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Welcome to Senior Health Partners (SHP)!

To maintain our standards of excellence and foster a positive and successful collaboration, please see a list of contact information that you should find useful in working with SHP staff.

We welcome your thoughts and ideas at any time, and look forward to seeing you at our scheduled provider orientation session. We schedule individual training sessions with providers, as well as training sessions focused on small and large groups. These sessions are a wonderful opportunity to meet other affiliated providers, learn more about how SHP operates, what you can expect from us and what we expect from you.

In addition, we distribute a comprehensive Provider Manual at the time of contract and we offer 24-hour access to claim, member eligibility, authorization and policy/procedure information on our secure provider website available at www.shpny.org. We update our providers regularly through real-time electronic notifications, quarterly electronic provider newsletters and, when needed, through formal postal mailings. To keep you up to date, we need to be kept abreast of any operational or staffing changes on your end so we can update our provider profile. Our Provider Services staff can be reached at 1-877-737-2693 to answer your questions and direct you to additional SHP resources.

We look forward to a long and successful collaboration with you, and thank you in advance for your cooperation. Together we will provide our members with the excellent quality of care they have come to expect.
1.2 Introduction to Senior Health Partners

What is Senior Health Partners?

- Senior Health Partners has a proud history of serving New York City since 2001.
- Senior Health Partners is a New York State Managed Long Term Care Plan (MLTCP) capitated by the Medicaid program. Members are free to choose their own providers.
- Senior Health Partners provides and coordinates services that are typically covered by Medicaid. However, we will also coordinate services covered by Medicare.
- Senior Health Partners provides access to services 24 hours a day, seven days a week, 365 days a year to ensure that members receive the care they need.

Who is eligible to enroll in Senior Health Partners?

To become a member of Senior Health Partners, you must:

- Be 21 years of age or older
- Be a resident of Manhattan, Brooklyn, Queens, Staten Island, or the Bronx, or of Nassau or Westchester counties
- Be Medicaid eligible or be willing to private pay
- Be an individual who has been assessed eligible for nursing home level of care (as of the time of enrollment)
- Require community-based long-term care services (CBLTCS) offered by Senior Health Partners (SHP) for more than 120 days from the date of enrollment. You must require at least one of the following services for more than 120 days from the effective date of enrollment:
  o Nursing services in the home
  o Therapies in the home
  o Home health aide services
  o Personal care services in the home
  o Adult day health care
  o Private duty nursing
  o Consumer Directed Personal Assistance Services
- With the exception of certain districts designated as mandatory for permanent nursing home enrollment, the individual must be capable at the time of enrollment of returning to or remaining in their home and community without jeopardy to their health and safety based on Department of Health criteria
- Agree to receive all covered services through Senior Health Partners
Section 2 - Members

2.1 How to Identify a Senior Health Partners Member

Every enrolled member receives one Senior Health Partners ID card in the mail. See examples below.

Member ID Card FRONT

![Member ID Card FRONT image]

Member ID Card BACK

![Member ID Card BACK image]
2.2 Member Rights and Responsibilities

Rights and Responsibilities of a Senior Health Partners Member

Senior Health Partners members have the right to:

- Receive medically necessary care
- Timely access to care and services
- Privacy about their medical record and when they get treatment
- Get information on available treatment options and alternatives presented in a manner and language they understand
- Obtain information in a language they understand; members can receive oral translation services free of charge
- Receive information necessary to give informed consent before the start of treatment
- Be treated with respect and dignity
- Receive a copy of their medical records and ask that the records be amended or corrected
- Take part in decisions about their healthcare, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion
- Be told where, when, and how to get the services they need from their managed long-term care plan, including how they can get covered benefits from out-of-network providers if they are not available in the plan network
- Complain to the New York State Department of Health or their Local Department of Social Services; and the right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate
- Appoint someone to speak for them about their care and treatment
- Seek assistance from the Participant Ombudsman program known as the Independent Consumer Advocacy Network (ICAN)

Responsibilities of Members

To have the greatest benefit from enrollment in Senior Health Partners, members have the following responsibilities:

1. To Participate Actively in Their Care and Care Decisions
   - To communicate openly and honestly with you (their doctor) and Care Team about health and care
   - To ask questions to be sure they understand their Person Centered Service
Plan (PCSP) and to consider consequences of not following their PCSP. Their PCSP and changes to their PCSP will be discussed and documented as part of our monthly care management call.

- To share in care decisions and continue to be in charge of their own health
- To complete self-care as planned
- To keep appointments or inform the Care Team of the need to change appointments
- To use Senior Health Partners providers like you for care except in emergency situations
- To notify Senior Health Partners if they receive health services from other healthcare providers
- To participate in policy development by writing to us, or calling us, or being part of the member advisory council
- To read and understand their roles and responsibilities in accordance with the “Consumer/Designated Representative Acknowledgement of the Roles and Responsibilities for Receiving CDPAS” signed by members in receipt of said service

2. To Support the Senior Health Partners Program

- To appropriately express opinions, concerns and suggestions to their Care Team, or through the Senior Health Partners Complaints and Appeals Process.
- To review the Member Handbook and follow procedures to receive services.
- To respect the rights and safety of all those involved in their care and to assist Senior Health Partners in maintaining a safe home environment.
- To promptly notify their Care Team at Senior Health Partners of any of the following:
  - if they are leaving the service area
  - if they have moved or have a new telephone number
  - if they have changed doctors
  - any changes that may affect our ability to provide care

2.3 Member Co-payments

Senior Health Partners members do not have co-payments (co-pays) for services they receive. All the services members receive that are covered by Senior Health Partners and are facilitated by a Senior Health Partners network provider will be free to the member. Providers should not seek cost sharing or reimbursement from Senior Health Partner’s members. All claims submissions and requests for payment should be made through Senior Health Partners’ Claims Reimbursement process or discussed with the member’s Primary Care Management Team.

2.4 Non-English Speaking Members

Senior Health Partners contracts with a language assistance line to ensure we can properly communicate with all members. Members who do not speak English or who need information in other formats, such as large print or braille, should call 1-800-633-9717 and TTY 1-888-542-3821, 24 hours a day, 7 days a week to request information that meets their needs.
Senior Health Partners contracted providers are also expected to meet the language needs of our members. If you need assistance, please call 1-800-633-9717.

2.5 Impaired Members

In compliance with Americans with Disabilities Act (ADA) requirements, Senior Health Partners accommodates visually impaired and hearing impaired members.

Members who need information in other formats, such as large print or braille, should call 1-800-633-9717 and TTY 1-888-542-3821, 24 hours a day, 7 days a week to request information that meets their needs.

Contracted providers are also expected to meet the needs of Senior Health Partner's members in accordance with all ADA obligations and requirements. If you need assistance, please contact 1-800-633-9717.
Section 3 - Care Management Teams

3.1 Care Management

Care Management is a process that ensures consistent oversight, coordination, and support to members and their families in accessing Managed Long Term Care covered services, as well as non-covered services. Working with members, the Care Management team develops a care plan of all services members require. The mutually agreed upon care plan is reviewed and revised over time in response to the changing needs of the member. Senior Health Partners is dedicated to the provision of services that will enable members to remain safe and secure in their own homes.

Upon enrollment, a member will be assigned to a Primary Care Manager (PCM). Their PCM is responsible for managing the member’s chronic health problems, supported by the Clinical Consultant Team (CCT), including a nutritionist, nurses, and social workers with specialized knowledge of various clinical topics, and ample support staff to assist with the member’s care. The Primary Care Management Team monitors changes in their health status, provides appropriate care, and encourages self-help. Members may request to change any member of their Primary Care Management Team at any time.

The Primary Care Management Team is available to assist the members with any issue.

The Primary Care Management Team will “coordinate services” the member receives, and will communicate with the member’s doctors on an ongoing basis. “Coordinate services” means that the Primary Care Management Team may arrange appointments for the member, arrange for transportation to and from appointments, and communicate with other care providers, regarding services covered by Senior Health Partners, as well as services not covered by Senior Health Partners.

When needed, the Primary Care Management Team may also help a member modify the member’s home to improve safety and convenience and coordinate for assistance from family, friends, and neighbors.

By helping the member manage all aspects of their care, the Primary Care Management Team can identify problems early, prevent problems from getting worse, and help the member avoid trips to the hospital and emergency room.

3.2 Coordination of Services

Senior Health Partners coordinates services designed to keep members safely living in their own homes for as long as possible. Senior Health Partners does this by providing a comprehensive approach in the delivery of long-term care services. The Primary Care Manager—a nurse or social worker with support from specialty teams—is responsible for coordinating services needed by members. Every member has their own Primary Care Manager and Care Management support who works with the member and their family/caregiver to provide an optimal and safe care plan.

At enrollment, Senior Health Partners has clinical and non-clinical staff dedicated exclusively to facilitating newly enrolled members. The staff work together to ensure coordinated services are in place at enrollment. The Welcome Team provides care management and service coordination for the first month of enrollment. Newly enrolled members are then transitioned to their permanent Care Manager for ongoing services.

The Senior Health Partners Primary Care Manager coordinates the services members receive, and communicates with the doctors and other health care providers on an ongoing basis. The Primary Care Manager may schedule appointments for members and ensures transportation services are available to and from appointments.

