16. Provider Compensation

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.

16.1 Payees

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 Primary Care Services/Primary Care Providers

Healthfirst has established a set of healthcare services which Healthfirst considers to be Primary Care Services and which are to be rendered by Primary Care Providers (PCPs) within the Healthfirst provider network. These services support the member's primary care needs in both an ambulatory (office or clinic) and an inpatient setting and include the following:

- Early and periodic screening, diagnostic and treatment (EPSDT) services, including preventive office visits and immunizations
- Primary care office visits for urgent conditions
- Primary care inpatient visits
- Basic hearing and vision screenings
- Urgent laboratory services for diagnosis and/or treatment of members with acute conditions
- Dual-energy X-ray absorptiometry, chest X-rays, and ultrasounds for the diagnosis and/or treatment of members with acute conditions
- Other basic diagnostic tests and simple treatments of urgent and chronic conditions

A complete list of reimbursable services for primary care physicians is detailed in Appendix XIV-B and listed by CPT code.

Given the important role that PCPs play in the Healthfirst network and in providing primary care services to members, PCPs are not expected to provide specialty or other healthcare services which are not primary care services as described in this Provider Manual. As explained more fully in Section 3.1, PCPs are responsible for coordinating all of the care a member receives and are expected to refer members to in-network specialists for care that is outside the scope of primary care.

With regard to Healthfirst commercial Leaf Plan products and Leaf Premier Plan products, when a member needs elective care that a PCP or OB/GYN (women can choose either an OB/GYN or PCP) cannot generally provide within the scope of his/her practice, a referral to an in-network Leaf Plan or Leaf Premier Plan provider who can perform these services will be required. Consistent with this requirement, Healthfirst will not reimburse PCPs for services other than the listed primary care services unless the PCP is also credentialed and designated by Healthfirst as a specialist. Note, however, that family practice providers who provide minor surgery, obstetrical, or gynecological care for members will also be reimbursed for those services.

Referrals are not required for the following services, among others:

- Emergency services
- Primary and preventive obstetric and gynecological services (OB/GYN), including annual examinations

- Care resulting from such annual examinations
- Treatment of acute gynecological conditions, or for any care related to a pregnancy from a qualified contracted provider of such services

If you are not yet credentialed as a specialist and wish to be credentialed by Healthfirst as a Specialist in addition to being a PCP, please speak to your Network Representative or contact Healthfirst Provider Services at 1-888-801-1660 for assistance in the application process.

To also ensure that PCPs are able to coordinate member care, Healthfirst members seeking primary care from your clinic or practice that are not assigned to your member panel must be directed back to their assigned PCP for care or referred within their PCP's own network, as appropriate. Claims submitted for primary care services rendered by a provider other than the member's assigned PCP will be denied. These claims will be denied for **"Intra-Network Primary Care – Not Member's PCP."** Members, however, are free to change their PCP. If the member is in need of an appointment immediately and wishes to switch to your panel, Member Services can make the appropriate changes right away. Members should call Member Services at **1-866-463-6743** for assistance in switching PCPs.

PCPs may be reimbursed either through monthly capitation or on a fee-for-service basis, depending on the terms and conditions of their provider agreement with Healthfirst.

Regardless of whether reimbursement is via capitation or fee-for-service, all PCPs must submit claims for all services, including capitated services, in order to provide encounter data. Healthfirst uses encounter data to verify the types and level of services provided and for mandatory reporting to federal and state regulatory agencies. See Section 14 for reporting requirements.

For more information on payments to providers who receive a monthly capitation for each member on their panel, see Appendix XIV-B.

16.3 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 Rating (OQR) and/or measure-specific rates/ratings.
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, CHP, 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 OQR, with providers participating in HQIP on a monthly and quarterly 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 OQR, 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 Preview 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.

16.4 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.

16.5 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.

16.6 Family Planning Services

Healthfirst reimburses for family planning services provided to Healthfirst members. Medicaid members may obtain family planning and reproductive services without a PCP referral from either in-network or out-of-network Medicaid providers. CHP, Leaf Plan, and Leaf Premier Plan members may obtain family planning and reproductive health services through any in-network CHP, Leaf Plan, or Leaf Premier Plan provider without approval from or notification to Healthfirst or their PCP. Healthfirst will not pay claims for Healthfirst CHP, Leaf Plan, or Leaf Premier Plan members seeking family planning and reproductive health services from out-of-network providers.

16.7 Healthfirst Consultation Payment Policy

In 2010, Medicare implemented a policy to no longer reimburse for consultation services. However, Healthfirst will pay for consultation services. Reimbursement for these services will be based on a new member visit or the hospital case rate. The consultation code mapping for Medicare-based contracts is listed below:

Billed Service Code	Billed Service Code Description	Paid Service Code	Paid at Rate Code Description
99241	Office consultation for a new or established patient; physicians typically spend 15 minutes face-to-face with the patient and/or family.	99201	Office or other outpatient visit for the evaluation and management of a new patient; physicians typically spend 10 minutes face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient; physicians typically spend 30 minutes face-to-face with the patient and/or family.	99202	Office or other outpatient visit for the evaluation and management of a new patient; physicians typically spend 20 minutes face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient; physicians typically spend 40 minutes face-to-face with the patient and/or family.	99203	Office or other outpatient visit for the evaluation and management of a new patient; physicians typically spend 30 minutes face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient; physicians typically spend 60 minutes face-to-face with the patient and/or family.	99204	Office or other outpatient visit for the evaluation and management of a new patient; physicians typically spend 45 minutes face-to-face with the patient and/or family.
99245	Office consultation for a new or	99205	Office or other outpatient visit for the evaluation

	established patient; physicians typically spend 80 minutes face-to-face with the patient and/or family.		and management of a new patient; physicians typically spend 60 minutes face-to-face with the patient and/or family.
99251	Inpatient consultation for a new or established patient; physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.	99221	Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99252	Inpatient consultation for a new or established patient; physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.	99221	Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99253	Inpatient consultation for a new or established patient; physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.	99222	Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.
99254	Inpatient consultation for a new or established patient; physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.	99223	Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.
99255	Inpatient consultation for a new or established patient; physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.	99223	Initial hospital care, per day, for the evaluation and management of a patient; physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

16.8 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 in order 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 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).