4. Eligibility and Membership

4.1 Introduction

Healthfirst Medicaid Managed Care Plan

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

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

Enrollment in a Medicaid Managed Care Plan is now mandatory for the Medicaid-eligible population living in New York City and in Nassau and Suffolk counties. Those individuals who do not voluntarily select a plan will be assigned to a participating managed care plan by the New York State enrollment broker, New York Medicaid CHOICE, which is responsible for managing the mandatory enrollment process. However, there are certain categories of Medicaid recipients who are either excluded from the Medicaid managed care program or are exempt from mandatory enrollment. If you are treating members who qualify for an exemption, you may be required to complete an exemption form. This form must be submitted to New York Medicaid CHOICE for State Department of Health approval of the exemption. Exempt individuals have the option of choosing to join a managed care plan. Please contact Healthfirst if you have questions regarding managed care exemptions. See Appendix III for a complete list of the Medicaid Managed Care excluded and exempt population groups. To obtain exemption forms, please call the New York Medicaid CHOICE helpline at **1-800-505-5678**.

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

Medicaid Recertification

Medicaid members must recertify their eligibility for the program on an annual basis. Members will receive notice to recertify from their local district of Social Services. Notification will be received via mail reminding a member to renew their coverage. A member will be able to send their renewal form through the mail or renew online (for NYC members only.

Child Health Plus (CHP)

CHP provides reasonably priced or no-cost healthcare coverage for children under the age of 19 for families who do not qualify for Medicaid and for whom the price of commercial health insurance is prohibitive. Those who qualify for Medicaid must pursue an application to participate in that program initially or upon recertification. The children are eligible for CHP regardless of immigration status, even if undocumented. Their families must be income-eligible to qualify for coverage under the New York State-sponsored CHP initiative that provides varying levels of subsidization for the insurance premium, depending on the family's income level. Coverage is available in Bronx, Kings, New York, Richmond, Queens, Nassau, and Suffolk counties.

The application for CHP requires supporting documentation for income, identity/date of birth, and residency (must reside in New York State). CHP members who are pregnant should be referred to Medicaid. They will remain in CHP until their Medicaid eligibility determination is made. Prospective members' eligibility will be determined by the contractor upon receipt of the application and required supporting documentation. If all requirements are not met, there is potential for a prospect to become a member with the plan and receive 60 days of temporary coverage—this is referred to as presumptive eligibility.

CHP Recertification

CHP members must recertify their eligibility for the program annually. An abbreviated application form, called the CHP Renewal Form, must be completed with new supporting documentation. The form is sent to a CHP member 90 days prior to the member's anniversary date. It must be completed and submitted no later than 30 days before the anniversary date to ensure continuation of benefits. If it is determined that a member is Medicaid eligible, the member's eligibility will be electronically submitted to HRA (NYC). For LI, the CHP Renewal Form will be submitted to the local district Social Services. If additional documentation is needed to properly process the recertification, a member may receive 60 days of presumptive coverage.

Providers are asked to note on the monthly enrollment roster which children are scheduled for annual renewal of eligibility and to communicate the importance of recertification to their families. This will avoid any lapse in coverage.

It may take up to 60 days to obtain documentation and verify eligibility for CHP. Therefore, applications are processed and members are considered presumptively eligible for 60 days while all documents are reviewed. Members will select PCPs and may access services during this period; providers will be compensated for services rendered. If, at the end of the 60 days, it is determined that the member is not eligible, he/she will be disenrolled.

Medicare

Our Medicare programs are offered by Managed Health, Inc./Healthfirst Medicare Plan. There are a variety of HMO products available to individual members who are eligible for Medicare Part A and B and who will continue to pay their Medicare Part B premium. Some plans have additional eligibility criteria. Coverage is available in Bronx, Kings, Nassau, New York, Queens, Richmond, and Westchester counties. Our 65+, IBP, and CBP plans are available in Bronx, Kings, New York, Queens, Richmond, and Nassau counties, and the LIP, CCP, and MAX plans are also available in Westchester county. Our JBP plan is available in New York, Kings, and Queens counties. Our CC plan is available in New York, Bronx, Kings, Queens, and Richmond counties.