Senior Health Partners members develop a unique and strong relationship with their Primary Care Manager, who acts as an advocate and liaison between providers and the member. The Primary Care Manager should be contacted whenever opportunities for improvement are identified. The Primary Care Manager will contact the provider’s staff when barriers are recognized and will work together to optimize
care and satisfaction. In addition, each Primary Care Manager has a network of resources within Senior Health Partners to assist them in their role.

**Service Authorizations**
Service authorizations are care decisions determined by Senior Health Partners with input from the member, family, physician, and other persons involved in the care of the member. Service authorizations ensure that covered services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished subject to the following:
- The services must be medically necessary
- The services furnished must reasonably be expected to achieve their purposes
- The services are authorized to maintain the member’s health and safety

**Procedures for authorizing services:**
- Once services are approved, the appropriate servicing provider is contacted by phone
- Upon authorization of the service, the member, the servicing provider, and/or requesting provider are provided a written notification of the authorization detailing the type, frequency, amount of service, duration and expected date of commencement
- Authorizations will be mailed to the member and faxed as well as mailed to the provider to confirm approval. Authorizations are also posted to the provider portal
- Providers should initiate providing services only upon receipt of written authorization to ensure payment. Servicing providers will receive written authorizations within 24 hours following a verbal approval, or the next business day. All authorizations are available on the provider portal.
Member Name: <<m_full_name>>
Member ID: <<m_id>>
Level of Care: <<Level I, Level II>>
Authorization Number: <<re_authorization_number>>
Approved Services:
<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>
<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>
<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>
<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>
<<re_procedure_code1>><<Comment Field Description>><< re_units_authorized1>>

SERVICE AUTHORIZATION

Dear «Prov_Firstname» «Prov_Lastname»:

Senior Health Partners has reviewed the request for service(s) for the member referenced above. Based on the information received, it has been determined that the service(s) are medically necessary and appropriate and therefore are approved. Senior Health Partners must be notified of any changes relating to the treatment plan or services approved.

This approval covers the period from <<re_referral_start_date>> to <<re_referral_end_date>>. The service(s) above are approved as part of the member’s plan of care. We will review the plan of care again at least every six (6) months or sooner if there is a change in the member’s health status or service needs.

Providers may not bill Senior Health Partners members under any circumstances for approved covered services.

This assessment of care has been made for coverage purposes and does not supersede the professional judgment of the provider of care. In all situations, the final decision regarding medical treatment remains with the provider and patient.
This authorization does not guarantee payment. Payment is based on the member’s active enrollment in Senior Health Partners at the time services are received. Coordination of benefits guidelines also apply.

Providers may confirm eligibility by contacting Senior Health Partners at 1-877-737-2693, our automated phone system is available 24 hours a day 7 days a week, live representatives are available Monday-Friday 9:00am-5:00pm or you can visit our website at www.healthfirst.org.

Senior Health Partners staff is here to assist with all our member’s healthcare needs. Should you have any questions, please call:

**Member Services Department 8:30am - 5:00pm (Monday - Friday)**

1-800-633-9717
TTY 1-888-542-3821

Sincerely,

Clinical Services Department

Healthfirst will reimburse providers at the applicable i) statutory rate (see NYS PHL 2807-c(a-2), 42 USCS § 1396u-2 and 1395w-22(k); ii) the Multiplan rate or iii) the Healthfirst fee schedule. If you do not agree to this reimbursement, you may call 1-855-709-3083 prior to services being rendered so that we may arrange for care with another provider

<<NYSDOH Approved 09/01/2016>>
Senior Health Partners, Managed Long-Term Care Plan
100 Church Street, New York, NY 10007
1-800-633-9717
TTY/TDD 1-888-542-3821

APPROVAL NOTICE

<<today_date_mmm_ddyyyy>>
<r_first_name> <<r_last_name>>
<r_address1>
<r_address2>
<r_city> <<r_state>> <<r_zip>>

Enrollee ID: <m_id>
Coverage type: <<m_coverage_plan_name>>
Service: [describe requested or claimed service including: amount/duration/date of service]
Provider: <<sp_full_name>>
Plan Reference Number: <<re_authorization_number>>

Dear <<m_full_name>>:

You are getting this notice because your health plan has approved your Outpatient Service.

On <<insert auth request date>> you asked Senior Health Partners, Managed Long-Term Care Plan for the service listed above.

Senior Health Partners Plan has decided this service is [a covered benefit] [medically necessary] [approved to be provided by an out-of-network provider].

[[Provider Name] is a [participating provider.] [an out of network provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any].

This approval does not guarantee payment. Payment is based on your active enrollment in Senior Health Partners Plan at the time you received the service. Your provider may confirm eligibility by contacting Senior Health Partners Plan at 1-877-737-2693, our automated phone system is available 24 hours a day 7 days a week, live representatives are available Monday to Friday 9:00am-5:00pm or your provider can visit our website at www.healthfirst.org. Coordination of benefits guidelines may also apply.

This review was done for coverage purposes and does not replace the professional opinion of your provider of care. The final decision about treatment belongs to you and your provider.

If you would like to speak to Senior Health Partners Plan about this decision, please call 1-800-633-9717.

<<SHP18_39 NYSDOH Approved 02142018>>
You can file a complaint about your managed care at any time with the New York State Department of Health by calling 1-866-712-7197.

Sincerely,

Clinical Services Department

cc: Requesting Provider

(Insert as applicable) [At your request, a copy of this notice has been sent to:

[Enrollee Representative(s)]

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, “Healthfirst”). Coverage for Senior Health Partners, Managed Long-Term Care Plan, is provided by Healthfirst PHSP, Inc.

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Home Health Care Determinations
Effective January 1, 2010, subdivision 3 of PHL 4903 was amended to change the timeframe for utilization review determinations of home health care following an inpatient hospital admission. Typically, the request for these home health care services following an inpatient stay is for skilled services and is reimbursable by Medicare.

If a service is Medicare qualified, it is the provider’s responsibility to determine if the member is Medicare eligible. If the member is Medicare eligible and the service is Medicare qualified, the provider must bill Medicare, and Senior Health Partners will be responsible for the co-pay of covered services.

Senior Health Partners will furnish utilization review determinations of home health care services following a Medicare denial or exhaustion of a Medicare benefit following an inpatient hospital admission: i.e., in a general hospital that provides inpatient care or inpatient services in an Article 28 rehabilitation facility, as follows:

• Within one business day of receipt of the necessary information OR
• Within 72 hours of receipt of the necessary information if the day after the request for services falls
on a weekend or holiday

If a request for home health care services and all necessary information is provided to Senior Health Partners prior to a member’s inpatient hospital discharge, Senior Health Partners will make arrangements to coordinate benefits with the Medicare plan. If no Medicare insurance plan is in place, Senior Health Partners shall not deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the determination is pending.

An appeal of a denial for home healthcare services following a discharge from a hospital admission will be treated as an expedited appeal.

Reports of Services Rendered
Providers are required to provide written reports to care managers following authorizations for service evaluations and after services provided to members. Payments may be deferred due to delays in receipt of required reports.

3.7 Covered, Coordinated and Non-Covered Services

Covered Services
- Care management
- Home health care (home health aide, PT, OT, SP, and medical social services)
- Nursing services
- Private duty nursing
- Non-emergent transportation
- Podiatry and routine care
- Optometry (including eyeglasses)
- Audiology, hearing aids and batteries
- Dental care
- Prosthetics and orthotics
- Medical equipment and supplies
- Enteral and parenteral nutritional supplements (limitations may apply)
- Personal emergency response system
- Social and environmental supports
- Dietary counseling
- Nursing home care
- Respiratory therapy
- Outpatient physical, occupational and speech therapies (Limited to 20 outpatient visits of each therapy type per calendar year, except for children under 21 and the developmentally disabled- Healthfirst may authorize additional visits for this population)
- Adult day health care
- Personal care
- Consumer Directed Personal Assistance Service
- Social day care
- Home-delivered or congregate meals
- Nutrition
- Telehealth
- Nursing home care (residential health care facility)
- Room and board for hospice care services

Coordinated Services and Noncovered Services
Your care team will coordinate medical services not covered by Senior Health Partners to help you remain at your best.

- In-patient and outpatient hospital services
- Laboratory and radiology/radioisotope services
- Prescription and non-prescription drugs, compounded prescriptions
- Physician services
Mental health services
Alcohol and substance abuse services
Chronic renal dialysis
Emergency transportation
Family planning service
Rural health clinic services
OPWDD services
Services listed in the Title XIX State Plan

3.8 Assessments of Members

The member must be determined eligible for long-term care services (CBLTCS)* by the Conflict Free Evaluation and Enrollment Center (CFEEC) before joining a Managed Long-Term Care Plan like Senior Health Partners. Once the member is determined eligible, the member has sixty (60) days to select a Managed Long-Term Care Plan like Senior Health Partners for enrollment.

The CFEEC is a statewide resource that will provide independent and conflict-free evaluation, education and enrollment services for new applicants in need of community based long-term care services. In New York, Maximus (New York Medicaid Choice) serves as the independent and conflict-free entity. This policy does not apply to individuals transferring from one plan to another or from one Managed Long-Term Care product to another. All new Managed Long-Term Care enrollees may contact the CFEEC at 1-855-222-8350. The member may call anytime Monday to Friday, 8:30 am to 8:00 pm or on Saturday, 10:00 am to 6:00 pm.

