vaccination; eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the infection site, and any other serious adverse events.

ADDITIONAL INFORMATION

For more information on disease reporting, call your local health department or the
New York State Department of Health
Bureau of Communicable Disease Control at
(518) 473-4439
or (866) 881-2809 after hours.
In New York City, 1 (866) NYC-DOH1.
To obtain reporting forms (DOH-389), call (518) 474-0548.

PLEASE POST THIS CONSPICUOUSLY

Appendix XIV – HEDIS/QARR Quick Reference Guides (QRG)

Healthcare Effectiveness Data and Information Set (HEDIS) and Quality Assurance Reporting Requirements (QARR) are Federal and New York State tools used to measure the performance of healthplans and practitioners on important aspects of care and service. The HEDIS/QARR Code Book – All Measures is available on the Healthfirst Provider Portal (**https://hfproviderportal.org**) in the Provider Resource Center tab.

The ***All Measures Code Book*** is a comprehensive list of measures. It contains measure descriptions and acronyms, criteria for denominator inclusion, and numerator adherence requirements. Each measure has a hyperlink that will take you directly to the code list.

Please go to the Healthfirst Provider Portal to learn more.

Measure Abbreviations
AAB Avoidance of Antibiotic Treatment in Adults for Acute Bronchitis/ Bronchiolitis
AAP Adults' Access to Preventive/Ambulatory Health Services
ADD Follow-Up Care for Children Prescribed ADHD Medication
ADV Annual Dental Visit
AMM Antidepressant Medication Management
AMR Asthma Medication Ratio
ADL Adolescent Preventive Care
APM Metabolic Monitoring for Children and Adolescents on Antipsychotics
APP Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
ART Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
AWC Adolescent Well-Care Visits
BCS Breast Cancer Screening
CBP Controlling High Blood Pressure
CCS Cervical Cancer Screening
CDC Comprehensive Diabetes Care
CHL Chlamydia Screening in Women
CIS Childhood Immunizations Status
COA Care for Older Adults
COL Colorectal Cancer Screening
CWP Appropriate Testing for Children with Pharyngitis
FUH Follow-Up After Hospitalization for Mental Illness
FUM Follow-Up After Emergency Department Visit for Mental Illness
FUA Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
IET Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
IMA Immunizations for Adolescents
LBP Use of Imaging Studies for Lower Back Pain
LCS Lead Screening in Children
MRP Medication Reconciliation Post-Discharge
NCS Non-Recommended Cervical Cancer Screening in Adolescent Females
OMW Osteoporosis Management in Women Who Had a Fracture
PCE Pharmacotherapy Management of COPD Exacerbation
PPC Timeliness of Postpartum Care, Prenatal Visits
PSA Non-Recommended Prostate-Specific Antigen (PSA) Screening in Older Men
SAA Adherence to Antipsychotic Medications for Individuals With Schizophrenia
SMC Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
SMD Diabetes Monitoring for People With Diabetes and Schizophrenia
SPC Statin Therapy for Patients With Cardiovascular Disease
SPD Statin Therapy for Patients With Diabetes
SPR Use of Spirometry Testing in the Assessment and Diagnosis of COPD
SSD Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Measure Abbreviations
TRC Transitions of Care
URI Appropriate Treatment for Children with Upper Respiratory Infection
W15 Well-Child Visits – 0–15 Months
W34 Well-Child Visits – 3–6
WCC Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Appendix XV – PHSP Quality Rating Measures

Quality Rating Measures: HEDIS Measures	
Access and Preventative Care	Annual Dental Visit (2–18 yrs.)
	Breast Cancer Screening
	Cervical Cancer Screening
	Childhood Immunizations – Combo 3
	Chlamydia Screening (16–24 yrs.)
	Colorectal Cancer Screening
	Controlling High Blood Pressure
	Immunizations for Adolescents – Combo 2
	Timeliness of Prenatal Care
	Postpartum Care
	Prenatal Immunization Status
	Well-Child Visit (first 30 months of life)
	Child and Adolescent Well-Care Visits
	Weight Assessment and Counseling for Children and Adolescents
	Developmental Screening in the First 3 Years of Life
	Adult Immunization Status – Influenza
Chronic Care Management	Asthma Medication Ratio (5–64 yrs.)
	Diabetes Care: Eye Exam
	Diabetes Care: Poor HbA1c Control
	Diabetes Care: Kidney Health Evaluation for Patients with Diabetes
	HIV Comprehensive Care: Viral Load Suppression
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Behavioral Health	Antidepressant Medication Management
	Depression Screening and Follow-up for Adults and Adolescents
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
	Initiation of Pharmacotherapy upon New Episode of Opioid Dependence
	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
	Follow-up After Discharge from the Emergency Department for Alcohol or Other Drug Dependence (7 days)
	Follow-up after Discharge from the Emergency Department for Mental Illness (7 days)
	Follow-up After High-Intensity Care for SUD (7 days)
	Pharmacotherapy for Opioid Use Disorder
	Follow-up after Hospitalization for Mental Illness (7 days)
	Follow-up for Children Newly Prescribed ADHD Medication
	Metabolic Monitoring for Children and Adolescents on Antipsychotics
Avoiding Admissions and Readmissions	PQI: Adult Composite
	PQI: Pediatric Composite
Medication Adherence and Use Measures	Statin Therapy for Persons with Cardiovascular Disease (80% adherence)
Enrollee Satisfaction Measures	Getting Needed Care
	Getting Care Quickly
	Rating of Health Plan
	Customer Service

Appendix XVI – Behavioral Health Addendum

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

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

Appointment Availability Standards for Behavioral Health Services

Healthfirst will provide appointment and availability times for the following Behavioral Health services (for additional information regarding appointment availability standards, please refer to Appendix I of this manual):

- For CPEP, inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services will be provided immediately upon presentation at a service delivery site.
- For urgently needed Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS-certified residential settings and mental health or Substance Use Disorder outpatient clinics, and Opioid Treatment Programs will be provided within 24 (twenty-four) hours of request. Urgently needed ACT would be immediately referred to SPOA, with mention of the urgent need in order for them to evaluate promptly. PROS referrals would be made within 24 hours, and we would encourage PROS to provide prompt service.
- For Behavioral Health specialist referrals which are not urgent:
    - CDT, and Rehabilitation services for residential Substance Use or Gambling Disorder treatment services will be provided within two (2) to four (4) weeks of request
    - PROS programs other than clinic services will be provided within two (2) weeks of request
- Following an emergency, hospital discharge, or release from incarceration, if known, follow-up visits with a behavioral health participating provider (as included in the benefit package) will be scheduled to occur within five (5) days of request, or as clinically indicated.
- Non-urgent mental health or Substance Use or Gambling Disorder visits with a participating provider that is a Mental Health and/or Substance Use Disorder Outpatient Clinic, including a PROS program with clinical treatment, will take place within one (1) week of request.

