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
- Obtain prior authorization for all elective admissions from the Healthfirst Medical Management Department
- 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
- Refer all Healthfirst **Leaf Plan** Members to In-Network specialists prior to the specialist service being rendered using the appropriate referral request form
- 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 the Healthfirst 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 the Healthfirst 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 of 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 most 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. Referrals or authorizations, when required, are essential for prompt claims payment. Please refer to Section 12 for more details on referral and 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 should also make referrals for an adequate number of visits to specialists to accommodate the treatment plan, and update treatment plans periodically. Please refer to Section 13 of this manual for more information.

Primary Care for Leaf Plan and Leaf Premier Plan Members

Primary Care Providers for Leaf Plan members will be required to generate referrals for Leaf Plan members for most specialist services. Referrals should be generated by the PCP prior to the specialist service being rendered, and can be submitted online through the Healthfirst Provider Portal.

Primary Care for HIV Positive Members

All HIV Specialist PCPs must meet additional credentialing requirements to serve this population. (See Appendix II-A) These multi-disciplinary 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 the Healthfirst 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 standing referral to 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, the Healthfirst 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 most Healthfirst products such as Medicaid, CHP, and FHP, members are able to access these specialty services without a referral from their PCP or authorization by Healthfirst. Healthfirst Leaf Plan and Leaf Premier Plan members require a referral for most specialty services as outlined in Section 12 of the Provider manual.

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 referrals to 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 health 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 for 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 who Healthfirst deems, at its sole discretion, are not necessary and appropriate to provide and manage 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.

Non-Discrimination

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 be in 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.

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 multi-lingual 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.

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, CHP, 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 developed by Healthfirst.

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.

Provider Information

Providers are responsible for contacting Healthfirst to report any changes in their practice. It is essential that Healthfirst maintain an accurate provider database in order 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, including hospital affiliation should be submitted at least 30 days prior to the effective date. Any changes to the following list of items should be reported to Healthfirst using our electronic Demographic Change Form found on the Healthfirst Secure Provider Portal, or changes can be faxed to Healthfirst at: **(646) 313-4634 / ATTN: Demographic Update Request**

These should be submitted with a fax cover sheet that includes full contact information, and a comprehensive request on the provider or group letterhead, that includes the provider's license number and identifies the

practice record for update. Any supporting documentation (such as a W9 form or a Board Certificate) should be faxed with these requests.

- Update in the Provider or Group name and Tax ID number (W9 required)
- Update in Provider/Group Practice Address, zip code, telephone or fax number (Full practice information required)
- Update in Provider/Group billing address (W9 required)
- Update in the member Age Limits for service at the practice (if applicable)
- Update in NY License, such as a new number, revocation or suspension (New Certificate or information on Action required if applicable)
- Closure of a Provider Panel (Reason for panel closure)
- Update in Hospital Affiliation (Copy of current and active hospital privileges)
- Update or addition of Specialty (Copy of Board Certificate or appropriate education information)
- Update in practicing Office Hours (PCP's need at least 16 hours)
- Update in Provider's Board eligibility/board certification status
- Update in Participation Status
- Update in NY Medicaid Number (if applicable)
- Update in National Provider Identification Number (if applicable)
- Update in Wheelchair Accessibility
- Update in Covering provider
- Update in Languages spoken in the provider's office

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 report in good faith actual or suspected wrongdoing.

Healthfirst is also required to refer potential fraud or misconduct related to the Medicare program to the Health and Human Services Office of the Inspector General (HHS-OIG) and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste and abuse related to the NY 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 and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity 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 this zero-tolerance policy, Healthfirst provides this information to vendors to achieve the following goals:

- Demonstrate its commitment to responsible corporate conduct
- Maintain an environment that encourages reporting of potential problems

- Ensure appropriate investigation of possible misconduct by the company

In general, Healthfirst has adopted various fraud prevention and detection programs for the purpose of protecting the member, the government, and/or Healthfirst from paying more for a service than it is obligated to pay. Therefore, Healthfirst established a Special Investigations Unit (SIU), which ensures that Healthfirst is in compliance with all applicable state and federal regulations.

The SIU is chiefly responsible for accepting referrals from both outside the company and within the company for investigation to determine if fraud or abuse has occurred. Therefore, Healthfirst employees and contracted entities have a responsibility to report any inappropriate activities to the SIU and the Regulatory Affairs Department or their immediate supervisor, if applicable.

For further information on our compliance program, please visit our provider web page at www.healthfirst.org and select *"A Guide to the Compliance Program."*

Definitions

Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

Fraud - An intentional deception or misrepresentation made by a provider, person or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Waste - The extravagant, careless or needless expenditure of funds resulting from deficient practices, systems, controls or decisions.