Once New York Medicaid Choice determines that a consumer is eligible for community based long-term care for more than 120 days, the consumer can choose a Managed Long-Term Care Plan. The consumer has several weeks to select a plan; however, the CFEEC evaluation will remain valid for 60 days. After such time, a new evaluation will be required if the consumer does not select a plan but continues to seek CBLTC.

Enrolling in Senior Health Partners is voluntary. If the member is interested in joining Senior Health Partners, the member or a member’s representative can call Senior Health Partners and our staff will assist clients new to Managed Long-Term Care in contacting New York Medicaid Choice to find out more about our program. If the member is 21 years of age or older, lives in our service area, has completed a New York Medicaid Choice evaluation, and has chosen Senior Health Partners, our Enrollment Medicaid Specialist will come to the member’s home to share more information about our program, at which time we will be able to collect more information about the member and their health care needs. The member may have a family member, or anyone else the member may wish, present when the Enrollment Medicaid Specialist comes to their home. If the member is still interested in joining Senior Health Partners after our Enrollment Medicaid Specialist has described the program to the member, our Enrollment Medicaid Specialist will confirm their Medicaid eligibility.

Medicaid eligibility must be reviewed and established for potential enrollees by the NYC Human Resources Administration or Local Department of Social Services
If the member does not currently have Medicaid, we will help the member apply for Medicaid coverage unless the member is a private pay member

Our Enrollment Medicaid Specialist will:
- Ask the member to sign an authorization for intake and nurse assessment, which allows the Clinical Eligibility Nurse to assess their healthcare needs and clinical eligibility
- Ask the member to sign a consent form that allows their healthcare providers to release their medical information to us
- Review the Member Handbook with the member

Our Clinical Eligibility Nurse will come to the member’s home within 30 (thirty) days of the request to join
Senior Health Partners or upon referral from the CFEEC to:
   Conduct an initial assessment
   If the member has Medicaid only, the initial assessment will determine if the member is eligible for
      nursing home level of care as required for enrollment
   Determine if the member requires community-based long-term care services offered by Senior Health
      Partners for more than 120 days
   Provide the member with information and the form regarding electing a Health Care Proxy
   Discuss the service needs with the member

After completing the initial assessment, our Clinical Eligibility Nurse will ask the member to sign the
Enrollment Agreement. By signing the Enrollment Agreement the member agrees to:
   Receive all covered services from Senior Health Partners and our network providers
   Participate in Senior Health Partners according to the terms and conditions described in the Member
      Handbook

During the time prior to their enrollment, the Welcome Team social worker will maintain contact with the
member to answer any of their questions, discuss the Person Centered Service Plan (PCSP), and help
the member with any service needs prior to their enrollment date.

A member's enrollment becomes effective on the first of the month. The member will receive their
membership letter and a Senior Health Partners membership identification card.
Following enrollment, their Primary Care Management Team will contact the member to review their
satisfaction with the PCSP and discuss any concerns the member may have. Changes in the PCSP can
be made as needed based on the member's needs. The Primary Care Management Team will ask the
member, their physician and their family/caregivers for input in development of changes in their PCSP. If
the member's services have been changed, the member will receive a letter explaining the change.

The PCSP changes as the member’s needs and condition change, and is re-evaluated at least every six
(6) months.
4.1 Network and Provider Relations

The Senior Health Partner's Provider Relations department maintains and supports the plan's provider network. The department is responsible for provider recruitment, contracting, credentialing, recredentialing, and education. Once providers join the network, Provider Relations staff schedule orientations to educate providers about Senior Health Partner's programs, policies, and procedures, and any other updates on plan information. The Provider Relations staff members work closely with the Claims and Quality Management departments in the review and resolution of complaints, provider reconsiderations, and provider appeals.

Provider Relations staff members review and update all contracts, as needed, and investigate and resolve all provider-related complaints. If you have any questions, please contact Senior Health Partners Provider Services line at 1-(877) 737-2693.

4.2 Provider e-Newsletter and Notices

Senior Health Partners contacts individual providers as needed to maximize care and service to members and oversee contractual requirements. Staff contact providers by telephone, and sends them periodic emails and a quarterly e-newsletter, to inform the providers of important updates in plan policies and procedures and to keep providers updated.

4.3 Provider Credentialing and Recredentialing

Senior Health Partners must complete a few steps before considering a provider a permanent part of its network. First, the provider must complete and return a completed provider application with the required supporting documents (e.g., copies of current Certificate of Liability, license/certification). The complete application package is then reviewed by the Medical Director for approval. After all required documentation is approved by the Medical Director, the provider package is presented to the Quality Management Committee for approval.

After the initial credentialing, all contracted providers must be recredentialed biannually, which requires that providers send updated information. The Senior Health Partners recredentialing process also involves a review of provider performance indicators, which may include the following:

- Member/family complaints;
- Information from quality improvement activities; and
- Member satisfaction surveys

If the recredentialing is denied, the provider is notified in writing of Senior Health Partners' decision and informed of his/her right to appeal that decision. Senior Health Partners may, at its option, terminate the Provider Agreement upon sixty (60) days written notice to the provider.

Effective October 1, 2009, newly licensed Health Care Professionals (HCPs), or HCPs relocating from another state who are joining the group practice of in-network providers, will be allowed to participate in Senior Health Partners' provider network only if they meet the participation and credentialing criteria outlined below.

- Senior Health Partners will make a determination within 90 days of receipt of a completed application. If no determination is made at that time, an HCP joining a group practice will be considered "provisionally" credentialed until a final determination is made
- If the final determination is denial, the HCP will revert to nonparticipating status. The group practice wishing to include the newly licensed or relocated HCP must agree to refund any payments made by Senior Health Partners for in-network services delivered by the provisionally
A credentialed HCP that exceed any out-of-network benefit. In addition, the provider group must agree to hold the member harmless from payment of any services denied during the provisional period.

- If Senior Health Partners offers a member transitional care and the transitional care is provided by a provisionally credentialed provider who was ultimately denied credentialing by Senior Health Partners, other medical group providers will assume responsibility for the member’s care. Medical groups are encouraged to provide full disclosure to members about a provider’s provisional status so that they can then determine whether to have a fully credentialed provider in charge of their care.

4.4 Provider Rights and Responsibilities and Dual Eligible Members

Provider Rights
Senior Health Partners’ participating providers can act within the lawful scope of their license to advise or advocate for members, and possess external appeal rights as follows:

1) Health Status or Plan of Care options (including sufficient information to enable the member to decide among various care plan options);

2) Filing a complaint or making a report or comment to an appropriate governmental body regarding Senior Health Partners’ policies if the provider believes that the policies negatively impact the quality of care or access to care; and

3) Effective January 1, 2010, Public Health Law 4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations (see Manual Sections 5–7).

Provider Responsibilities
Senior Health Partners’ participating providers’ responsibilities include, but are not limited to:

1) Provide quality care.

2) Provide care within scope of practice (as defined by Senior Health Partners) and in accordance with Senior Health Partners access, quality, and participation standards.

3) Adhere to Senior Health Partners’ clinical guidelines (see Section 1.3—Provider Agreement).

4) Provide optimal care to members without regard to age, race, sex, religious background, national origin, and disability, and sexual orientation, source of payment, veteran status, claims experience, social status, health status, or marital status.

5) Comply with the Americans with Disabilities Act (ADA) guidelines set forth by the New York Department of Health; e.g., wheelchair access.

Dual Eligible Members
If a service is Medicare qualified, it is the provider’s responsibility to determine if the member is Medicare eligible. If the member is Medicare eligible and the service is Medicare qualified, the provider must bill Medicare, and Senior Health Partners will be responsible for the copay of the covered service.

Senior Health Partners’ Responsibilities to Providers
Senior Health Partners recognizes its obligation to assure participating providers the following:

a) Comprehensive plan training and orientation programs
b) Timely and ongoing communication from knowledgeable staff

c) Timely payment for covered services rendered to members

d) Timely responses to questions or concerns

e) Assistance with complex member issues

f) Timely resolution of grievances and appeals

4.5 Provider Nondisclosure and Confidentiality

The Health Insurance Portability and Accountability Act (‘‘HIPAA’’)

The HIPAA Privacy Rule requires providers to take reasonable steps to protect and safeguard the Protected Health Information (‘‘PHI’’) of members/patients. A member’s PHI is subject to the protections established by the Privacy Rule and under the contractual relationship between Senior Health Partners and the member, and between Senior Health Partners and the provider. PHI includes information regarding enrollment with Senior Health Partners, medical records, claims submitted for payment, etc. Such PHI must be safeguarded and held in strict confidence so as to comply with applicable privacy provisions of State and Federal laws, including the Health Insurance Portability and Accountability Act (HIPAA). Ways in which a provider can protect member/patient PHI include ensuring that only authorized provider office employees have access to member/patient charts, including limited information on member/patient sign-in sheets and restricting non-employees from being in areas of the office that contain member/patient records.