Commercial/QHP

Our commercial programs are called Healthfirst Healthy NY, Healthfirst Leaf Plans, Healthfirst HMO A-D plans, and Healthfirst small group plans. Members are covered through individual contracts. New York State's Healthy NY program no longer offers coverage for individuals and sole proprietors, as of December 31, 2013. Healthfirst Leaf Plans, Healthfirst Leaf Premier Plans, and Healthfirst HMO A-D plans for individuals and families are available in Bronx, Kings, New York, Richmond, Queens, Suffolk, and Nassau Counties. Healthfirst Healthy NY for small group coverage is available in Bronx, Kings, New York, Richmond, Queens, Nassau, and Suffolk counties.

4.2 Marketing, Advertising, Outreach and Enrollment

Healthfirst has implemented advertising, enrollment, and outreach/education guidelines and policies to govern the outreach/education of its government-sponsored programs such as Medicare, Medicaid, CHP, and by healthcare providers. These guidelines and policies are based on requirements set by CMS and the New York State Department of Health. The goal of these guidelines is to ensure that advertising, enrollment, and outreach/education activities by all parties involved in Healthfirst programs are conducted in a responsible manner so that potential members receive the most accurate and complete information possible. Providers may advise their members of managed care plans with which they participate, but they must list all plans and cannot promote one plan over another.

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

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

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

If you have members in your practice who are interested in or eligible for one of the Healthfirst programs, you may refer them to Healthfirst Member Services. Healthfirst representatives will assist these individuals with the applicable enrollment or application process and will function as the liaison with Maximus, the Medicaid managed care enrollment office, for potential Medicaid members or as the liaison with NY State of Health—the New York health insurance marketplace—for those potential members who may be eligible for a Healthfirst commercial plan.

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

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

4.3 PHSP Enrollment and Disenrollment

Mandatory Medicaid Managed Care

Medicaid recipients will have 30 days from notification that they must select a managed care plan to enroll in the plan of their choice. Family members may be enrolled into different plans and are no longer required to

have one plan per family. Medicaid eligibles who do not select a managed care plan within the allotted time period will be "auto-assigned" to a plan by Maximus, the enrollment broker charged with managing all mandatory Medicaid managed care enrollments and disenrollments.

Once enrolled in a managed care plan, members will have 90 days to change plans, regardless of whether the selection was through choice or auto-assignment. After this period expires, members will be "locked in" to the plan for a period of nine months following the effective date of enrollment. If a member loses and regains Medicaid eligibility within three months, he/she will be automatically re-enrolled with Healthfirst.

Healthfirst will assign a maximum of 1,500 members to a Physician and 1,000 members to a Nurse Practitioner based on a 40-hour FTE. Panel sizes will be prorated when providers carry less than 40 hours at a practice site.

Child Health Plus (CHPlus)

Members will enroll in Healthfirst through the application process outlined in Section 4.1. The advertising/outreach guidelines and enrollment process described above also applies to the CHPlus Program.

Member Enrollment Rosters

Members are enrolled monthly into the Healthfirst programs. Each month, Healthfirst will provide PCPs with an enrollment roster for each program that identifies new members in the provider's panel as well as those members who have left the practice. Providers may use these rosters to verify eligibility, however, if a member is not listed on the roster and says that he/she belongs to the provider's panel, the provider should verify eligibility by accessing the Member Eligibility section of our web site or by calling Member Services. Member Enrollment Rosters are available on our web site at www.healthfirst.org/providers.