Relevant Statutes and Regulations

Stark Law

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 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 in order 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

The Medicare and Medicaid Patient Protection Act of 1987, provides the basis for this statute. It provides for criminal penalties for certain acts which impact Medicare and 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

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistle-blowers) can help reduce fraud against the government. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (the act does not cover tax fraud).

For the purposes of this policy, "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

False Claims Act Penalties

Those that defraud the government can end up paying triple the damages done to the government, a fine (between $10,957 and $21,916) for every 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.

Protections for Whistle Blowers

Whistle-blower 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 whistle blower. If an employer retaliates in anyway, whistle-blower 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, you can go to https://oig.hhs.gov/fraud/report-fraud/index.asp.

The following are the applicable false claim act regulations, for reference:

Federal False Claims Act Civil Remedies Act

31 U.S.C. 3801-3812

For a copy of this citation, please 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 August 1, 2016, False Claims Act civil penalties increase to between $10,781 and $21,563 per claim, plus three times the amount of damages that the federal government sustains because of the false claim. 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 tracts 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 $10,781 to $21,563 per claim 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 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 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and five (5) years for 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 the use of 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 thirty (30) 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 considered overpayments and Healthfirst will utilize an extrapolation methodology to determine the total overpayment and ask the selected provider to refund the monies paid. If appropriate education will be provided to ensure further billings are submitted according to established guidelines. The results of these reviews are presented to the Healthfirst Fraud, Waste and Abuse Committee.

Failure to cooperate may result in the non-renewal or termination of your contract with Healthfirst and/or additional reporting to state and/or federal authorities.

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 and/or recommendations to the Healthfirst Credentialing Subcommittee 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.

Upon referral by the FWAC, the Credentialing Subcommittee will conduct a separate review of the allegations involving improper billing or potential fraudulent and/or abusive activity committed by a provider. The Credentialing Subcommittee 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.

The Fraud, Waste and Abuse Committee meets approximately fifteen (15) during the year and is comprised of the following Healthfirst staff members:

- Vice President Deputy General Counsel
- Chief Medical Officer (or his/her representative)
- Vice President Claims
- Vice President Regulatory Affairs

- Vice President Compliance and Audit
- Vice President Network Management
- Director 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 are (1) submitted timely; (2) submitted to Healthfirst at 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.

Where the FWAC determines that a provider should be placed on PPR due to identification or reasonable suspicion of fraud, waste or abuse, Healthfirst's vendor administer (the "Vendor") will notify the provider of the FWAC's decision and that they will be on PPR for a period of at least six months. The FWAC will review the the provider after at least each six month period that a provider is on PPR to determine if the provider has changed their behavior, is maintaining the required documentation, and, where applicable, has resolved any overpayment requests. The Vendor will also send a request(s) for medical records to the provider for all subsequently submitted claims 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 30 days to submit requested records. In the event records are not submitted within 30 days of the request, the claims at issue will be denied. Records received after the 30 day deadline will not be considered.

All records must be sent to the address listed in the PPR medical record request letter from the Vendor. Records sent to any other address will not be considered.

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 (e.g. that the services billed were rendered, were medically necessary, and were appropriately performed and documented, etc.), the claim will be approved for payment. The provider should submit all necessary information and records including, but not limited to, records to indicate that the services were rendered, all test results, records to indiciate an ongoing course of treatment, evidence of a referral, etc. 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 informed of the PPR decisions through the provider portal or an explanation of payment.

If providers disagree with the PPR claim determination, they may submit a review and recondiseration (e.g. first level appeal) within ninety (90) calendar days of the claim decision. Providers must submit additional supporting documentation directly to the Vendor at the address listed in the PPR medical record request letter 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 pursuant to the "Claims Appeal Process" detailed in section 17.6 of the Provider Manual. All Appeals must be submitted to Healthfirst at the address indicated in section 17.6 of the Provider Manual and include a cover letter noting that this is an appeal from a PPR determination. The review and reconsideration and the appeal processes shall otherwise be conducted in accordance with section 17.6 of the Provider Manual.

Retrospective or Post-Payment Review

Periodically, the Vendor and the SIU conducts audits of claims that have previously been paid by Healthfirst. In such audits, 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. Vendor then presents the audit outcome to the provider in an Audit Findings Report (AFR). If the provider disagrees with the findings in the AFR, 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 AFR 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.). Most retrospective reviews are based on a statistically valid sample, however, in some instances, audits may be conducted based on specific ICD 9/10 code issues.
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.