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

Authorization, Continued Stay, and Discharge Criteria

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

- For mental health inpatient, Partial Hospitalization Program, and Intensive Outpatient settings of care, Healthfirst will use MCG clinical care guidelines.
- For all OASAS services for Substance Use Disorder settings of care, providers will use LOCADTR 3.0 to determine the most appropriate treatment setting for treatment of a member. All Healthfirst clinical staff have access to the HCS system and have been trained on the LOCADTR 3.0 tool in order to best understand the recommended level of care for the member.
- For all OASAS services for Gambling Disorder settings of care, providers will use the LOCADTR for Gambling Disorders to determine the most appropriate treatment setting for treatment of a member. All Healthfirst clinical staff have access to the HCS system and have been trained on the LOCADTR for Gambling Disorders tool in order to best understand the recommended level of care for the member.
- NYS has issued specific criteria for PROS, ACT, and CDT services. These criteria have been adopted and will be used by Healthfirst Care Managers in reviewing and managing these services.
- NYS has also issued review guidelines and criteria for all adult and child Home and Community Based Services (HCBS) and Community Oriented Recovery and Empowerment Services (CORE).
    - Healthfirst Care Managers will follow these processes as members complete the assessment by the Health Home (HH) care manager and recommended services are requested by HCBS providers. The guidance from NYS includes admission, continuing stay, and discharge criteria for each HCBS service.
    - Healthfirst Care Managers will monitor utilization of CORE services, following receipt of the CORE Service Initiation Notification Form from the CORE provider.

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

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
MH Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request	Within 5 business days of request
Partial Hospitalization				Within 5 business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			
OTP		Within 24 hours	Within 1 week of request	Within 5 business days of request	Within 5 business days of request
Crisis Intervention	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	
CPST		Within 24 hours (for intensive in-home and crisis response services under definition)	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of	Within 1	Within 72 hours	Within 72 hours of

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
		request	week of request	of request	request
Family Peer Support Services		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training			Within 1 week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/Family Supports and Services			Within 5 business days of request	Within 5 business days of request	Within 5 business days of request
Planned Respite			Within 1 week of request	Within 1 week of request	
Prevocational Services			Within 2 weeks of request		Within 2 weeks of request
Supported Employment			Within 2 weeks of request		Within 2 weeks of request
Community Self-Advocacy Training and Support			Within 5 business days of request		Within 2 weeks of request
Habilitation			Within 2 weeks of request		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	

Behavioral Health Utilization Management

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

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

- A comprehensive assessment
- A person-centered, needs-based, goal-oriented plan of care that includes services best suited to support recovery needs and preferences
- Timely access to services that will engage and support individuals and families throughout stages of recovery
- Cost-effective services in the most appropriate setting
- Services consistent with medical necessity criteria and evidence-based practices
- Active treatment at every level of care that supports progression toward recovery goals and takes into consideration the individual's readiness to change, readiness to participate in treatment, and family, cultural, and linguistic needs
- Integrated, coordinated care that includes services for co-occurring physical, behavioral health, and social conditions

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

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

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

Utilization Management Level of Care Guidelines

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

Behavioral Health UM criteria tools include:

- MCG clinical care guidelines for mental health services; ASAS LOCADTR 3.0 criteria for SUD treatment; OASAS LOCADTR criteria for Gambling Disorder treatment
- New York State OASAS Clinical Guidance (https://www.oasas.ny.gov/AdMed/recommend/reommendations.cfm)
- The NYS HCBS Provider Manual. This manual outlines how HCBS care planning and utilization management emphasizes attention to member strengths, goals, and preferences, and also ensures member choice of service options and providers (latest version available at https://www.omh.ny.gov/omhweb/guidance/hcbs/html/services-application/)

- The NYS CORE Services Provider Manual. This manual outlines how CORE service planning, documentation, and service delivery emphasize attention to member strengths, goals, and preferences, and also ensures member choice of service options and providers (latest version available at CORE Operations Manual (ny.gov)
- New York State OMH Clinic Standards of Care: (www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html)
- New York State OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013 (https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf)
- New York State OCFS Working Together: Health Services for Children/Youth in Foster Care Manual (http://ocfs.ny.gov/main/sppd/health_services/manual.asp)
- New York State Principles for Medically Fragile Children: (Refer to Attachment G in NYS's MMCO Children's System Transformation Requirements and Standards): https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-07-31_mc_plan_rqmts.pdf
- Internally developed Healthfirst criteria based on evidence-based practices

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

Authorization is required for admissions, all out-of-network care, and select outpatient services such as

Electroconvulsive Therapy (ECT), Neuropsychological Testing, Partial Hospital program, Applied Behavior Analysis (ABA), Intensive Outpatient Treatment (IOP) for mental health, Assertive Community Treatment (ACT), and, and Adult Behavioral Health Home and Community Based Services (Adult BH HCBS).

Members in need of care, or providers wishing to arrange these services for Healthfirst members, should call the Healthfirst Behavioral Health department at 1-888-394-4327 for assistance. For additional guidance on authorization requirements, please see Section 9.4 of the Manual.

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

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

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

Clinical Practice Guidelines for Behavioral Health

Clinical practice guidelines (found in Appendix A) are systematically developed standards that help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. The use of clinical practice guidelines gives Healthfirst the ability to measure the impact of guidelines on outcomes of care and may reduce

practice variations in diagnosis and treatment. In addition to guidelines and recommendations required by CMS, the NYSDOH, OHIP, and the local departments of health, participating providers are expected to comply with the guidelines adopted by Healthfirst.

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

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

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

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

- American Psychiatric Association
- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics – Attention Deficit Hyperactivity Disorder (ADHD)

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

- OMH Standards: www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html
- OASAS Standards: www.oasas.ny.gov/treatment/documents/ClinicalGuidance-Final.pdf
- OHIP Standards for Children in Foster Care: www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf
- OCFS Standards for Children in Foster Care: http://ocfs.ny.gov/main/sppd/health_services/manual.asp
- OHIP Principles for Medically Fragile Children (Refer to Attachment G in NYS's MMCO Children's System Transformation Requirements and Standards): https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-07-31_mc_plan_rqmts.pdf

Healthfirst also has experience with the following clinical practice guidelines:

- Tobacco Cessation
- Seeking Safety
- Motivational Enhancement Therapy
- Integrated Care and Management of Depression
- Integrated Care and Management of Anxiety Disorders

Healthfirst Partnerships for Medical Outcomes goal is to promote the Quintuple Aim throughout the delivery systems that impact members and to identify and act upon opportunities to improve health outcomes for the most vulnerable Healthfirst members and their communities through collaboration with clinical and community partners. The Healthfirst Partnerships team conducts meetings focused on improving medical outcomes with our Sponsors and primary care practices to establish a trusted and collaborative relationship. Data-informed, action-oriented, practice-specific performance improvement roadmaps to address the needs of populations in practices that need additional help to optimize their health. Partnerships' advisories, workshops, symposia, and conferences advance relevant approaches to achieving health equity and optimal, evidence-base outcomes.

Behavioral Health Care Management Automatic Call Distribution

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

Vibrant is Healthfirst's after-hours behavioral health crisis manager. They use licensed, trained clinicians as their agents, who respond immediately to calls that are warm transferred from Concentrix, Healthfirst's call center after-hours vendor. Concentrix agents are trained to warm transfer to Vibrant for any behavioral health issue, and they understand the importance of keeping the member on the phone and completing the warm transfer before disconnecting on their end. Vibrant' s licensed BH clinicians work telephonically performing crisis intervention, triage and referral, and assist members and providers with locating services for members using the web-based Healthfirst provider database. Vibrant staff thoroughly document all of their activities and send the information to Healthfirst on the next business day for any necessary follow-up with the member.