Member Authorization and Consent

Authorization must be obtained from the member/patient or qualified person before any personal health information can be released to an outside organization or agency, unless release of that information is legally required or permitted. Senior Health Partners members sign an authorization at the time of enrollment that allows Senior Health Partners to review, release, and use their respective PHI. In addition, at the time of the initial encounter with each Senior Health Partners member, direct medical care providers are required to obtain the member’s written consent to disclose personal health information to Senior Health Partners, and provide the member with a copy of their Privacy Notice indicating that their PHI will be shared with Senior Health Partners and other entities. This written consent and written acknowledgement of the provider’s Privacy Notice are to be maintained in the provider’s records and are subject to audit by Senior Health Partners. All providers should take all reasonable measures to protect the privacy and confidentiality of the member’s nonpublic personal information at all times, and to prevent the use or disclosure to any non-affiliated third party.

All providers should remain aware that PHI about the provision of substance abuse services, and those that identify the presence of HIV-related illness, are governed by a special set of confidentiality rules. Release of these records requires a special authorization. They should not be released to anyone other than the patient except under tightly defined and controlled circumstances. If you have any questions regarding the disclosure of Senior Health Partners member’s information, please call 1-212-324-2600.

Confidentiality of HIV-related Information

HIV-related information is any information that shows a person:

- Had an HIV-related test (such as an HIV antibody test, PCR test, CD4 test for HIV, viral load test, or other test);
- Has HIV infection, HIV-related illness, or AIDS;
- Has been exposed to HIV; or
- Has one of these conditions, including information on the individual's contacts
All providers must develop policies and procedures to assure the confidentiality of HIV-related information. Such policies and procedures shall assure that such information is disclosed to employees or contractors only when appropriate. Such policies and procedures shall include:

- develop and implement policies and procedures to maintain the confidentiality of confidential HIV-related information
- initial employee education and annual in-service education of employees
- maintenance of a list of job titles and the specific employee functions within those titles for which employees are authorized to access such information
- procedures to limit access to trained staff (including contractors)
- protocols for ensuring that records are stored appropriately (including electronic storage)
- procedures for handling requests by other parties for confidential HIV-related information
- protocols prohibiting employees/agents/contractors from discriminating against persons having or suspected of having HIV infection
- review of the policies and procedures on at least an annual basis

**Members’ Access to Medical Records**

The HIPAA Privacy Rule gives Senior Health Partners members the right to access, review, copy, and request amendments to his or her medical records held by providers. Senior Health Partners members or other individuals authorized by the member may submit a written request to his or her provider for a copy of such medical records. Additionally, a member or a member’s representative may challenge the accuracy of the information in the medical records. Providers should have appropriate policies and procedures in place to address such requests for medical records.

**Nondisclosure**

Providers and employees, agents, or independent contractors of the provider (all of whom shall be deemed to be the Provider for the purposes of this section) may not disclose to third parties Senior Health Partners Trade Secret and Intellectual Property, regardless of whether such information is marked or designated "confidential," without the prior written consent of Senior Health Partners. In addition, the Provider must take commercially reasonable steps to safeguard Senior Health Partners Trade Secret and Intellectual Property to prevent its unauthorized or improper use or copying.

**Return of Trade Secret and Intellectual Property**

Upon termination of the Provider’s Agreement for any reason, the provider promises to return (or destroy, at the option of Senior Health Partners) any and all material that falls under Senior Health Partners Trade Secrets and Intellectual Property to Senior Health Partners or Senior Health Partners’ designee.
4.6 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE EFFECTIVE DATE OF THIS NOTICE IS JULY 1, 2016.

At Healthfirst (made up of Healthfirst, Inc., Healthfirst PHSP, Inc., Healthfirst Health Plan, Inc., and Senior Health Partners, Inc.), we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, provide you this notice, and abide by the terms of this notice. This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights as our valued customer and how you can exercise those rights. Healthfirst is sending this notice to you because our records show that we provide health and/or dental benefits to you under an individual or group policy.

This notice applies to Healthfirst, Inc., Healthfirst PHSP, Inc., Healthfirst Health Plan, Inc., and Senior Health Partners, Inc. We are required to follow the terms of this notice until we replace it, and we reserve the right to change the terms of this notice at any time. If we make material changes to our Privacy practices, we will revise it and provide a new Privacy Notice to all persons to whom we are required to give the new notice within 60 days of the change. We will also post any material revision of this notice on our Healthfirst, Inc. website. We reserve the right to make the new changes apply to your health information maintained by us before and after the effective date of the new notice. Every three years, we will notify our members about the availability of the Privacy Notice and how to obtain it.

Healthfirst participates in an Organized Health Care Arrangement (OHCA) under the Health Insurance Portability and Accountability Act. An OHCA is an arrangement that allows Healthfirst and its hospital partners covered by this notice to share protected health information (PHI) about their patients or plan members to promote the joint operations of the participating entities. The organizations participating in this OHCA may use and disclose your health information with each other as necessary for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive, and for any other joint healthcare operations of the OHCA.
The covered entities participating in the OHCA agree to abide by the terms of this notice with respect to PHI created or received by the covered entity as part of its participation in the OHCA. The covered entities are: Mount Sinai Health System (Mount Sinai Hospital, Mount Sinai Beth Israel, Mount Sinai St. Luke’s, Mount Sinai West Roosevelt), St. Barnabas Hospital, Medisys Health Network, Maimonides Medical Center, Bronx Lebanon Hospital, NYC Health & Hospitals, The Brooklyn Hospital Center, NorthWell Health, Montefiore Medical Center, Stony Brook University Medical Center, Interfaith Medical Center, St. John’s Episcopal Hospital, SUNY-Downstate Medical Center/University Hospital of Brooklyn and NuHealth. The covered entities, which comprise the OHCA, are in numerous locations throughout the greater New York area. This notice applies to all these sites.

The covered entities participating in the OHCA will share protected health information with each other as the information is necessary to carry out treatment, payment, or healthcare operations. The covered entities that make up the OHCA may have different policies and procedures regarding the use and disclosure of health information created and maintained in each of their facilities. Additionally, while all of the entities that make up the OHCA will use this notice for OHCA-related activities, they may use a notice specific to their own facilities when they are providing services at their organizations. If you have questions about any part of this notice or if you want more information about the OHCA-covered entities, please contact the Privacy Office at 1-212-801-6299.

How We Use or Share Information
In this notice, when we talk about “information” or “health information,” we mean information we receive directly/indirectly from you through enrollment forms, such as your name, address, and other demographic data; information from your transactions with us or our providers, such as medical history, healthcare treatment, prescriptions, healthcare claims and encounters, health service requests, and appeal or grievance information; or financial information pertaining to your eligibility for governmental health programs or pertaining to your payment of premiums.

Permissible Uses and Disclosures Without Your Consent or Authorization
The following are ways we may use or share information about you.

Healthcare Providers’ Treatment Purposes
We may disclose your health information to your doctor, at the doctor’s request, for your treatment; use the information to help pay your medical bills that have been submitted to us by doctors and hospitals for payment; share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, we may give them access to any
medical records sent to us by your doctor. We may use or share your information with others to help manage your healthcare. For example, we might talk to your doctor to suggest a disease-management or wellness program that could help improve your health.

**Healthcare Payment**
We may disclose your health information to obtain premiums; to obtain or provide reimbursement for your medical bills; to help a hospital or doctor determine your eligibility or coverage; for billing claims management and other reimbursement activities; for review of healthcare services with respect to medical necessity, appropriateness of care, or justification of charges; for utilization review activities including preauthorization, precertification, concurrent and retrospective review of services; and for disclosure to consumer reporting agencies of any protected health information related to the collection of premiums or other reimbursement.

**Healthcare Operations**
We may use and disclose your health information to conduct quality assessment and improvement activities; for underwriting, or other activities relating to the creation, renewal, or replacement of a contract of health insurance; share your information with others who help us manage, plan, or develop our business operations; to authorize business associates to perform data aggregation services; to participate in case management or care coordination. We will not share your information with these outside groups unless they agree to keep it protected, and we are prohibited from using or disclosing your genetic information for underwriting purposes. In some situations, we may disclose your health information to another covered entity for the limited healthcare operations activities and healthcare fraud and abuse compliance activities of the entity that receives your health information.

**Healthcare Services**
We may use or share your information to give you information about alternative medical treatments and programs or about health-related products and services that you may be interested in. For example, we might send you information about asthma, diabetes control, or health management programs. We do not sell your information to outside groups who may want to sell their products/services to you, such as a catalog company. We may disclose your health information to our business associates to assist us with these activities.

**Health Information Exchange**
We may use or share your information electronically via our Health Information Exchange to the hospitals and providers that participate in our OHCA. This information may include visit and clinical information including admissions, discharge, and transfer notifications, blood pressure readings, body mass indexes, visit summaries, and lab results. We may share information including filled pharmacy claims, medical encounters, and quality care gaps. We will not share information to any physician’s offices, hospitals, clinics, labs, or other sites that are not part of the OHCA.
As Required by Law
State and federal laws may require us to release your health information to others. We may be required to report information to state and federal agencies that regulate us, such as the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, New York State and City Departments of Health, Local Districts of Social Services, and New York State Attorney General.

We may also use and disclose your health information as follows:

- To someone who has the legal right to act for you (your personal representative, medical power of attorney, or legal guardian) in order to administer your rights as described in this notice;
- To report information to public health agencies if we believe there is a serious health or safety threat;
- To provide information to a court or administrative agency (for example, pursuant to a court order, subpoena, or child protective order);
- To report information to a government authority regarding child abuse, neglect, or domestic violence; report information for law enforcement purposes;
- To share information for public health activities;
- To share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others;
- For research purposes in limited circumstances;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To an organ procurement organization in limited circumstances; and
- To prevent serious threat to your health or safety or the health or safety of others.