Newborns

When a Healthfirst member is pregnant, the PCP should notify Member Services and Medical Management as soon as the pregnancy is confirmed. The mother's name, member ID number, the choice of PCP for the infant and the anticipated date of delivery should be provided at this time. Hospitals must notify Medical Management of all deliveries within one (1) business day of the child's birth. Hospitals must also provide Healthfirst with the newborn's Client Identification Number (CIN).

All newborns of Medicaid-eligible mothers are automatically assigned to the mother's managed care plan at birth. Healthfirst Providers are required to accept a mother's Healthfirst enrollment as sufficient proof of the newborn's enrollment in the mother's plan. The mother does not have to produce a Medicaid or Healthfirst ID for the infant.

Early notification of the pregnancy enables Healthfirst staff to ensure that a PCP is selected for the infant before the actual delivery takes place and that the member is offered Care Management prenatally and post-partum. The only exceptions to this policy are newborns that meet the exclusion criteria listed in the Medicaid Managed Care Exclusions table (see Appendix III). These infants are excluded from enrollment in any Medicaid managed care plan.

PCP Selection

Healthfirst members select a PCP upon enrollment. If no PCP is indicated on the enrollment form, Healthfirst will assign a PCP and issue notice to the member. Healthfirst Member Services staff provides assistance with PCP selection and changes. PCP changes are effective immediately.

Involuntary Change of PCP (Requesting Member Transfer)

PCPs may wish to arrange the transfer of a member to another provider. The provider may request a transfer of a member when the following situations exist:

- Member is persistently noncompliant with a therapeutic regime
- Member is verbally abusive to provider or staff

- Member makes medically inappropriate demands or unreasonably refuses the provider's recommendations

Providers should initially speak with the member to try to resolve the issue(s). If that cannot be done or is not successful, the following steps should be followed:

- The member must receive a letter informing him/her that the PCP cannot remain his/her provider and the reason for this change
- The letter must indicate that the member will have thirty (30) days from receipt of the letter to select another PCP and must inform the member that he/she should contact Healthfirst Member Services for assistance, if necessary
- The member must be informed that the PCP will provide any needed care, medical services and/or prescriptions during the 30 day period
- The member must be informed that the PCP will provide the member's medical records to the new PCP if requested
- The letter to the member should be sent certified mail, return receipt requested in order to ensure that the member receives the letter
- A copy of the letter must be placed in the member's medical record
- A copy of the letter must be sent to the Provider Services Department
- The provider should contact Healthfirst Member Services, provide the member's name and Healthfirst ID number and inform them that the member requires assistance in selecting a new PCP

All of the above situations should be clearly documented in the medical record. For more information, please call Member Services at 1-866-463-6743.

Continuity of Care for New Members

In some situations, members enrolling with Healthfirst may continue care with their existing healthcare provider for a 60-day transitional period when there is a life-threatening, degenerative or disabling disease or condition under treatment. New members in the second trimester of pregnancy at the effective date of enrollment will be allowed to continue with their existing provider through the post-partum care associated with the delivery. Services received during this period must be consistent with the scope of benefits available to Medicare or Medicaid recipients, or those covered under the CHPlus program.

Non-participating providers who care for Healthfirst members during a transition period must adhere to the Healthfirst quality assurance protocols, policies and procedures and must accept Healthfirst reimbursement rates. Further, the practitioner will provide Healthfirst and the member's new Healthfirst provider with medical information relevant to the member's care.

New members may have preexisting appointments arranged for specialty care that were scheduled before their Healthfirst membership became active and the appropriate Healthfirst referral generated. If a new Healthfirst member presents in your office under these circumstances and does not have a referral from their Healthfirst PCP, please call Medical Management for assistance.

Disenrollment

There are two (2) types of disenrollment processes: voluntary and involuntary. Members may elect to disenroll from Healthfirst or Healthfirst may disenroll members for a variety of reasons.