Emergent Care

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

Services must be provided by facilities or healthcare professionals qualified to render emergency medical care.

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

Definition of an Emergency Medical Condition

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

- Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Emergency Guidelines

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

If the PCP is referring the member for emergency care, the PCP should send the member to his or her assigned hospital whenever possible or to the emergency room of the closest hospital. The PCP should contact the emergency room by telephone or fax to provide necessary medical information. Members should be instructed to return to the PCP's office for follow-up, when appropriate, after an emergency room visit. If the member has received emergency

care and the follow-up care cannot be safely postponed until the member returns, the member should be instructed to seek follow-up care from the appropriate out-of-area provider.

Emergency Inpatient Admissions

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

Healthfirst hospitals (Level III providers) should contact their hospital liaison to arrange for admission to the appropriate participating hospital in emergency situations as well as in elective cases.

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

Access to Behavioral Health Services

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

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

Behavioral Health Quality Improvement Utilization Management Committees (BH QI-UMC)

The Behavioral Health Quality Improvement – Utilization Management Committees (BH QI-UMC) are multidisciplinary Committees that meet on a quarterly basis in each county or region (e.g., NYC) as required. In order to ensure provider and member representation reflects the needs and services of the regions where we provide coverage, each BH QI-UMC committee within the Healthfirst approved service area includes distinct local representation for each county or region as required. The BH QI-UM Committees are responsible for carrying out the planned activities of the BH QM and UM programs and is accountable to and reports regularly to the governing board or its designee concerning BH QM activities. The BH QI-UM Committees reviews behavioral health quality, utilization and operational metrics, and promotes behavioral health programs and initiatives. The BH QI-UM Committees are also responsible for oversight of Health Homes and their activities as they pertain to Healthfirst members. The BH QI-UM Committees report to the Quality Improvement Committee (QIC) at least twice a year.

Attendees include:

- Assistant Vice President, Medical Director, Behavioral Health (Chairperson)
- Medical Director, Children's Services
- Executive Medical Director, Vice President, General Medical
- Vice President, Behavioral Health Services (or designee)
- Director, HARP (or designee)
- Director, Behavioral Health Clinical Program Management (or designee)
- Director, Behavioral Health Services (or designee)
- Director, HARP Clinical Management (or designee)
- Director, Children's Services (or designee)
- Director, Clinical Operations, Children's (or designee)
- Director, Behavioral Health Strategic Integration (or designee)

- Director, Clinical Quality (or designee)
- Director, Clinical Informatics (or designee)
- Director, Pharmacy (or designee)
- Senior Manager, QI, Behavioral Health (or designee)
- Manager, Behavioral Health Operations (or designee)
- Manager, Network/Ancillary Operations (or designee)
- Network provider
- Stakeholders in an advisory capacity:
- Member representative
- Family member representative
- Peer Specialist
- Advocate
- Health Home representative
- Providers
- Subcontractors
- Regional Planning Consortium
- Member serving agencies
- Other Clinical and non-clinical staff from Healthfirst

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

The Children's QI-UMC is a multidisciplinary committee that meets on a quarterly basis and consists of members from both a quality improvement and utilization management background. It is responsible for carrying out the planned activities of the Children's QM and UM programs. The Children's QI-UMC reports to the BH QI-UMC at least quarterly.

Attendees include:

- Medical Director, Children's Behavioral Health (Chairperson)
- Assistant Vice President, Pediatrics Medical Director/Care Management
- Executive Medical Director, CMO Administration
- Assistant Vice President, Medical Director, Children's General Medical
- Vice President, Behavioral Health Services (or designee)
- Assistant Vice President, Appeals and Grievances (or designee)
- Director, Behavioral Health Services (or designee)
- Director, Children's Services (or designee)
- Director of Clinical Operations, Children (or designee)
- Director, Clinical Quality (or designee)
- Director, Behavioral Health Strategic Integration (or designee)
- Director, Clinical Informatics (or designee)
- Senior Manager, BH Quality Improvement (or designee)
- Director, Pharmacy (or designee)
- Manager, Network/Ancillary Operations (or designee)
- Senior Manager, Health Home (or designee)
- Network provider
- Youth and family peer support specialist
- Child serving Providers
- Stakeholders in an advisory capacity:
- Member representative
- Family member representative

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

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

- Critical-incident reports and trends including abuse, neglect, and exploitation occurrences
- Complaint tracking and resolution for both members and providers
- Over-utilization and under-utilization of costs and services
- Readmission rates, trends, post-discharge follow-up and average length of stay (ALOS) for mental health inpatient, and residential substance use disorder inpatient stays and RTCs
- Inpatient civil commitments and outpatient civil commitments (AOT)
- Follow-up after discharge rates from mental health inpatient, substance use disorder (SUD) inpatient, and RTC
- Rates of SUD IET initiation and engagement
- Emergency department utilization and crisis service use
- Behavioral Health prior authorization/denial and notices of action
- Psychotropic medication utilization a well as separate analysis for children in foster care
- Addiction medication utilization

Transitional issues for youth ages 18–23 years, focusing on continuity of care and service utilization

- Recovery outcomes (i.e., housing, homeless, criminal justice)
- Avoidable hospital admissions and readmission rates and the average LOS for all MH, SUD, residential levels of care, and medical inpatient facilities
- Use of crisis diversion services
- Pharmacy utilization, including psychotropic, addiction, and physical health medications
- All applicable physical health measures required by the MCO model contract
- All applicable behavioral health measures determined by the State
- Rates of initiation and engagement of individuals with FEP in services
- Health Home utilization and quality measures
- Discussion, tracking/trending, analysis, and follow-up related to PH services for medically fragile children with complex conditions
- Prior authorization/denials and notices of action
- Maintains records (documenting attendance, committee findings, recommendations, and actions)
- Implements a process to collect, monitor, analyze, evaluate, and report utilization data consistent with all reporting requirements
- Informs of child-specific training needs for providers and staff

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

- Use of crisis diversion and crisis intervention services
- Prior authorization/denial and notices of action
- HCBS utilization
- HCBS quality assurance measures as determined by the State

Behavioral Health Credentialing Criteria

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

- Healthfirst will accept OMH license, OASAS licenses, and other state designations of providers, in place of Healthfirst's credentialing process, for individual employees, subcontractors, or agents of such providers. Healthfirst will collect and accept program integrity–related information as part of the licensing and certification process.
- When contracting with NYS-designated providers, Healthfirst will not separately credential individual staff members in their capacity as employees of these programs.
- Healthfirst requires that OMH and OASAS providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid programs.

Confidentiality

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

Provider Training

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

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

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

1. Demographic Confirmation
2. Introduction to Healthfirst
3. Documentation Requirements
4. Cultural Competence in Practice
5. Authorization Requests and UM Protocols
6. HCBS Eligibility Criteria and Processes for Adults and Children
7. Adult CORE Processes
8. Healthfirst Provider Portal and other Online Tools
9. Claims Submission, Billing and Coding

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

Quality Assurance

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

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

First-Episode Psychosis

OnTrack-NY is an evidence-based program to address the specific needs of those suffering a first-episode psychosis who are 18–30 years of age. Members identified through the Healthfirst Care Management Program are referred to an HF Behavioral Health Case Manager and evaluated to determine if they meet criteria for first-episode psychosis (FEP). The member and his/her care team (including providers and support persons) are educated about OnTrack-NY (OTNY), and members who are interested in the program are assisted with making a referral to facilitate engagement in services. HF Case Managers provide appropriate, alternative treatment referrals to all members who are not interested in participating in OTNY.

