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.

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

As of 10/1/11, pharmacy services are a covered benefit for Managed Care Healthfirst identification. A comprehensive formulary is available on the Healthfirst website. 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, you may call Healthfirst Provider Services at **1-888-801-1660 for Medicaid, CHPlus program, Commercial, Leaf Plans**, and **Medicare**. A list of participating pharmacies is available from Member Services at **1-866-463-6743 for Medicaid, CHPlus program**, **and Commercial; 1-888-250-2220 for Healthfirst Leaf Plans; and 1-888-260-1010 for Medicare**.

Pharmacy services are a covered benefit in the Medicaid, CHPlus program and Leaf Plans. Medicaid, CHPlus and Leaf Plan members should present their Healthfirst identification cards to pharmacy staff when accessing pharmacy services. A comprehensive formulary is available on the Healthfirst website. 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, you may call Healthfirst Provider Services at **1-888-801-1660 for Medicaid, CHPlus program, Commercial, Leaf Plans**, and **Medicare**. Healthfirst will not cover prescription drugs or biologicals that are used for mercy killings. Please note, members who participate in the Restricted Recipient Program will be restricted to a pharmacy chosen by Healthfirst.

Medicare 65+, IBP, LIP, CC, AC and Commercial: Healthfirst provides coverage for prescription drugs for many of its products. Please refer to the member ID card to determine if a member has pharmacy coverage.

Medicare CBP: Healthfirst does not provide coverage for pharmacy services for CBP members. These members may obtain their prescription coverage from a retiree health plan, the Veterans Administration, or other creditable coverage they may have.

All prescriptions must be filled at a Healthfirst participating pharmacy. Healthfirst may require prior authorization of certain pharmaceuticals. 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 a 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 assist a member in filing 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 our HF Leaf Plans, Medicare, Medicaid, CompleteCare and CHPlus are available on

our website at www.healthfirst.org.

Generic Drugs

Healthfirst strongly encourages the use of generic drugs when clinically appropriate. The member's copayment will be less if a generic equivalent is prescribed. Please note the following maximum days' supply:

- Commercial [Healthy NY Small Group; Healthfirst HMO B Small Group] – 30 days
- HF Leaf Plans – 90 days Leaf Plans – 90 days
- Medicaid and CHPlus – 30 days
- CHPlus – 30 days
- Medicare – 90 days
- Mail order for Commercial, HF Leaf Plans, and Medicare – 90 days
- Over-the-Counter (OTC) Benefits (Medicare)

Eligible Medicare plan members can obtain OTC or nonprescription drugs and health-related items without a prescription at any OTC network pharmacy location. Eligible members will receive a Healthfirst OTC Card with a prefunded monthly benefit allowance upon enrollment. With this allowance, the member may purchase eligible OTC and health-related items (i.e., aspirin, cold & flu relief medications, and adhesive bandages) at any participating OTC network pharmacy, including any Rite Aid, Duane Reade, Walgreens, CVS, or Family Dollar location. In addition, the Healthfirst OTC card can be used at many neighborhood pharmacies.

To purchase items, members will take their eligible items to the front checkout lanes of a participating store and swipe the card at any register. Purchases for eligible items are automatically deducted from the OTC card balance. Any remaining balance will carry over until the next purchase.. Any unused balances automatically expire at the end of the calendar year on December 31st or upon disenrollment from the plan.

If a member makes purchases of eligible OTC items at a store without the product-linked OTC card technology or from a store where the product-linked OTC card technology failed or was unavailable, he/she may submit an Over-The-Counter (OTC) Reimbursement Claim Form. This form is available at www.healthfirst.org or by calling Member Services.

For a complete list of covered OTC items, please visit www.healthfirst.org.

Specialty Medications

Healthfirst uses a pharmacy vendor to help manage the care members receive and who need oral and injectable specialty medications. The vendor verifies eligibility, submits requests for prior authorization, and bills the member-appropriate copayments or coinsurance for medications. Providers must order specialty medications directly through the delegated vendor. Providers will not be reimbursed for specialty medication claims submitted to Healthfirst.

The following items are not covered, or are covered as noted:

- 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

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

DME, 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.

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 it relates to rental periods for all contracted providers.

DME and orthotic and prosthetic vendors must call to obtain prior authorization from Medical Management for all items. Diabetic supplies are limited to Bayer, Healthfirst's exclusive, preferred manufacturer.

10.5 Home Healthcare

Healthfirst members are eligible to receive medically necessary home healthcare services provided by a Certified Home Health Agency (CHHA). Home care providers participating with Healthfirst include CHHAs maintained by member hospitals, and other contracted CHHAs. For a listing of participating CHHAs, see the Provider Directory.

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) 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 Medical 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.

Prior Authorization Process: General Guidelines

Home healthcare providers are responsible for obtaining authorization from Medical 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 requested solely for convenience, for activities of daily living, or that are custodial in nature are not a covered benefit.

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.