Permissible Uses and Disclosures With Your Consent or Authorization
If one of the above reasons does not apply to our use or disclosure of your health information, we must get your written permission prior to using or disclosing your health information. For example, most uses and disclosures of psychotherapy notes (if maintained by Healthfirst), uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require that we obtain your written authorization prior to disclosing the information. If you give us written permission to use or disclose your personal health information and you change your mind, you may revoke your written permission at any time. Your revocation will be effective for all your health information
we maintain, unless we have taken action in reliance on your authorization.

**Your Rights**
The following are your rights with respect to your health information that we maintain. You may make a written request to us to do one or more of the following concerning your health information:

- You have the right to request a copy of this notice to be mailed to you if you received this notice through means other than by U.S. mail. You can also view a copy of the notice on our website at www.healthfirst.org.

- You have the right to request copies of your health information. In limited situations, we do not have to agree to your request (e.g., information contained in psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and information subject to certain federal laws governing biological products and clinical laboratories). In certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed. You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or healthcare operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your healthcare or payment for your healthcare. While we may honor your request, we are not required to agree to these restrictions.

- You have the right to submit special instructions to us regarding how we send plan information to you that contains protected health information. For example, you may request that we send your information by a specific means (such as U.S. mail or fax) or to a specified address if you believe that you would be harmed if we send your information to you by other means (for example, in situations involving domestic disputes or violence). We will accommodate your reasonable requests as explained above. Even though you requested that we communicate with you through alternative means, we may provide the contract holder with cost information.

- You have the right to inspect and obtain a copy of information that we maintain about you in your “designated record set.” The designated record set is the group of records that we use in order to make decisions about you, and includes enrollment, payment, claims adjudication, and case management records.

- You have the right to ask us to make changes to information we maintain about you in your designated record set. These changes are known as amendments. Your written request must include a reason for your
request. Denied requests to amend will be communicated to you in writing, with an explanation for the denial. You have a right to file a written statement of disagreement.

- You have the right to receive an accounting of certain disclosures of your information made by us during the six (6) years prior to your request. We are not required to provide you with an accounting of the following disclosures:
  - Disclosures made prior to April 14, 2003;
  - Disclosures made for treatment, payment, and healthcare operations purposes;
  - Disclosures made to you, your personal representative, or pursuant to your authorization;
  - Disclosures made incident to a use or disclosure otherwise permitted;
  - Disclosures made to persons involved in your care or other notification purposes;
  - Disclosures made for national security or intelligence purposes;
  - Disclosures made to correctional institutions, law enforcement officials, or health oversight agencies; or
  - Disclosures made as part of a limited data set for research, public health, or healthcare operations purposes.

- You will be notified by Healthfirst following a breach of unsecured protected health information.

**Exercising Your Rights**

If you would like to exercise the rights described in this notice, please contact our Privacy Office (below), Monday through Friday, from 9am to 5pm, by phone, email, or in writing. We will provide you with the necessary information and forms for you to complete and return to our Privacy Office. In some cases, we may charge you a cost-based fee to carry out your request. If you have any questions about this notice or about how we use or share information, please contact the Healthfirst Privacy Office.

**Complaints**

If you believe that we have violated your privacy rights, you have the right to file a complaint with us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by calling or writing the Privacy Office (below). We will not take action against you for filing a complaint with us or with the U.S. Department of Health and Human Services:

**Healthfirst Privacy Office**
P.O. Box 5183
New York, NY 10274-5183
Phone: 1-212-801-6299
Email: HIPAAPrivacy@healthfirst.org

**Office for Civil Rights**
U.S. Department of Health
and Human Services
Jacob Javits Federal Building, Suite 3312
New York, NY 10278
O.C.R. Hotlines-Voice: 1-800-368-1019
TDD: 1-800-537-7697
Email: ocrmail@hhs.gov
Website: www.hhs.gov/ocr/
New York State Privacy Notice

What is this notice?
At Healthfirst, Inc. (made up of Healthfirst PHSP, Inc., Healthfirst Health Plan, Inc., Senior Health Partners, Inc., and Healthfirst Insurance Company, Inc.), we appreciate the trust our members place in us, and we recognize the importance and sensitivity of protecting the confidentiality of the non-public personal information that we collect about them. We collect nonpublic personal information from our members to effectively administer our health plans and to provide healthcare benefits to members of our health plans. Protecting this information is our top priority, and we are pleased to share our Privacy Policy with you.

What is Nonpublic Personal Information?
Nonpublic personal information ("NPI") is information that identifies an individual enrolled in a Healthfirst health plan (e.g., Child Health Plus, Healthfirst Medicare Plan, and Healthfirst Insurance Company, Inc.) and relates to: an individual’s enrollment in the plan; an individual’s participation in the plan; an individual’s physical or mental/behavioral health condition; the provision of healthcare to that individual; or payment for the provision of healthcare rendered to that individual. NPI does not include publicly available information, or information that is reported or available in an aggregate form, without any personal identifiers.

What types of NPI does Healthfirst collect?
Like all other healthcare plans, we collect the following types of NPI about our members and their dependents in the normal course of business in order to provide healthcare services to you.

- Information we receive directly or indirectly from you or city/state governmental agencies through eligibility and enrollment applications and other forms, such as: name, address, date of birth, social security number, marital status, dependent information, assets, and income tax returns.
- Information about your transactions with us, our affiliated healthcare providers or others, including, but not limited to, appeals and grievance information, claims for benefits, premium payment history medical records, and coordination of benefits information. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.
- Information about your activity on our website.

What NPI does Healthfirst use or disclose to third parties, and why?
We do not disclose NPI to anyone without your written authorization, except as permitted by law. If we were to do so in the future, we will notify you of such change in policy and advise you of your right to instruct us not to make such disclosure. At any time, you can tell us not to share any of your personal information with affiliated companies that provide offers other than our products or services. If you wish to exercise your opt-out option, or to revoke a previous opt-out request, you need to provide the following information to process your request: your name, date of birth, and your member identification number.
You can use any of the methods below to request or revoke your opt-out:

- Call us at 1-212-801-6299
- Email us at HIPAAprivacy@Healthfirst.org
- Send your opt-out request to us in writing:

  Healthfirst Privacy Office
  P.O. Box 5183
  New York, NY 10274-5183

How does Healthfirst treat NPI that relates to your personal health information? Healthfirst will not disclose any of your nonpublic health information without your written authorization, except as otherwise permitted by law. Nonpublic health information is individually identifiable information that we maintain relating to the provision of your healthcare or payment of your healthcare, including your medical records and claims payment information.

Under the law, Healthfirst is permitted to disclose nonpublic health information in order to administer your healthcare benefits, including; authorizing requests for healthcare services, payment of claims for services, ensuring quality improvement and assurance practices, resolving appeals or grievance inquiries, and any disclosure required to applicable governmental agencies.

If at any time in the future Healthfirst seeks to disclose your nonpublic health information in any manner not permitted under the law, we will send you a special consent form to complete and sign before we disclose your information.

What are Healthfirst’s Confidentiality and Security Policies for NPI?

We restrict access to NPI about you to those Healthfirst employees who need to know that information in order to provide services to you. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your NPI. Employees who violate our confidentiality or security policies are subject to disciplinary action, up to and including termination of employment.

Women’s Health and Cancer Rights Act of 1998

In accordance with the Women’s Health and Cancer Rights Act of 1998, your Healthfirst plan covers the following procedures for a person receiving benefits for a mastectomy:

- All stages of reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical or balanced appearance;
- Prostheses (artificial replacements) and treatment for physical complications of all stages of the mastectomy, including lymfedemas.
- Treatment of physical complications of the mastectomy, including lymfedema.

This coverage will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy. For answers to questions about this plan’s coverage of mastectomies and reconstructive surgery, call Member Services at the number shown on your member ID card.
Your Member Rights and Responsibilities

Your Rights
As a member of Healthfirst, you have a right to:

- Be cared for with respect, without regard to health status, sex, race, color, religion, national origin, age, marital status, or sexual orientation.
- Be told where, when, and how to get the services you need from Healthfirst.
- Be told by your PCP and other healthcare providers what is wrong, what can be done for you, and what will likely be the result in a language you understand.
- Get a second opinion about your care.
- Give your consent to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical records and talk about it with your PCP or healthcare provider, and ask, if needed, that your medical records be amended or corrected.
- Be sure that your medical records are private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use the Healthfirst complaint system, or to contact the New York State Department of Health or New York State Department of Financial Services any time you feel you were not fairly treated.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Your Responsibilities
As a member of Healthfirst, you agree to:

- Work with your PCP to guard and improve your health.
- Find out how your healthcare system works.
- Listen to your PCP’s advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat healthcare staff with the respect you expect yourself.
- Tell us if you have problems with any healthcare staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after hours.