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

Emergency Pharmacy Protocols for Enrollees with Behavioral Health Conditions

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

1. Placing the health or safety of the person afflicted with such condition or other personor persons in serious jeopardy;
2. Serious impairment to such person's bodily functions;
3. Serious dysfunction of any bodily organ or part of such person;
4. Serious disfigurement of such person; or
5. Severe discomfort – for enrollees with a behavioral health condition, a determination of severe discomfort shall include a situation where the enrollee is:
    a. Experiencing substantial discomfort or the expectation that such discomfort will result without the medication;
    b. Stable on a medication that is prescribed by the enrollee's current provider but is transferring to a new provider or to a new level of care;
    c. Stable on a medication and is changing healthcare plans; and/or
    d. Experiencing a return or worsening of behavioral health symptomatology as a result of the anticipation of cessation of the medication.

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

Healthfirst Utilization Management Staff Responsibilities

The Healthfirst Behavioral Health Utilization Management staff make authorizations for admission, continued stay, and step-down level of care decisions to ensure the right intensity of treatment at the least restrictive level to meet the member's clinical needs. The goal is to provide appropriate resources to support the member and sustain him/her in the community, reducing ED visits and re-admissions to acute care while facilitating access to essential person-centered, integrated, health and recovery-oriented services in the community. If a medical necessity denial for a level of care takes place because the treatment plan is felt not adequate or appropriate for the member, and Healthfirst

cannot reach an agreement on length of stay or adequacy of the treatment plan, the clinician managing this member will work with the facility on next steps for continued care for the member which might be at a higher or lower intensity setting of care and will collaborate to ensure that the member is referred and connected to the services that will be most appropriate for his/her clinical and psychosocial needs. The clinical staff is committed to continuing to follow the member's care so long as the clinical needs exist, and matching services and settings of care to those needs will be the priority.

Continuity of Care – Supplement to Provider Manual Section

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

- Adhere to Healthfirst's quality assurance requirements;
- Abide by all Healthfirst policies and procedures;
- Provide Healthfirst with medical information related to the member's care;
- Obtain prior authorization from Healthfirst Clinical teams for applicable services;
- Agree not to "balance-bill" the member for services provided.

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

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

- New EPSDT SPA services, including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports
- OASAS clinics (Article 32 certified programs)
- All OMH Licensed Ambulatory Programs (Article 31 licensed programs)
- Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

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

- May receive a transitional rate for no more than 24 months after the carve-in date
- The transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home

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

Adult BH HCBS providers, CORE providers, and child HCBS providers will be paid according to the NYS fee schedule

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

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

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

1. Utilization data identifies:
    a. Members with chronic conditions; physical health, mental illness and/or substance use disorders
    b. Members with frequent emergency department (ED) utilizations
    c. Members with frequent hospitalizations
    d. Members with high-risk comorbidities
    e. Other high-risk groups such as members with first-episode psychosis, pregnant, I/DD or older adults with a BH condition, individuals with a SUD in need of medication-assisted treatment
2. Demographic, encounter, and other data identify high-risk populations such as homeless individuals, transition age youth, individuals with AOT orders.
3. Community referrals
4. Internal referrals (e.g., Member Services, network, UR, A/G)
5. External referrals (e.g., PCP, specialist, home care agency, hospital discharge planners)
6. Step-down from Health Home Care Management
7. Member /Family self-referrals

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

Healthfirst regularly screens members to determine their eligibility to participate in New York State's Health Home program. Members meeting program diagnostic and eligibility criteria established by the state are referred and/or warm-transferred to a Health Home for engagement and enrollment in Health Home care management.

Peer Reviewers

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

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

Health Home Care Management

The Healthfirst (HF) Health Home Program provides reimbursement for care management to contracted Health Home providers for the following services provided to members with behavioral health and/or chronic medical conditions: comprehensive care management, care coordination and health promotion; transitional care from inpatient to other settings, including follow-up; individual and family support, which includes authorized representatives, referrals to community and social support services; and use of health information technology (HIT) to link services.

Through collaboration between Healthfirst and contracted Health Homes, the HF Health Home Program

provides member referrals and warm transfers, including key data to support engagement and enrollment, member assessment, care planning and performance monitoring, and care coordination support as indicated.

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

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

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

- Volume and transition of enrollment statuses of high-risk members;
- Health Home Care Management Agency network participation and outstanding issues;
- Quality-of-care issues (e.g., coordination of care efforts, access to care, reduction of gaps in care, etc.);
- Plan of Care creation, review, submission, and monitoring processes;
- Claims submission and quality of documentation

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

Children's Medicaid Redesign

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

- OMH Serious Emotional Disturbance (SED) 1915c waiver (NY.0296)
- Bridges to Health (B2H) SED 1915c waiver (NY.0469)
- Bridges to Health (B2H) Medically Fragile 1915c waiver (NY.0471)
- Bridges to Health (B2H) DD 1915c waiver (NY.0470)
- DOH Care at Home (CAH) I/II 1915c waiver (NY.4125)
- Office for People With Developmental Disabilities (OPWDD) Care At Home (CAH) waiver (NY.40176)

As of July 1, 2021, children in 29-I Health Facilities were enrolled in Medicaid Managed Care. Medicaid eligibility criteria was expanded to children who meet at-risk Level of Need criteria and are determined to be Medicaid eligible through Family of One and receive HCBS once final date is determined by NYSDOH.

Utilization Management:

Please see sections IV, V, VII, and VIII of the Behavioral Health Addendum (Addendum 18.1) for further guidance. Medically Fragile (MF) Children: Healthfirst will make every effort to contract with providers who have expertise in caring for Medically Fragile children to ensure that MF children, including children with co-occurring developmental disabilities, receive services from appropriate providers. Network providers will refer to appropriate network community and facility providers to meet the needs of MF children. In the event that network providers are unable to make such referrals, they will seek authorization to refer to out-of-network providers.

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

Home and Community-Based Services (HCBS) for Children

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

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

- For members who opt out of Health Home care management, the State-designated Independent Entity (IE), C-YES will conduct the HCBS Eligibility assessment.
- When a member is found eligible for HCBS, the HHCM or C-YES will develop a fully integrated person-centered Plan of Care (POC) in collaboration with the member, and in consultation with providers, family members, and legal guardians as necessary. This POC will be shared with Healthfirst as a request to access HCBS. Healthfirst Care Managers will review and acknowledge receipt of the POC, and issue an initial "level of service determination."
- When an initial POC is received, and on an ongoing basis, Healthfirst will review and make determinations regarding the appropriateness of the POC. Healthfirst Care Managers will review Plans of Care to assure that all federal and state HCBS regulations are addressed in the member's care.
- Ongoing determinations regarding the appropriateness and utilization of HCBS will be made utilizing the UM guidelines for HCBS, taking into account the member's preferences and desired outcomes. Healthfirst CMs will review care plans, along with authorization and claims data, to ensure appropriate utilization of HCBS as delineated in the POC.