Voluntary Disenrollment

Medicaid members may disenroll or transfer from Healthfirst after the 90-day grace period or for a "good cause" reason during the nine-month lock-in period. To disenroll from a Healthfirst program, such as CHPlus,

members may contact the Member Services Department. For the Medicaid managed care program, members should contact New York Medicaid CHOICE at 1-800-505-5678. New York Medicaid CHOICE now processes all plan disenrollments. Medicare members should contact Medicare at **1-800-633-4227** or **TTY 1-877-486-2048** for the hearing and speech impaired. Please note that there are restrictions on when and how Medicare beneficiaries can disenroll from Medicare plans. PCPs will be notified of all member disenrollments affecting their panels through the monthly enrollment rosters.

Involuntary Disenrollment

Healthfirst will not, either verbally or in writing, or by any action or inaction, request or encourage a member to disenroll from a Healthfirst program. However, there may be circumstances that require Healthfirst to involuntarily disenroll a member. These are as follows:

- The member moves out of the Healthfirst service area
- The member loses Medicare or Medicaid eligibility or is no longer eligible for CHPlus coverage
- A member supplies fraudulent information or makes misrepresentations on the enrollment application that materially affects his or her eligibility to enroll in Healthfirst
- A member's behavior is disruptive, unruly, abusive or uncooperative to the extent that the Healthfirst practitioner's ability to provide services is impaired (except where such behavior is related to an underlying physical and/or mental condition such as Tourette's Syndrome)
- A member knowingly permits abuse or misuse of the Healthfirst membership card
- A member who is enrolled in CHPlus, Increased Benefits Plan, Life Improvement Plan, Maximum Plan or a commercial plan that has premium obligations fails to pay premiums. Reasonable efforts will be made to secure receipt of delinquent premiums; however, Healthfirst reserves the right to disenroll members under these circumstances if acceptable mitigating circumstances are not demonstrated

Commercial Plans Enrollment and Disenrollment

Enrollment

Individuals and families can enroll in Healthfirst Leaf plans through the NY State of Health website or in HMO A-D plans directly through Healthfirst. The following individuals are eligible to sign up for a Healthfirst Leaf Plan:

- Are under 65, are uninsured, and can't get health insurance through their job.
- Don't currently have health insurance.
- Are underinsured. People are considered underinsured if their insurance plan does not cover the Essential Health Benefits required by the ACA.
- Live within the five boroughs of New York City or Nassau County.

Members must pay their monthly premiums to maintain enrollment in the health plan. Members who receive federal premium subsidies have a 90 day 'grace period' to pay their premium, and members who do not receive subsidies have a 30 day grace period to pay their premium in full, should they miss a payment. Members may enroll in a health plan during Open Enrollment. The open enrollment period for 2015 when members can choose and enroll in a plan is 11/15/2014 – 1/15/2015.

Newborns

When a Healthfirst member is pregnant, the PCP should notify Member Services and Medical Management as soon as the pregnancy is confirmed. The mother's name, member ID number, the choice of PCP for the infant and the anticipated date of delivery should be provided at this time. Hospitals must notify Medical Management of all deliveries within one (1) business day of the child's birth. Hospitals must also provide

Healthfirst with the newborn's Client Identification Number (CIN).

PCP Selection

Healthfirst members select a PCP upon enrollment. If no PCP is indicated on the enrollment form, Healthfirst will assign a PCP and issue notice to the member. Healthfirst Member Services staff provides assistance with PCP selection and changes. PCP changes are effective immediately.

Voluntary Disenrollment

Healthfirst Leaf Plan members may disenroll or transfer from Healthfirst during the open enrollment period or after a qualifying event. A qualifying event is any event that results in a change of income or family size such as marriage, divorce, birth of a child, loss of job. To disenroll from a Healthfirst program, members may contact the NY State of Health website or the Member Services Department.