Pursuant to federal rules that implement the Affordable Care Act, individual health insurance policies must be written on a calendar year basis beginning in 2015. This means that, for 2018 coverage, if your effective date of coverage is a date later than January 1, the initial term of coverage for your policy will be for less than a full year and will end on December 31, 2018. Please be advised that all benefits and cost sharing under your policy, including the full annual deductible, apply to the partial year of coverage. Please refer to the Schedule of Benefits in your enclosed policy for the dollar amount of your deductible.
4.7 Termination of Provider Agreement

Termination by Senior Health Partners
Senior Health Partners may, at its option, terminate this Agreement immediately and without notice to Provider in the event of: (i) conduct by Provider or Provider's employees or agents which in the sole judgment of Senior Health Partners poses imminent harm to an Enrollee(s); (ii) circumstances that result in Provider being legally unable to deliver the Covered Services specified herein; (iii) a determination by Senior Health Partners that Provider or Provider's employees or agents have engaged in fraud; (iv) a final determination by a state licensing board or other governmental agency that impairs Provider’s ability to provide services under this Agreement, including without limitation, a decision by DOH or its agents to suspend, terminate or deny approval to Provider to participate in the New York State Medicaid Program.

Termination by Providers
In the event that Senior Health Partners defaults in the performance of any material duty or obligation hereunder, Provider may, at its option, give Senior Health Partners written notice identifying the alleged default or breach, and if Senior Health Partners does not cure such default or breach within thirty (30) days, Provider may, at its option, terminate this Agreement upon thirty (30) days written notice to Senior Health Partners.

In the event a provider is no longer interested in participating with Senior Health Partners, please call the Senior Health Partners Provider Services line at 1-877-737-2693.

4.8 Provider Participation in Senior Health Partners’ Operations
Senior Health Partners values its relationship with providers and the unique perspectives that both parties bring to maximizing care and efficient operations. Informal access is available on an ongoing basis through communications with the Provider Relations department and other plan staff. Plan staff also reach out to providers regarding updates to policies or operational procedures to ensure timely and efficient services. Examples of formal input and participation by Senior Health Partners’ providers include internal committee involvement and completion of Provider Satisfaction Surveys.

Committee Participation
Selected providers may be requested to participate in committee activities. An example of this involvement occurs with Senior Health Partners’ Quality and Utilization Management (QUM) Committee. Participation is requested based on the event or issues to be explored.

Provider Satisfaction Survey Participation
While provider input is welcome at all times, Senior Health Partners conducts periodic surveys of provider satisfaction. Results are used to determine system and operational improvements to maximize clinical outcomes and operational effectiveness. Examples of actions taken as a result of satisfaction survey results include changes to staff meeting times to later in the morning to make staff more accessible to early-morning provider calls; the installation of a new telephone system that allows direct dialing to staff; a weekly internal communication system among our office managers, on-call staff, and our answering service; and the ability to patch provider after-hours calls through quickly in cases of emergency. Provider data is completed and returned in a confidential manner. The data is aggregated, with no individual identifiers noted.

4.9 Network Evaluation
The adequacy of the current provider network is reviewed and analyzed on an annual and ongoing basis. Our mission of service provision is to provide the appropriate
service, in the appropriate manner, at the appropriate time, with the appropriate provider.

Senior Health Partners monitors service outcomes by documentation of best practices or when service delivery does not match standards or are not delivered within the timeframes specified.

Tracking and trending of utilization and services provides an opportunity for Care Management Team members to report positive efforts by providers and their staff. Data are logged, and analyzed and used to identify best practices as well as provider and access issues, potential inadequacy of the network, and a need to expand the providers of service.
Section 5 - Billing Reimbursement Procedures

5.1 - Billing Reimbursement Procedures

Senior Health Partners is committed to providing the highest level of service in claims processing, including rapid reimbursement. Senior Health Partners also adheres to the New York State Insurance Department’s prompt payment requirement in Insurance Law §3224-a.

5.3 Provider Information

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

- Provider’s name and Tax ID number(s)
- Provider’s address, zip code, telephone or fax number
- Provider’s billing address
- Languages spoken in the provider’s office
- National Provider Identification Number (if applicable)
- Office hours
- Provider closes their agency to new business

Providers should call the Senior Health Partners Provider Services number at 1-877-737-2693 with any questions or fax all updates to the Provider Services department at 1-646-313-4634.

5.4 Fraud Waste and 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).

5.5 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
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 the Stark Law 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 federally funded 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
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., whistleblowers) 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 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 Whistleblowers**

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

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

The following are the applicable False Claims 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 healthcare 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 tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including healthcare programs such as Medicaid. The penalty for filing a false claim is $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 five years, a penalty of up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

**Social Services Law §145-c Sanctions**

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

**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 30 (thirty) 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 prepayment
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 15 (fifteen) times during the year and comprises 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

Prepayment Review

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

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 administrator (the “Vendor”) will notify the provider of the FWAC’s decision and that the provider will be on PPR for a period of at least six months. The FWAC will review 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 indicate 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 reconsideration (e.g., first-level appeal) within 90 (ninety) 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 must 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 conduct audits of claims that have previously been paid by Healthfirst. In such audits, the Vendor or the SIU will request documentation from providers which is required to be maintained in accordance with applicable laws, rules, and regulations; coding requirements; and contractual requirements. The Vendor then presents the audit outcome to the provider in 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 "Prepayment 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 5.5 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’s work 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 healthcare, and unnecessary costs to the Medicaid program are prevented.

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

- Vice President, 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 constitute fraud, waste, and/or abuse, we have provided some typical examples for your reference.

Fabrication of Claims: In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate member names and insurance information either to concoct entirely fictitious claims or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed. Examples are as follows:

- Submitting claims for services not rendered
- A provider who, using existing information on his or her members, creates claims for office visits or services that never took place
- A provider who, in the course of billing for actual member treatments, adds charges for X-rays or laboratory tests that were never performed
- A durable medical equipment provider submitting claims for equipment and supplies never delivered, or continuing to submit claims for rented equipment after it has been picked up

Falsification of Claims: In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim for the purpose of obtaining a payment to which he or she is not entitled. Examples are as follows:

- A provider performs medically unnecessary services solely in order to bill and be paid for doing so
- A provider falsifies symptoms or other diagnostic information in order to obtain payment for an uncovered service. This is somewhat more common in certain specialties, such as cosmetic surgery
- A provider falsifies the dates on which services were provided so that they fall within a given eligibility period of the member
- A provider falsifies the identity of the provider of services so as to obtain payment for services rendered by a noncovered and/or nonlicensed provider (e.g., 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 inducements 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 and Affiliates 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 Centers 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 and 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 that 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
By phone – 1-212-453-4495

By phone – 1-212-801-3292

**5.6 Requests for Review and Reconsideration of a Claim**

At times, a provider may be dissatisfied with a decision made by Senior Health Partners regarding a claim determination. Some of the common reasons include, but are not limited to, incorrectly processed or denied claim, the untimely submission of claims, or failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by Senior Health Partners must submit a written request for review and reconsideration with all supporting documentation to Senior Health Partners within **90 (ninety) calendar days** from paid date on the provider’s Explanation of Payment (EOP). Written requests, including attachments, must be mailed to the following location:

**Senior Health Partners Claims Department**

P.O. Box 958439
Lake Mary, FL 32795-8439

All written requests for Review and Reconsideration should include the following information: a copy of the EOP, the claim, any supporting documentation, and a written statement explaining why you disagree with Senior Health Partners’ determination as to the amount or denial of payment.

Examples of information and supporting documentation that should be submitted with a written request for review and reconsideration include:

- A written statement explaining why you disagree with Senior Health Partners’ claim determination
- Provider’s name, address, and telephone number
- Provider’s identification number
- Member’s name and Senior Health Partners identification number
- Date(s) of service
- Senior Health Partners claim number
- A copy of the original claim or corrected claim, if applicable
- A copy of the Senior Health Partners EOP
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting
medical records to demonstrate medical necessity
- Contract rate sheet to support payment rate or fee schedule
- Evidence of eligibility verification (e.g., copy of Senior Health Partners Member ID card)
- Evidence of timely filing
  - Please note: Senior Health Partners does not accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software, as proof of timely filing
- Copy of the approval number issued by the Care Management Team

Senior Health Partners will investigate all written requests for Review and Reconsideration and issue a written explanation—stating that the claim has been either reprocessed or the initial denial has been upheld—within 30 (thirty) calendar days from the date of receipt of the provider’s request for Review and Reconsideration.

**Senior Health Partners will not review or reconsider claims determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the 90 (ninety) calendar day timeframe, the request is deemed ineligible and will be denied. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for review and reconsideration is not timely filed. In such cases, providers may not bill members for services rendered.**

All questions concerning requests for review and reconsideration should be directed to the Provider Services unit at 1-877-737-2693.

### 5.7 Overpayment Recovery Appeals Process

Senior Health Partners periodically reviews payments made to providers to ensure the accuracy of the claim payments pursuant to the terms of the provider contracts, or as part of its continuing utilization review and fraud control programs. In doing so, Senior Health Partners may identify instances when we have overpaid a provider for certain services. When this happens, Senior Health Partners provides notice to the provider and recoups the overpayment consistent with Section 3224-b of the New York State Insurance Law.

Senior Health Partners will not pursue overpayment recovery efforts for claims older than 24 (twenty-four) months after the date of the original payment to a provider unless the overpayment is (1) based upon a reasonable belief of fraud, intentional misconduct, or abusive billing; (2) required by or initiated at the request of a self-insured plan; or (3) required by a state or federal government program. The above restrictions shall not apply to any overpayment recovery efforts made by Senior Health Partners prior to January 1, 2007 when notice has been provided to the provider of such recovery efforts.