Foster Care

29- I Credentialing Criteria

- Credentialing for 29-I Health Facilities is done at the agency level
- Healthfirst will not separately credential individual staff members in their capacity as employees of the 29-I Health Facility except for providers that elect to credential as a PCP
- 29-I Health Facilities licensed under PHL Article 29-I that provide primary care may elect to credential as a PCP with Healthfirst. The 29-I Health Facility PCP must meet the credentialing standards and PCP requirements.
- When credentialing a licensed 29-I Health Facility, Healthfirst will accept DOH designation, licensure, or operating certificates

Contracting

Healthfirst will endeavor to contract with providers servicing children in Foster Care, including but not limited to 29-I Health Facilities, primary care and other healthcare providers, and Behavioral Health providers in its service area. Healthfirst will execute Single Case Agreements with any provider for a child placed outside its service area, in order to ensure there is no disruption of the care plan in place for that child. Healthfirst will permit the enrollee to access a new primary care provider and other healthcare providers, including those with expertise treating children involved in Foster Care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services. Healthfirst will ensure there is no disruption in the Plan of Care.

Foster Care Initial Health Services

Effective July 1, 2021, children in Foster Care will be transitioned into Medicaid Managed Care plans. Healthfirst will ensure to enhance its network to include practitioners who deliver services to children in foster care to ensure access to providers who can complete the initial diagnostic assessments upon intake into Foster Care and any additional assessments mandated by the Office for Children and Family Services (OCFS), the Local Department of Social Services (LDSS), 29-I Health Facilities, and/or the Voluntary Foster Care Agency (VFCA). These assessments will be completed to enrollees within the required timeframes. The plan will reimburse practitioners for the intake screen, the complete diagnostic assessments, and any additional mandated assessments as identified by LDSS/29-I Health Facility/VFCA.

A series of assessments is required to provide a complete picture of the Foster Care child's health needs and forms the basis for developing a comprehensive Plan of Care. Following these assessments, Healthfirst shall facilitate access to providers and coordinate care for recommended treatment.

The initial health activities include:

1. Immediate screening (within 24 hours) of the child's medical condition, including assessment for child abuse/neglect.
2. Initial determination (within 5 days) of capacity to consent for HIV risk assessment and testing
3. Request (within 10 days) for release of medical records and treatment
4. Comprehensive health evaluation to be completed within 30 days of entering Foster Care to be conducted in compliance with Federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandates which includes:
    a. Comprehensive health and developmental history, including physical exam, immunizations, laboratory tests (including lead toxicity screening), and health education;
    b. Hearing;
    c. Dental, including ongoing preventive and restorative care;
    d. Mental Health/SUD;
    e. Vision;
    f. Family Planning education and counseling and follow-up healthcare for youth age 12 and older (or younger, as appropriate);
    g. HIV risk assessment (within 30 days) for child with possibility to consent. Arrange HIV testing (within 30 days) for child with no possibility of capacity to consent and assessed to be at risk of HIV infection. Initial developmental assessment (within 45 days);
    h. Follow-up health evaluation and treatments (within 60 days) that incorporate information from the five initial assessments;
    i. Conduct an HIV risk assessment on children under the age of 13 within five days of entering foster care placement and annually thereafter
    j. All patients age 13 or older receiving primary care services must be offered HIV testing at least once as a routine part of healthcare;
    k. Ongoing efforts to obtain child's existing medical records and document medical activities;

Healthfirst will help facilitate access to providers who can complete the required assessments and provider care coordination for enrollees in foster care.

See the table below for additional requirements regarding initial health services assessments for children/youth in Foster Care:

Timeframe for Initial Health Activities to be Completed Upon Placement to 29-I Health Facility

The table below outlines the timeframes for initial health activities to be completed within 60 days of foster care placement. An "X" in the Mandated Activity and/or Mandated Timeframe column indicates that the activity is required within the indicated time frame. An "R" in the Mandated Activity and/or Mandated Timeframe column indicates that the activity is required by OCFS.

Foster Care Initial Health Services and Ongoing Assessment and Treatment

*OCFS Regulations regarding HIV Counseling and Testing of children and youth in foster care have been revised to reflect the May 2017 updates to Public Health Law. VFCA/LDSS are required to conduct an HIV risk assessment on children under the age of 13 within five days of entering foster care placement and annually thereafter. All patients age 13 or older receiving primary care services must be offered HIV testing at least once as a routine part of healthcare.

In addition to the above, there are assessments/evaluations that are required to be completed during the course of the foster care placement. These assessments are time sensitive and impact child's health, safety, and well-being. MMCPs are not permitted to require prior authorization for these assessments. Examples of ongoing assessments include:

- Following absent without consent (AWOC)
- For purposes of determining eligibility for residential placements (OPWDD, OMH, OASAS and OCFS placement)

- Updated/repeated assessments/evaluations are routine and standard. Children/youth in foster care often require multiple assessments/evaluations, as they may experience changes in functionality and/or clinical presentation that impact service intensity.

Notification of Life-Changing Events

When a life-changing event happens to the foster child, the 29-I Health Facility should contact Healthfirst with the relevant details of such change. Examples of a life-changing event impacting a Healthfirst member include admission and discharge to a hospital, or elopement (leaving a foster home, or a healthcare or educational facility, without permission). Correspondence should be sent to #FCLiaison@healthfirst.org.

XVII – Applied Behavior Analysis (ABA)

Effective January 1, 2023, Applied Behavior Analysis (ABA) services provided by Licensed Behavior Analyst (LBA), Certified Behavior Analyst Assistant (CBAA) working under the supervision of LBAs, or other individuals specified under Article 167 of NYS education law, will be included in the MMC benefit package for eligible children/youth under age 21 with a diagnosis of autism spectrum disorder and/or Rett Syndrome as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). ABA is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. Healthfirst will cover ABA, coordinating these services for plan membership and enhancing the provider network.

- Eligible enrollee must be under age 21 with a diagnosis of autism spectrum disorder and/or Rett Syndrome, as defined by the Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition (DSM-5).
- ABA services are provided by Licensed Behavior Analyst (LBA), Certified Behavior Analyst Assistant (CBAA) working under the supervision of LBAs, or other individuals specified under Article 167 of NYS education law.
- CBAAs must be supervised by an LBA. LBAs bill for services of CBAAs under their supervision and can supervise up to 6 CBAAs.
- LBAs may form a group practice. CBAAs may work in a group practice but cannot own a group practice The New York State Education Department (NYSED) recognizes “unlicensed aides” as individuals who can provide certain services and/or activities under the supervision of a “multi-disciplinary” team providing ABA services.
- LBAs and CBAAs may work in any setting that may legally provide ABA services. Examples of such settings may include: private practice, settings where patients/clients reside full-time or part-time, clinics, hospitals, residences, and community settings.
- LBAs and CBAAs must enroll in the NYS Medicaid Program.
    - LBAs can enroll as billing or ordering/prescribing/referring/attending (OPRA) non-billing provider (OPRA enrollment for MMC participation for providers not servicing FFS recipients).
    - CBAAs enroll as an OPRA non-billing provider (CBAAs cannot bill).
    - “Unlicensed aides” cannot enroll as a provider.
- Providers should bill on a professional claim.