Personal Care Services—Medicaid, CompleteCare and AbsoluteCare

Healthfirst Personal Care Services provides qualified members with partial or total assistance with personal hygiene, dressing and feeding, and nutritional and environmental support functions. Such services must be essential to the maintenance of the member's health and safety within his or her own home, as determined by Healthfirst in accordance with the regulations of DOH; ordered by the attending provider based on an assessment of the beneficiary's needs; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse.

There are two levels of personal care services:

- Level I services are limited to the performance of environmental and nutritional functions, including dusting, vacuuming, dishwashing, shopping, laundry, and meal preparation and Healthfirst confidential and proprietary information. Unauthorized use, disclosure or reproduction is strictly prohibited.
- Level II services include Level I services and personal care functions such as assisting members with bathing, grooming, bathroom and/or bedpan routines, walking, transferring from bed to chair or wheelchair, and assistance with self-administration of medications.

10.6 Dental

Dental services for Healthfirst members are provided and managed by DentaQuest, a delegated vendor that maintains a comprehensive network of dental providers. Healthfirst Medicare members should refer to their Evidence of Coverage (EOC) to determine the extent of their dental benefit. Members may access any network dental provider without a referral. To assist a member in obtaining dental services, please contact Healthfirst Member Services at **1-866-463-6743**. Members may contact Healthfirst Member Services or DentaQuest Member Services at **1-800-508-2047** if they have questions regarding dental benefits.

In addition to providing primary care dental services, the network includes specialty care dental providers such as orthodontists, endodontists, and oral surgeons. These providers see Healthfirst members without a referral but with approvals obtained from the delegated vendor. In general, the oral surgery performed by these providers is done in the provider's office and involves procedures such as the extraction of impacted wisdom teeth; however, there may be oral surgery cases involving small children that must be performed under general anesthesia in a hospital setting. In these situations, the delegated vendor authorizes the oral surgery and reimburses the surgeon, but the hospital and anesthesia service component of the treatment must be pre-authorized by Healthfirst. This may be handled through communication initiated by either the hospital or the member's PCP.

In situations when oral surgery is required to treat medical problems such as head and neck cancers, a referral from the member's PCP to the oral surgeon is required, and all required prior authorization must be obtained from the Healthfirst Medical Management department. In these cases, all services are authorized and reimbursed by Healthfirst.

HIV-positive members may select an HIV specialist dentist by contacting the DentaQuest Dental Member Service Department at **1-800-508-2047.**

Members may call Healthfirst Member Services with any questions at **1-866-463-6743**.

10.7 Routine Vision

Healthfirst Medicaid and Medicare members are entitled to routine eye examinations and eyeglasses

provided through Davis Vision, 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.

Healthfirst Leaf *Premier* members are entitled to routine eye examinations and eyeglasses provided through Davis Vision. 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. Healthfirst Leaf members ages 19 and under (pediatric) are entitled to routine eye examinations and eyeglasses provided through Davis Vision. Pediatric 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. Members may contact Davis Vision at **1-800-753-3311**.

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

Hospice care requires prior authorization and is covered by Healthfirst for Medicaid, Personal Wellness Plan, CHPlus, Leaf Plans, and Commercial members. Hospice is not covered under our Medicare product offerings. Hospice is a coordinated program that is designed to provide comfort and alleviate the pain of symptoms connected with a terminal illness. This benefit is covered directly by Medicare fee-for-service for Healthfirst Medicare members and must be elected by qualifying individuals. Prior authorization is required from fee-for-service Medicare. Since the hospice benefit is covered directly by Medicare for Healthfirst Medicare members, these members will continue to be covered through Healthfirst for treatment for conditions other than the terminal illness.

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.

Under the Medicare Hospice Benefit, “terminally ill” means that the individual has a medical prognosis of six months or less if the illness runs its normal course. The beneficiary (or his or her representative) must file and sign an election statement with the particular hospice. 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 must be entitled to Medicare Part A
- Member must have a terminal illness as certified by their PCP
- Member must have a life expectancy of less than six (6) months
- Member must waive the right to receive treatment for the terminal condition from any provider other than the hospice and attending providers

Hospice service for a Healthfirst Medicare member is covered under Original Medicare, not under the Healthfirst Medicare Plan.

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.

Transportation for Newborns (Medicaid)

Healthfirst covers transportation of newborns from the birth hospital to a Regional Perinatal Care Center (RPCC) for neonatal services. RPCCs directly arrange for one-way transport of newborns to the RPCC, and this service should be billed as rate code A0225 for an enrolled newborn or the newborn of an enrolled mother. Transport from the RPCC to the hospital is arranged by Healthfirst's transportation vendor, not by the RPCC, and is billed by the transportation vendor as a routine transportation service.

Public Transportation

Participating PCPs, OB/GYNs, behavioral health providers, dental providers, and hospital facilities are responsible for distributing a round-trip MetroCard, or its equivalent, for each verifiable visit for Medicaid services. PCPs, OB/GYNs, and hospital facilities are also responsible for distributing a round-trip MetroCard, or its equivalent, for specialty care services. If services are provided at a hospital, the member must present his/her Healthfirst card and proof of an encounter/visit to the hospital's transportation coordinator before reimbursement is given. Reimbursement for public transportation is available (in MetroCards) regardless of the member's proximity to the service site.