In addition, we may at times apply the procedures described in this section in order to recoup duplication claims payments but reserve the right to use other procedures to do so. In addition, if a provider asserts that Senior Health Partners has underpaid any claim(s) to a provider, Senior Health Partners may offset any underpayments that may be owed against past overpayments made by Senior Health Partners dating as far back as the claimed underpayment.

**We Will Provide Notice of Overpayments Before We Seek Recovery**

If Senior Health Partners has determined that an overpayment has occurred, Senior Health Partners will provide 60 (sixty) days written notice to the provider of the overpayment and request repayment. This notice will include the member’s name, service dates, payment amounts, proposed adjustments, and a reasonably specific explanation of the reason for the overpayment and the proposed adjustment. In response to this notice, the provider may dispute the finding or remit payment, as outlined below.

**If You Agree That We Have Overpaid You**

Upon the receipt of a request for repayment, providers may voluntarily submit a refund check made
payable to Senior Health Partners within 60 (sixty) days from the date the overpayment notice was mailed by Senior Health Partners. Providers should further include a statement in writing regarding the purpose of the refund check to ensure the proper recording and timely processing of the refund.

If You Disagree That We Have Overpaid You

If a provider disagrees with Senior Health Partners’ determination concerning the overpayment, the provider must submit a written request for an appeal within 60 (sixty) days from the date the overpayment notice was mailed by Senior Health Partners and include all supporting documentation in accordance with the provider appeal procedure described in Section 5.4. If, upon reviewing all supporting documentation submitted by a provider, Senior Health Partners determines that the overpayment determination should be upheld, providers may initiate arbitration pursuant to their provider agreement. Senior Health Partners will proceed to offset the amount of the overpayment prior to the final determination made pursuant to appeal for reconsideration.

If You Fail to Respond to Our Notice of Overpayments

If a provider fails to dispute a request for repayment concerning an overpayment determination made by Senior Health Partners within 60 (sixty) days from the date the overpayment notice was mailed by Senior Health Partners, the provider is deemed to have acknowledged and accepted the amount demanded by Senior Health Partners and, subject to the provider’s right to arbitration pursuant to the provider agreement, Senior Health Partners will offset the amount outstanding against current and future claim remittance(s) until the full amount is recovered by Senior Health Partners.

If an Offset Results in a Negative Balance

If an overpayment offset results in a negative balance to the provider’s account, the provider will not receive an explanation of payment until the entire offset amount has been recovered. The provider will receive a weekly negative balance letter that states the current negative amount and any claim activity that has taken place since the check cycle period. Once the entire negative amount has been recovered, the provider will resume receiving explanation of payments.

5.8 Provider External Appeals – Effective January 1, 2010

Provider External Appeal Rights

Public Health Law 4914 was amended to extend external appeal rights to providers in connection with concurrent adverse determinations. A provider will be responsible for the full cost of an external appeal for a concurrent adverse determination upheld in favor of Senior Health Partners; Senior Health Partners is responsible for the full cost of an appeal that is overturned; and the provider and Senior Health Partners must evenly divide the cost of a concurrent adverse determination that is overturned in part.

The fee requirements do not apply to providers who are acting as the member’s designee, in which case the cost of the external appeal is the responsibility of the MCO. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member will require completion of the external appeal application (see Attached External Appeals Application and Instructions) and the standard designation forms delivered by the State. The Superintendent has the authority to confirm the designation or to request additional information from the member. Where the member has not responded, the Superintendent will inform the provider to file an appeal. A provider responding within the timeframe will be subject to the external appeal payment provision described above. If the provider is unresponsive, the appeal will be rejected.

Hold Harmless

Public Health Law was amended to add a new section 4917. A provider requesting an external appeal of a concurrent adverse determination, including a provider requesting the external appeal as the member’s designee, is prohibited from seeking payment, except applicable copays, from a member for services determined to be not medically necessary by the external appeal agent. Thus, members are held harmless in such cases.
New York State External Appeal Application

New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209

If an HMO or insurer (health plan) denies health care services as not medically necessary, experimental / investigational, a clinical trial, a rare disease treatment, or out-of-network, complete and send this application to the above address within 45 days of the plan’s final adverse determination. For help call 1-800-400-8882.

1. Applicant Name: ____________________________________________

(Please check one) [ ] Insured/Patient [ ] Patient’s Designee [ ] Provider

2. Patient Name: ____________________________________________

3. Patient Address: ____________________________________________

4. Patient Phone Number:
   Home(______) __________________ Work(______) __________________

5. Patient E-mail (if you want contact by e-mail): ____________________

6. Health Plan Name: ____________________________________________

7. If the patient is covered under a Medicaid Managed Care Plan, has the patient requested a fair hearing through Medicaid or received a fair hearing determination?
   Yes _______ No_______

8. Reason for Health Plan Denial: (Please check one.)
   [ ] Not medically necessary. [ ] Experimental / investigational.
   [ ] Clinical trial. [ ] The treatment is for a rare disease.
   [ ] Out-of-network and the health plan proposed an alternate in-network service.

9. Describe the service and the date(s) of service. Attach the final adverse determination from the first level of appeal with the health plan, or the health plan’s letter waiving the appeal, along with any other information you would like considered.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
10. If the patient has not received the service, the appeal may be expedited if the patient's physician fills out the attached form stating a delay will seriously threaten the patient's health. An expedited decision will be made in 3 days instead of 30 days, even if the patient or the patient’s physician do not provide needed medical information to the external appeal agent.

Is this a request for an expedited appeal? [ ] Yes [ ] No

11. If this is a request for an expedited appeal, an appeal of experimental / investigational services, a clinical trial denial, an out-of-network denial, or a rare disease treatment, the patient must give the attached Physician Attestation (pages 3-5) to the physician who prescribed the treatment. (See special rules for rare diseases on page 3.) The physician must complete the form and send it to the Insurance Department. (Please check one.)

[ ] I gave the form to my physician [ ] I did not give the form to my physician.

12. **External Appeal Fee:** You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you. (Please check one.)

[ ] I enclosed a check or money order made out to the health plan.

[ ] I faxed my application and will mail the fee to the Insurance Department within 3 days.

[ ] The patient is covered under Medicaid, Child Health Plus or Family Health Plus and no fee is charged.

[ ] The patient requests a fee waiver for hardship and the patient will provide documentation to the health plan.

[ ] The health plan does not charge a fee for an external appeal / the fee is not required.

13. **I am sending this application to the Insurance Department by:** (Please check one.)

[ ] Certified or registered mail to New York State Insurance Department, PO Box 7209, Albany, NY 12224-0209.

[ ] Fax to 1-800-332-2729. If your appeal is expedited, you must also call toll free 1-888-990-3991 to tell us.

14. **Name of the Patient’s Physician / Provider:** ________________________________________________________________

   Address: ________________________________________________________________________________________________

   Phone Number: (____)______________________________

   Fax Number: (____)______________________________

15. **Complete this only if a designee submits this external appeal on the patient’s behalf.** The patient is under no obligation to request an appeal and may be asked to confirm that a designee was authorized.

   **Name of Designee:** __________________________________

   **Relationship to Patient:** ________________________

   **Address:** ____________________________________________________________________________________________
16. The patient must sign and date this external appeal request and consent to the release of medical records. An external appeal agent assigned by the New York State Insurance Department will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I, ___________________________________________ hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related, mental health, or alcohol / substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on my appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Insurance Department in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent’s decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

______________________________
Signature of Patient

(Date)

(Or the patient’s representative who can consent to the release of the patient’s medical records. If a parent signs for a minor child, indicate the age of the child. If a guardian or executor signs, include proof of the appointment.)

Patient’s Health Plan
ID#: ________________________________

17. Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. This item should only be completed by providers appealing on their own behalf, or as the patient’s designee. The health plan’s initial denial and final adverse determination from the first level of appeal must be attached. I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient’s designee, the $50.00 fee is not required; however, I agree to pay the external appeal agent’s fee in full if the health plan’s concurrent denial is upheld, or to pay half of the agent’s fee if the health plan’s concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent’s decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.

Provider Name: ________________________________
Provider Contact Person: ________________________________
Phone Number: (______)__________________________
PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

New York State Insurance Department, PO Box 7209, Albany NY, 12224-0209

The patient’s physician must complete this attestation for any external appeal of a health plan’s denial of services as experimental / investigational; a clinical trial; a rare disease; out-of-network; or for any expedited appeal.

• For an experimental / investigational denial, the patient’s physician must complete items 1-12 and 16.
• For a clinical trial denial, the patient’s physician must complete items 1-10, 13 and 16.
• For an out-of-network denial, the patient’s physician must complete items 1-9, 12 and 16.
• For a rare disease denial, a physician, other than the treating physician, must complete items 1-9, 14 and 16.
• For an expedited appeal, the patient’s physician must complete items 1-9, 15 and 16.

You must mail this attestation to the above address or fax it to 1-800-332-2729. The Insurance Department or the external appeal agent may need to request additional information from you, including the patient’s medical records. This information should be provided immediately. If you have any questions call 1-800-400-8882.