Additional requirements can be found in Healthfirst’s ABA policy.

Provider Training

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

Healthfirst requires that providers meet the applicable State minimum training requirements, including minimum hours and topics of training.

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

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

1. Demographic Confirmation
2. Introduction to Healthfirst
3. Documentation Requirements
4. Cultural Competence in Practice
5. Authorization Requests and UM Protocols
6. HCBS Eligibility Criteria and Processes for Adults and Children
7. Adult CORE Processes
8. Healthfirst Provider Portal and other Online Tools
9. Claims Submission, Billing, and Coding

In addition, clinical training will be made available to providers.

Appendix XVII – Health and Recovery Plan (HARP)

XVII.A Recovery-Oriented Principles

Roles and responsibilities relating to recovery-oriented principles are covered in the main provider manual, Section 9.1.

XVII.B Non-Urgent Care

Within the HARP, access to an enhanced benefit package is offered in addition to all Medicaid behavioral health and physical health benefits. The enhanced benefit package of Adult Behavioral Health Home and Community Based Services (BH HCBS) is designed to assist enrollees in their recovery and continued tenure in the community. In order to receive Adult BH HCBS, members must receive an initial eligibility assessment, with follow-up assessments done annually. Members enrolled in HARP receive an assessment for Adult BH HCBS eligibility using a tool derived from the inter-RAI Community Mental Health Assessment designed for New York. The HCBS eligibility assessment is conducted within the first 30 days of HARP enrollment. To improve access to rehabilitative care, New York State received federal approval to transition four Adult Behavioral Health Home and Community Based Services (BH HCBS) to a new service array called Community Oriented Recovery and Empowerment (CORE) services starting February 1, 2022. Community Oriented Recovery and Empowerment (CORE) are available to members who are enrolled in Healthfirst's HARP and in Medicaid Advantage Plus. POC guidelines do not apply to CORE services.

These four Adult BH HCBS will transition to CORE services: Psychosocial Rehabilitation Community Psychiatric Support and Treatment Empowerment Services – Peer Support Family Support & Training

Please refer to the following link for more information: CORE Transition: https://hfproviders.org/documents/root/0059-22_CORE-Transition-Important-Workflow-Reminders-and-FAQs_v5_FINAL.pdf

Required Steps for Adult BH HCBS Eligibility Assessment and Authorization

It is anticipated that all members enrolled in a HARP will receive care management from a Health Home Care Management Agency (HH CMA). The HH CMA conducts the assessment to determine eligibility for Adult BH HCBS and develops the Plan of Care (POC), which indicates which Adult BH HCBS the member will be referred to, including frequency, scope, and duration recommendations. Because Health Home enrollment is voluntary, HARP members may opt out of Health Home care management. Members who opt out are still entitled to receive an eligibility assessment for HCBS. In this instance, the assessments and POC formulation are conducted by State-designated Recovery Coordination Agencies (RCA). HH CMAs and RCAs use the Health Commerce System (HCS) to access the assessment tools,

Guidelines listed in the NYS HCBS Provider Manual (latest version available at https://omh.ny.gov/omhweb/bho/docs/hcbs-manual.pdf) outline how Adult BH HCBS care planning and utilization management activities shall emphasize attention to member strengths, goals, and preferences and ensure member choice of service options and providers.

Plan of Care (POC) Requirements

Members in the HARP will have a needs-based, person-centered, integrated, recovery-oriented Plan of Care (POC). The POC is developed by the HH CMA or RCA and is informed by the member and their family, in collaboration with the comprehensive care team.

- In collaboration with the member, and in consultation with providers as necessary, HH CMA or RCA develops a fully integrated Plan of Care (POC) according to Federal Documentation Requirements that includes physical and behavioral health services and recommended Adult BH HCBS, including the scope, duration, and frequency of HCBS, and selected in-network providers. HH CMA or RCA forwards the fully integrated POC to Healthfirst for review and approval. Healthfirst Care Managers work collaboratively with the HH CMA or RCA and member to finalize an approved POC.

Based on a conflict-free independent assessment of functioning, the Adult BH HCBS portion of the POC must meet the following requirements:

- The POC will include services chosen by the member to support independent community living in the setting of his or her own choice and must support integration in the community, including opportunities to seek employment, to engage in community life, to control personal resources, and to receive services within the community;
- Include the member's strengths and weaknesses; be developed to include clinical and support needs that are indicated by the independent functional assessment;
- Comprise goals and desired outcomes chosen by the member;
- Include Medicaid and non-Medicaid services and supports (natural supports and other community resources) that will enable the member to meet the goals and outcomes identified in their service plan;
- Include identification of risk factors and barriers with strategies to overcome them;
- Be reviewed and approved by member and their family/support persons, as appropriate;
- Include the member and the entity that is responsible for the implementation and oversight of the POC, review of progress, and need for modifications if desired outcomes are not being met or the member's needs change;
- Include an informed consent of the individual in writing, along with signatures of all individuals responsible for the POC implementation;
- Be sent to all the individuals and others involved in implementing and monitoring the POC; and
- The POC should not include services that are duplicative, unnecessary, or inappropriate.

XVII.C Adult Behavioral Health Home and Community-Based Services (BH-HCBS)

Healthfirst will follow the required appointment and availability standards for access for the following Adult BH HCBS:

- For Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, Family Support and Training services will be provided within two (2) weeks of request (unless appointment is response to an emergency or hospital discharge or release from incarceration, in which case the standard is within five [5] days of the request)
- Educational and Employment Support Services will be provided within two (2) weeks of the request
- Peer Support Services (PSS) will be provided within one (1) week of request (unless appointment is pursuant to an emergency of hospital discharge, in which case the standard is five [5] days, or if PSS are urgently needed for symptom management, in which case the standard for access is 24 [twenty-four] hours)

XVII.D Appointment Availability Standards for BH-HCBS

Healthfirst will follow the required appointment and availability standards for access for the following Adult BH HCBS:

- For Psychosocial Rehabilitation, Community Psychiatric Support and Treatment, Habilitation Services, Family Support and Training services will be provided within two (2) weeks of request (unless appointment is response to an emergency or hospital discharge or release from incarceration, in which case the standard is within five [5] days of the request)
- Educational and Employment Support Services will be provided within two (2) weeks of the request
- Peer Support Services (PSS) will be provided within one (1) week of request (unless appointment is pursuant to an emergency of hospital discharge, in which case the standard is five [5] days, or if PSS are urgently needed for symptom management, in which case the standard for access is 24 [twenty-four] hours)

XVII.E Credentialing Criteria for Designated Adult BH-HCBS Providers

Healthfirst credentialing criteria for designated providers is as follows, and is subject to final credentialing issues:

- Healthfirst will accept State-issued designation letter, in place of Healthfirst's credentialing process, for these providers and any individual employees, subcontractors, or agents
- Healthfirst will collect and accept program integrity–related information as part of the licensing and certification process
- Healthfirst requires that these providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program

XVII.F Description of Referral Process

Adult Behavioral Health Home and Community Based Services (BH HCBS) are available to Healthfirst members who are enrolled in Healthfirst's HARP plan and have been assessed and found eligible to receive such services by either a Health Home Care Management Agency (HH CMA) or a Recovery Coordination Agency (RCA).