Involuntary Disenrollment

Healthfirst will not, either verbally or in writing, or by any action or inaction, request or encourage a member to disenroll from a Healthfirst program. However, there may be circumstances that require Healthfirst to involuntarily disenroll a member. These are as follows:

- The member moves out of the Healthfirst service area
- The member gains Medicaid eligibility
- A member supplies fraudulent information or makes misrepresentations on the enrollment application that materially affects his or her eligibility to enroll in Healthfirst
- A member's behavior is disruptive, unruly, abusive or uncooperative to the extent that the Healthfirst practitioner's ability to provide services is impaired (except where such behavior is related to an underlying physical and/or mental condition such as Tourette's Syndrome)
- A member knowingly permits abuse or misuse of the Healthfirst membership card
- A member who is enrolled a commercial plan that has premium obligations fails to pay premiums. Reasonable efforts will be made to secure receipt of delinquent premiums; however, Healthfirst reserves the right to disenroll members under these circumstances if acceptable mitigating circumstances are not demonstrated

4.4 Eligibility Verification

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

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

View the Member ID Card

Each Healthfirst member is issued an identification card which includes the member's PCP, affiliated hospital, and mental health and substance abuse benefits manager, as well as other identification and informational items. If a Healthfirst member is eligible for dental coverage, the dental phone number will be printed on the

member ID card. Medicaid members should keep their Healthfirst Medicaid, Managed Care, and Medicaid identification cards together, since some benefits can be accessed only through the Medicaid card. Go to www.healthfirst.org to view a sample of member ID cards for all Healthfirst products.

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

Verify Online (www.healthfirst.org/providers)

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

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

Check the Member Enrollment Roster

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

Check eMedNY

Codes:

- **Code SF** to verify enrollment in the Healthfirst Medicaid plan
- **Code Y8** to verify enrollment in the Healthfirst Medicare/Medicaid integrated Maximum Care Plan (MAX) Plan
- **Code MH** to verify enrollment in the Healthfirst Medicare/Medicaid with Long Term Care benefits for CompleteCare (CC) Plan

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

information.

Commercial Plans

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

- Call Provider Services at **1-888-801-1660**
- Log on to the provider portal, www.healthfirst.org/providers

4.5 Member Rights and Responsibilities

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

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

Members Have the RIGHT to:

- High-quality healthcare services provided in a professional and responsible way
- Choose a PCP
- Complete and current information about available treatments, including diagnosis and prognosis as applicable, in terms the member can be expected to understand
- Have information provided to an appropriate person acting on the member's behalf when it is not appropriate to give such information directly to the enrollee
- Access to assistance for medical care through the PCP's office by telephone 24 hours a day, 7 days a week
- Privacy and confidentiality of their healthcare records, except as otherwise provided by law
- Refuse treatment, as far as the law allows, and to understand the consequences of refusing treatment
- Receive information as necessary to give informed consent prior to the start of any procedure
- Express their concerns or complaints to Healthfirst and receive a timely response
- Receive considerate and respectful medical care and treatment from Healthfirst staff and providers without discrimination due to race, color, sex, age, national origin, sexual orientation, and/or physical or mental condition
- Accept or refuse medical treatment, including life-support treatment

- Information regarding advance directives

Members Have the RESPONSIBILITY to:

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

Commercial members

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

4.6 Member Services and Education

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

New Member Outreach and Orientation

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

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

As part of the mandatory Medicaid managed care program, Maximus, the enrollment broker, issues health risk assessment questionnaires to newly enrolled individuals and families as part of the enrollment process. Healthfirst also sends health risk assessment forms to new members and once annually to all existing Medicare Special Needs Plan (SNP) members (e.g., members in Healthfirst's Maximum, CompleteCare, and

Life Improvement Plans). Healthfirst uses these self-reported health assessment tools to better understand the member's health and lifestyle, their wellness, or specific service needs. Healthfirst encourages these members to visit their PCP as soon as possible to obtain services. In addition, Healthfirst Case Managers call members with complex medical needs to ensure that they receive appropriate attention and care.

Special Outreach and Care Management

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

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

Commercial Plans

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

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

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