If it is essential that an escort(s) accompany the member in need of care or if a child accompanies a parent/guardian, a round-trip MetroCard will be provided for each escort. There is no limit to the number of escorts who may accompany a member.

All provider MetroCard transportation forms should be mailed to Logisticare for reimbursement. Providers should call Logisticare at **1-877-564-5925** for details and instructions for reimbursement deliveries.

Special Program for Medicaid Members

This program offers free car service to qualified Healthfirst Medicaid members who need the following services:

- Prenatal visits – Only if in the first trimester of pregnancy (0 to 3 months) or first prenatal visit within forty-two (42) days, or six (6) weeks, of enrollment with Healthfirst.
- Post-partum visit – Only if within twenty-one (21) to fifty-six (56) days, or three (3) to eight (8) weeks, after delivery
- Well-child visits and immunizations:
- Offered for members up to twenty-four (24) months old (total of six (6) round trips)
- Two (2) weeks after birth
- Six (6) weeks after birth
- One (1) round trip every two (2) months thereafter for a maximum of six (6) round trips

To access this service, members located in Nassau, Suffolk, and Westchester should call Member Services at **1-866-463-6743**. Members located in the New York City area should contact Logisticare at **1-877-564-5925.**

Nonpublic, Non-emergency Transportation

If a member has a non-emergent medical condition but requires an ambulance, ambulette, stretcher ambulette, or livery service to access medical care, the PCP, OB/GYN, behavioral healthcare, or dental provider must notify Member Services (for all Medicare and Medicaid members outside New York City) or Logisticare (for Medicaid and Essential Plan members located in New York City) 48 hours before the transportation is required. Member Services will arrange for appropriate transportation based on the member's medical needs. Member Services is staffed Monday through Friday, 9 am to 6 pm, and can be

reached by calling **1-866-463-6743**. The after-hours service maintained by Healthfirst has instructions for assistance with transportation needs. Logisticare can be reached at **1-877-564-5925** to schedule transportation for Medicaid members in New York City.

Ambulance, Ambulette, and Livery Providers

Transportation providers who wish to have written confirmation that transportation was approved and arranged by Healthfirst have the option to request documentation on a Transportation Arrangement Form. To receive this form on a regular basis, transportation providers should contact their Network Representatives.

See Appendix IX for copies of all transportation forms.

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 authorization.
Healthfirst will provide the authorization for custodial care and the MAP 2159i form.
As per the DOH guidelines, The Nursing Home is responsible for compiling all required documentation, as part of the request for custodial eligibility and application, and submission to LDSS/HRA within 90 days from the start date the member is authorized for custodial care including the following documents:

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

Note: The nursing home facility must provide proof (see section below) to Healthfirst that the application was submitted to HRA/LDSS. Please note, Healthfirst may recoup reimbursement made for any period of

eligibility.

Proof of Submission Requirements

Paper Submitters: Nursing homes must send two copies of the MAP-648P form to LDSS/HRA. LDSS/HRA will return a copy to the nursing home as proof of submission. The nursing home must email a copy of this form to: NursingHomeHF@Healthfirst.org.

EDITS Submitters: Submitters using EDITS will receive and electronic notification "EASYng Case Status History" response form EDITS. The nursing home must email a copy of this response to: NursingHomeHF@Healthfirst.org.

LDSS/HRA has forty-five (45) days from the date of application to complete the eligibility determination, including 60 months and look-back period and transfer of asset rules.
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.

Once HRA/LDSS approve eligibility and determine NAMI amount it will be documented on monthly Nursing Home Report (specialty) file.

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

Bed Hold Authorization

The nursing home must notify Healthfirst when a bed hold authorization is required.

Reserved bed days related to leaves of absence for temporary hospitalizations shall be made at 50% of the Medicaid FFS rate for a maximum of 14 days in a 12 month period.
Reserved beds related to non-hospitalization leave of absence (therapeutic leave) shall be at 95% of the Medicaid rate for a maximum of 10 days in a 12 month period.

Access to Care and Quality

Healthfirst closely monitors and coordinates the care for members who are typically frail and have multiple, chronic conditions that reside in nursing facilities that require long term care.
Patient care after placement:

- Person Centered Care Plan
- Healthfirst arranges for UAS-NY assessment every 6 months or when enrollee condition changes
- Coordinates with NH to share assessment data
- Healthfirst may review for service coverage and medical necessity
- Healthfirst reauthorizes stay under concurrent review at identified intervals
- Healthfirst ensures enrollee has a PCP
- Healthfirst arranges for other covered services enrollee needs

Communication and Coordination of Care:

- The nursing facility must inform Healthfirst care management of a change in member Status and Sentinel Event in order to assure UAS assessment.

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

- For any issues regarding the MAP 2195i form please contact the Healthfirst at NursingHomeHF@Healthfirst.org

Discharge Planning

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

- Coordinate 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 plan back into the community.
- Nursing Facility must work with Healthfirst to reinstate community LDSS coverage
- Ensure that appropriate community supports are in place prior to discharge.

Billing Guidelines

The Billing Guidelines are located online at our website, www.healthfirst.org.