For Adult BH HCBS, the process follows, and a visual reference can be found at https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/workflow_visual.pdf:

The HH CMA or RCA conducts the Adult BH HCBS eligibility assessment with the member to determine the full array of recommended Adult BH HCBS.

After the HH CMA or RCA completes the NYS Eligibility Assessment and determines that the member is eligible for and interested in a referral to BH HCBS, the HH CMA or RCA submits an Adult BH HCBS Level of Service Determination request to Healthfirst. This request may be made in a written or verbal format. At minimum, the request shall include the following information:

1. BH HCBS Eligibility Report Summary (indicating Tier 1 or Tier 2 eligibility)
2. All services the member currently receives
3. The member's recovery goal(s), and
4. The specific Adult BH HCBS recommended.

Healthfirst Care Managers review the request and issue a Level of Service Determination within three business days of receipt of all information (as listed above), but no more than 14 days of the request. Healthfirst may extend this time by up to 14 days if more information is needed and the extension is in the member's best interest. If Healthfirst approves the Level of Service request, the Level of Service Determination will include confirmation that the level of Adult BH HCBS proposed for the member is appropriate.

The Level of Service Determination should not be mistaken for an authorization for services but rather Healthfirst's agreement with the level of Adult BH HCBS proposed by the HH CMA or RCA.

The member must be given a choice of at least two Adult BH HCBS providers from Healthfirst's network for each requested service, and there must be documentation in the POC that choice was given to the member

The HH CMA or RCA ensures the member is referred for the services listed in the Level of Service Determination issued by Healthfirst

Upon receiving the referral from the HH CMA or RCA, each Adult BH HCBS provider shall notify and provide Healthfirst with the date of their initial scheduled intake/evaluation appointment with the member. If this initial date changes, the Adult BH HCBS provider must notify Healthfirst. The provider has up to three (3) visits with the member within 14 days of the initial visit to evaluate for scope, duration, and frequency of Adult BH HCBS. If more time or visits are needed, the Adult BH HCBS provider must notify Healthfirst and request authorization for additional time/visits needed.

After the notification of initial intake/evaluation, the Adult HCBS provider submits the Adult Behavioral Health Home and Community Based Services (BH HCBS): Prior and/or Continuing Authorization Request Form for continued service authorization. A template of this form can be found at https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/bh_hcbs_authorization_request_form.pdf

The HH Care Manager monitors the POC, ensures that the member is getting Adult BH HCBS reflected in the POC, and revises the POC when necessary, incorporating member input and choice. When the POC is revised, the Healthfirst Care Manager will review and communicate questions or concerns back to the HH CMA.

For CORE, the process follows, and a NYS guidance memo can be found at omh.ny.gov/omhweb/bho/core/lpha-memo-and-recommendation-form.pdf:

A member must have the NYS high-needs BH criteria (commonly referred to as HARP eligibility algorithm) and be enrolled in an eligible Plan type, HARP or HIV SNP, to be eligible for CORE services. You can find out someone's H-code status by looking in ePACES or PSYCKES, or by calling their Managed Care plan.

CORE services require a recommendation of a Licensed Practitioner of the Healing Arts (LPHA). An LPHA is defined as: Nurse Practitioner; Physician; Physician Assistant; Psychiatric Nurse Practitioner; Psychiatrist; Psychologist; Registered Professional Nurse; Licensed Mental Health Counselor; Licensed Creative Arts Therapist; Licensed Marriage & Family Therapist; Licensed Psychoanalyst; Licensed Clinical Social Worker; Licensed Master Social Worker, under the supervision of an LCSW, licensed psychologist, or psychiatrist employed by the agency.

Any qualified LPHA connected to the member should complete the recommendation. This may include, but is not limited to, outpatient clinicians, primary care practitioners, and qualified care managers/ supervisors. Additionally, the CORE services provider may have an internal LPHA able to complete the recommendation upon referral, but capacity for this will vary by provider.

The LPHA recommendation is a determination of medical necessity for CORE services. The recommendation may be made for one or multiple services. There is no standardized assessment process or tool necessary to complete the recommendation; the recommendation is based on the LPHA's clinical discretion.

The LPHA Recommendation Form should be kept on file in the member's CORE services case record. If the member is found eligible for services, the CORE services provider will conduct an intake and engage the member in a person-centered planning process to determine frequency, scope and duration.

CORE service providers should submit the CORE Service Initiation Notification Form for any Healthfirst members they are servicing via the Healthfirst Web Auth Portal.

XVII.G Adult BH HCBS and CORE Utilization Monitoring

Please reference the Provider Contract Exhibit 1.5 and the main Provider Manual Sections 3.2 and 3.7 for requirements for monitoring Adult BH HCBS and CORE utilization for each enrollee

XVII.H Utilization Management

Healthfirst views utilization management as an opportunity to review cases and engage in collegial clinical discussions. In the review, HF Care Manager (HF CM) will focus on the assessment, diagnosis, and treatment plan established by the treatment provider. The plan is expected to delineate clear goals and state how the treatment plan will lead to movement toward those goals.

As described elsewhere in this document, the care plan development is done with the full involvement of the member and, as appropriate, his/her support system. The plan should not only meet the needs based on strengths and deficits, but should also be culturally sensitive. It is expected that the member has consented to the plan submitted for approval.

The goal is to provide appropriate resources to support the member and sustain him/her in the community, reducing ED visits and re-admissions to acute care while facilitating access to essential person-centered, integrated, health and recovery-oriented services in the community.

Healthfirst clinical staff collaborate with the member's HH CMA, as appropriate, to ensure an integrated and consistent approach for members with co-occurring physical and behavioral health conditions. The HH CMA ensures that all community supports, including appropriate housing, are considered and in place whenever possible, before discharge, and that all relevant providers are aware of the goals and interventions described in the member's care plan to the extent necessary to facilitate communication, interface, and collaboration among clinical providers and community care/services and support.

XVII.I Maintenance of Member Records

Healthfirst monitors Adult BH HCBS and CORE provider adherence to established practice guidelines. All providers rendering Adult BH HCBS and CORE to our members are required to maintain a member health record in accordance with standards adopted by Healthfirst and in compliance with CMS and NCQA Guidelines for record review.

Healthfirst also strongly recommends that Adult BH HCBS and CORE providers comply with professional standards and take steps to safeguard confidentiality when sharing medical record information with other providers.

Healthfirst periodically requests medical records to conduct reviews to evaluate practice patterns, to identify opportunities for improvement, and to ensure compliance with quality standards. All Healthfirst medical-record reviews are conducted by clinical professionals, and all information contained in the records is kept strictly confidential. Healthfirst requires contracted Adult BH HCBS and CORE providers to make medical records available upon request by Healthfirst.