Prescription FWA - Premier Audit Meetings

In addition to the Fraud, Waste and Abuse Committee discussed above, Healthfirst also conducts quarterly Premier Prescription FWA Audit meetings. This committee is concerned with fraud, waste and 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
- Director 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 RRP Providers 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 RRP 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 health care and unnecessary costs to the Medicaid program are prevented.

The MRRC is a professional team comprised of, at a minimum, a physician, a registered professional nurse and a pharmacist. The MRRC shall review and determine whether the enrollee has demonstrated a pattern of over-utilization, under-utilization or mis-utilization of services included in the Benefit Package and whether such behavior should be managed by the Restricted Recipient Program. The MRRC is also responsible to ensure that the directives of the team regarding placing restriction of recipients are carried out. The MMRC consists of the following staff members

- Vice President Associate General Counsel
- Chief Medical Officer (or his/her representative)

- Vice President Claims
- Vice President Regulatory Affairs
- Vice President Compliance and Audit
- Vice President Network Management
- Pharmacy Director or pharmacist alternate
- Director Special Investigations Unit

Common Methods of Fraud and Abuse

In order to assist you with understanding and/or identifying what may constituent 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 nonlicensed 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 code (Resection of small intestine) along with multiple incidental procedure codes (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 includes 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 (PBM)

- 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

FDR & 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; we are 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.

Failure to meet the requirements may lead to a Corrective Action Plan, retraining, or the termination of a contract and relationship with Healthfirst.

First Tier entities are responsible for ensuring that their downstream and related entities are in compliance with Healthfirst policy 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 www.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 First Tier, Downstream and Related Entities (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 at:	**Special Investigations Unit (SIU) at:**
100 Church Street, New York, NY 10007	100 Church Street, New York, NY 10007
By phone – 212-453-4495	By phone - 212-801-3292
E-Mail – compliance@healthfirst.org	E-Mail - 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 www.hfcompliance.ethicspoint.com. This service is 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 Medicaid, managed care, and CHPlus PCP must practice at least two (2) days per week and maintain a minimum of 16 office hours per week at each primary care site. HIV Specialist PCPs working at academic institutions may have some flexibility with this requirement. Medicare and commercial providers must maintain a minimum of ten (10) office hours per week at each primary care site. Providers who care for the homeless population are not required to maintain a minimum of 16 office hours per week at each primacy 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 have key Healthfirst telephone numbers available at all times

- 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 particular 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 time frame 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.

Provisional Credentialing

Newly licensed providers and providers relocating from other states can apply for provisional credentialing if Healthfirst is unable to credential providers within 90 days after the receipt of a completed application.

Providers are eligible to apply for provisional credentialing only after 90 days have passed since Healthfirst has received a completed application and the following two requirements are met:

- Provider(s) must be newly licensed in the State of New York or relocating from other state(s)
- 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.

Healthfirst will notify providers as soon as possible within 90 days of receipt of a completed application as to whether the provider has been credentialed, whether the application has been denied, or if additional information is needed to complete the credentialing process.

The Credentialing Subcommittee

The Credentialing Subcommittee is a multi-disciplinary committee of clinical practitioners from Healthfirst participating hospitals, as well as the Healthfirst Chief Medical Officer, Vice President of Quality Improvement 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 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 Credentials Subcommittee Meetings
- Review recommendations made by the Fraud, Waste and Abuse Review Committee concerning alleged improper billing practices and suspected fraud and/or abuse committed by a provider. If the Credentialing Subcommittee determines that formal termination of a provider is warranted, the Subcommittee will submit its recommendations to the Health Care Quality Council in this regard for final determination
- 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 managing 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 by a provider, Healthfirst will provide a copy of the provider profile, data, and analysis used to evaluate a 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.

Healthfirst's monitoring and evaluation of its provider network is done internally and the results are not disclosed to Healthfirst's members or the public. Healthfirst does not engage in any public "ranking", "tiering" or other publication of any provider's performance in regards to cost or quality. 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 to by the Medical Director to make a determination 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. 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 upon 60 days prior written notice to the provider, or upon notice as set forth in the provider's agreement with Healthfirst, in the event of:

- Repeated failure to comply with quality assurance, peer review and utilization management procedures
- Unprofessional conduct as determined by the appropriate state professional licensing agency
- Conviction for a criminal offense related to the practice of medicine or any felony unrelated to such practice, or any activity that would cause imminent harm or danger to a Healthfirst member
- Failure to comply with Healthfirst credentialing standards and procedures
- Revocation, reduction or suspension of privileges at any participating hospital or any hospital where the provider conducts his or her primary practice
- 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 members in the second trimester of pregnancy, 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.**