Medical records are reviewed as part of the following activities:

- Investigating clinical quality of care
- Monitoring utilization to identify underuse and overuse of services, timely receipt of preventive and medically necessary services, and to determine root causes for potential action
- Monitoring for accuracy and completeness of coding
- Validating claims
- Monitoring for compliance with approved Clinical Practice Guidelines and Standards of Care, reporting for Quality Improvement studies
- Monitoring of Adult BH HCBS and CORE provider compliance with regulatory guidelines and reporting requirements
- Monitoring for compliance with Healthfirst Medical Record Documentation Standards

The guidelines and performance indicators chosen by the clinical members of the HARP QI committee are communicated to providers through the Provider Manual, annual mailings, newsletters, and the plan's website. Performance against chosen indicators is measured annually. The annual evaluation also helps to drive the activities for the next year's Quality Improvement Work Plan by determining which successful interventions and actions should be continued or expanded and which actions and activities did not result in noticeable improvement and should be modified or discontinued.

The annual evaluation is developed by all relevant parties and is presented to the regional Quality Improvement Committees (QIC) and the regional Quality Committees (QC) for review and approval.

XVII.J Provider Education and Training

The Healthfirst Behavioral Health Network team will provide initial and ongoing provider education to ensure that providers and their office staff are knowledgeable about Healthfirst policies and procedures, reference documents about the needs of special-needs members and how to assist in the access of covered services to ensure that providers are fully cognizant and compliant with federal and state regulations and program standards.

Clinical training courses are made available through the Healthfirst Provider Portal on an as-needed basis.

XVII.K Adult BH HCBS Plan of Care Submission and Utilization Review Criteria

Healthfirst Care Managers work closely with Health Home Care Management Agencies to oversee the development and management of integrated Plans of Care (POC). The HH CMA or RCA submits the written POC to Healthfirst for review no less than annually. Each POC is reviewed in collaboration with the member and their care team to ensure a person-centered, integrated, and recovery-oriented plan; an appropriate match of need to service; progression toward goals within expected time frames; adjustments with change in physical, behavioral, or social status; and effective use (no duplication) and coordination of Medicaid and non-Medicaid resources. Goals that are not achieved will be evaluated for appropriateness of attainability for each member and revised, as necessary.

Where questions arise, HF Care Managers partner with the member's care team to discuss treatment and service alternatives, acting as a resource to the team to facilitate the development of an individualized POC that optimally utilizes network and community resources, including Adult BH HCBS.

HF utilizes the Adult BH HCBS utilization review criteria developed in concert with OMH. The process of Adult BH HCBS review has been described in L3 B.6

XVII.L Billing Compliance

Please reference the MMC/FHP Contract Section 16.15 (b).

XVII.M Required Documentation for Reimbursement

Please reference the MMC/FHP Contract Section 16.15 (b).

XVII.N Appeals and Grievances

Healthfirst provides an opportunity for HARP members to appeal decisions that adversely affect access to Adult BH Home and Community-Based Services (see operating policy AG MCD-003v28).

Individuals have the right to appeal when any of the following adverse determinations occur:

- Adult BH HCBS are either denied, reduced, or changed
- Individuals are denied the provider of their choice

For HARP eligibility determinations, while NYS has delegated the Adult BH HCBS evaluation to the HARP, only the State can make the final determination regarding approval or denial of HARP enrollment.

Members who require assistance with the appeal process can call the dedicated HARP Member Services at 1-855-659-5971.

Appendix XVIII — Provisions from the 2007 Managed Care Reform Bill

Managed Care Reform Bill

This legislation was signed into law in August 2007and imposes new requirements on healthcare payors and providers. Specifically, the bill includes the following provisions:

- Claims Deadline for Public Programs (effective January 1, 2008) Requires out-of-network providers of services to Medicaid, FHPlus and CHPlus beneficiaries to submit claims to plans within 15 months from the date of service.
- Cooling Off Period for Hospitals and HMOs in Contract Terminations Imposes a two-month “cooling off period” after the expiration of a contract between a hospital and a health plan.
    - During this period, the terms of the terminated contract remain in place. Health plan members are notified of the impending termination 15 days after the commencement of the cooling off period. For example, if the contract terminated on December 31, 2007, the end of the newly mandated cooling off period is February 28, 2008. The 45-day advance notice to enrolled members would have occurred on January 15, 2008.
    - The purpose of this provision is to avoid the use of termination notices to health plan members and DOH as a vehicle for leveraging concessions in contract negotiations. The cooling off period may be waived by DOH in the event of a termination for cause. It is not required in the context of mutual terminations that are recorded in writing.
- Binding Pre-authorizations (effective January 1, 2008) Prohibits plans from denying claims for pre-authorized services, except under certain circumstances.
    - The exceptions include: (1) The patient was not covered at the time the service was provided; (2) The claim was not timely; (3) The patient exceeded policy limits; (4) The preauthorization was based on materially inaccurate or incomplete information; (5) The claim is related to a pre-existing condition that is excluded from coverage; (6) Provider fraud or abuse; and (7) The health plan that pre-authorized the service is not the primary payor.
    - Of particular importance is the first exception that imposes limits on when health plans may retroactively terminate coverage and thus reverse a preauthorization previously issued by the health plan. The bill states that if a provider submits the claims for per-authorized care within 90 days of the date of service, the health plan’s termination may be retroactive more than120 days. If the retroactive period is longer than 120 days, the plan has to pay claims for any pre-authorized care rendered more than 120 days before the retroactive termination date.
- Out-of-Network Treatments (effective April 1, 2008) Expands the scope of the external review process to include denials of treatments not approved by a physician participating in the health plan’s network and are to be provided by an out-of-network physician.
    - The appeal process for such denials involves a two-step inquiry: (1) Is the requested treatment materially different from the treatment available in the network? (2) If so, would it be “more clinically beneficial” and not substantially riskier than the in-network treatment?
- The appeals process then has two steps. A single external reviewer first determines whether the proposed out of network service is materially different. If so, a larger external review panel is convened to determine whether the alternative is likely to be “more clinically beneficial” and whether the adverse risk of the proposed service would likely not be substantially increased over the in- network service.

Appendix XIX – Health Information Exchange and Organized Health Care Arrangement

Healthfirst operates the Healthfirst Health Information Exchange ("HIE"), which allows the exchange of Healthfirst member data between and among Healthfirst and certain qualified participating providers. Providers that participate in the HIE may access information about Healthfirst members to coordinate services, improve quality and manage the cost of care.

By participating in the HIE and/or uploading member data to the HIE, providers agree as follows:

1. to abide by the Healthfirst Health Information Exchange Policies and Procedures (the "HIE Policies"), as posted on the Healthfirst website and as updated by Healthfirst from time to time; and
2. to the extent applicable, to be part of an Organized Health Care Arrangement ("OHCA") with Healthfirst and other providers participating in the HIE for purposes of HIPAA to carry out joint quality improvement, care coordination and utilization management activities, in accordance with Healthfirst's Notice of Privacy Practices.

As of May 2022, members of the OHCA are as follows:

OHCA Members		
NYC Health + Hospitals	BronxCare Health System	NuHealth - Nassau University Medical Center
Stony Brook Medicine	Montefiore Health System	MediSys
St. John's Episcopal Hospital	Interfaith Medical Center	Northwell Health
SUNY Downstate	Maimonides Medical Center	Mount Sinai Health System
The Brooklyn Hospital Center	SBH Health System	NYU Langone Health