1. Name of Physician completing this form:

________________________________________________________________________

To appeal an experimental / investigational, clinical trial, or out-of-network denial, the physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the patient, who recommended the patient’s treatment. For a rare disease appeal, a physician must meet the above requirements but may not be the patient’s treating physician.

2. Physician Address:

________________________________________________________________________

3. Contact Person:

________________________________________________________________________

4. Phone Number: (______)__________________________

Fax Number: (______)__________________________

5. Physician E-mail (if you want contact by e-mail):

________________________________________________________________________

6. Name of Patient:

________________________________________________________________________

7. Patient Address:

________________________________________________________________________

8. Patient Phone Number:

________________________________________________________________________

9. Patient Health Plan Name and ID Number:

________________________________________________________________________

10. Complete this item for an external appeal of an experimental / investigational denial or a clinical trial denial. DO NOT complete this item for an appeal of an out-of-network denial or a rare disease denial. As the patient’s physician, I attest: (Select a or b without altering.)

a. _____ The patient has a life-threatening condition or disease with a high probability of causing the
patient’s death.

OR

b. ___ The patient has a disabling condition or disease which renders the patient unable to engage in any substantial gainful activities by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has or can be expected to last for a continuous period of not less than 12 months; or who, in the case of a child under the age of 18, suffers from any medically determinable physical or mental impairment of comparable severity.

11. Complete this item for an external appeal of an experimental / investigational denial. DO NOT complete this item for an appeal of a patient’s clinical trial participation, an out-of-network denial, or a rare disease denial. As the patient’s physician, I attest: (Select a or b without altering.)

a. ___ Standard health services or procedures have been ineffective or would be medically inappropriate.

OR

b. ___ There does not exist a more beneficial standard health service or procedure covered by the health plan.

12. Complete this item for an external appeal of an experimental / investigational denial or an out-of-network denial. DO NOT complete this item for an appeal of a patient’s clinical trial participation or rare disease.

For an experimental / investigational denial: As the patient’s physician I attest that I recommended a health service or pharmaceutical product that, based on the following two documents of medical and scientific evidence, is likely to be more beneficial to the patient than any covered standard health service. (Complete a and b below.)

For an out-of-network denial: As the patient’s physician I attest that the out-of-network health service (identify service)

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

is materially different from the alternate in-network health service recommended by the health plan, and based on the following two documents of medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service. (Complete a and b below.)

a. List the documents relied upon in the space below and attach a copy of the documents.

Document #1 Title: ____________________________________________________________
Publication Name: ________________________________________________________________________________
Issue Number : ______ Date: ______

Document #2 Title: ____________________________________________________________
Publication Name: ________________________________________________________________________________
Issue Number : ______ Date: ______
b. The medical and scientific evidence listed above meets one of the following criteria (note peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer): (Check the applicable items below for each of the documents.)

[ ] Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medica, Medline and MEDLARS database Health Services Technology Assessment Research;

Document #1 [ ] Document #2 [ ]

[ ] Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

Document #1 [ ] Document #2 [ ]

[ ] Peer-reviewed abstracts accepted for presentation at major medical association meetings;

Document #1 [ ] Document #2 [ ]

[ ] Medical journals recognized by the Secretary of Health and Human Services, under section 1861(t)(2) of the Federal Social Security Act;

Document #1 [ ] Document #2 [ ]

[ ] The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the American Medical Association Drug Evaluation; (iii) the American Dental Association Accepted Dental Therapeutics; and (iv) the United States Pharmacopeia-Drug Information;

Document #1 [ ] Document #2 [ ]

[ ] Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

Document #1 [ ] Document #2 [ ]

13. **Complete this item only for a denial of a patient’s participation in a clinical trial.**

a. ___ There exists a clinical trial which is open, the patient is eligible to participate, and the patient has or will likely be accepted. (Although not required, it is recommended you enclose the clinical trial protocols and related information.)

The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

14. **Complete this item only for a rare disease denial.**

As a physician other than the patient’s treating physician, I attest the patient has a rare life-threatening or disabling condition or disease. There is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service, the requested service is likely to benefit the patient in the
treatment of the patient’s rare disease, and such benefit outweighs the risk of the service. I do____ do not____ (check one) have a material financial or professional relationship with the provider of the service AND: (Select a or b without altering.)

a. ___ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.

OR

b. ___ The patient’s rare disease affects fewer than 200,000 U.S. residents per year.

* If provision of the service requires approval of an Institutional Review Board include the approval with this attestation.

15. Complete this item only for an expedited appeal.

If the patient has not yet received the treatment, and a delay would pose an imminent or serious threat to the patient’s health, the patient’s physician may request the appeal to be expedited. The external appeal agent must make an expedited decision in 3 days, instead of 30 days, regardless of whether you provide all necessary medical information or records to the agent. You must send any information to the agent immediately in order for it to be considered. (Please check one.)

___YES, this appeal must be expedited. I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 3 days of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.

During non-business days I can be reached at: ________________________________

___NO, this appeal does not need to be expedited.

16. Complete this item for an external appeal of a health plan’s denial of services as experimental / investigational; a clinical trial; a rare disease treatment; out-of-network; or for any expedited appeal.

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Physician Name (Please Print Clearly):

____________________________________________________

Signature of Physician (Date)

EXTERNAL APPEAL INSTRUCTIONS & APPLICATION

Consumers have the right to an external appeal when health care services are denied by an HMO or insurer (health plan) as not medically necessary, experimental/ investigational, a clinical trial, a rare disease treatment, or out-of-network. Providers have their own right to an external appeal when these health care services are denied concurrently or retrospectively. To request an external appeal, complete the attached application and send it to the New York State Insurance Department within 45 days of the date of the health plan’s final adverse determination.

What Is An External Appeal? It is a request you make to the New York State Insurance Department when a health plan denies health care services. Your appeal will be reviewed by an independent external appeal agent with medical experts that will either overturn (in whole or part), or uphold the health plan’s denial.

When Do I Request An External Appeal? You must send an external appeal application to the
Insurance Department within 45 days from the date of the final adverse determination from the first level of appeal with the health plan OR the health plan’s letter waiving the internal appeal process. If your application is not sent to the Insurance Department within 45 days (with an additional 8 days allowed for mailing), you will not be eligible for an external appeal.

**What If A Health Plan Offers A Second Level Of Internal Appeal?** You do not have to request a second level of internal appeal. However, if you request a second-level internal appeal, you must still request an external appeal within 45 days of the health plan’s first level appeal determination.

**What If Services Are Denied As Experimental / Investigational, A Clinical Trial, Or A Rare Disease?** The patient must have a life-threatening or disabling condition or disease and the patient’s physician (who for rare diseases may not be the treating physician) must complete and send pages 3-5 of the application to the Insurance Department.

**What If Services Are Denied As Out-Of-Network?** The patient must be covered under an HMO or managed care insurance contract and a pre-authorization request must be denied because the requested service is not available in-network and the health plan recommends an alternate in-network service that it believes is not materially different from the out-of-network service. The patient’s physician must complete and send pages 3-5 of the application to the Insurance Department.

**When Will An External Appeal Agent Make A Decision?** In 3 days for expedited appeals or 30 days for standard appeals. The external appeal agent’s decision is binding on the patient and the patient’s health plan.

**How Do I Request An Expedited (fast-tracked) External Appeal?** The patient’s physician must complete pages 3-5 of the application and attest that the patient has not received the treatment and a delay would pose a serious threat to the patient’s health. Once an appeal is expedited, a decision will be made in 3 days, even if all of the patient’s medical information has not been submitted.

**When Can I Send Information To The External Appeal Agent?** The patient, the patient’s designee, and where appropriate the patient’s provider, will be notified when an external appeal agent is assigned to the appeal. You must send any information to the agent immediately. Once the agent makes a decision, additional information will not be considered.

**Do I Pay A Fee For An External Appeal?** Some health plans charge $50.00, which is waived for patients who appeal and are covered under Medicaid, Child Health Plus, Family Health Plus, or if the fee will pose a hardship to the patient. The fee will be returned to you if the external appeal agent overturns the health plan’s denial.

**What If A Patient Has Medicare Or Medicaid Coverage?** Patients covered under Medicare are not eligible for an external appeal and should call 1-800-MEDICARE or visit www.medicare.gov. Patients covered under regular Medicaid are not eligible for an external appeal; however, patients covered under a Medicaid Managed Care Plan are eligible. All Medicaid patients may also request a fair hearing, and the fair hearing decision will be the one that applies. Call 1-800-342-3334 or visit www.otda.state.ny.us/oah for fair hearing information.

**What Are My External Appeal Rights If I Am A Health Care Provider?** You have your own right to an external appeal of a concurrent or retrospective final adverse determination. Regardless of whether you appeal on your own behalf, or as the patient’s designee, you may not pursue reimbursement from the patient for the health care service if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance, or deductible.

FOR QUESTIONS OR HELP WITH AN APPLICATION CALL THE NEW YORK STATE INSURANCE DEPARTMENT AT 1-800-400-8882 OR VISIT [http://www.dfs.ny.gov/insurance/extapp/extappl.pdf](http://www.dfs.ny.gov/insurance/extapp/extappl.pdf)

### 5.9 Adverse Reimbursement Change

Effective January 1, 2010, Public Health Law 4406-c was amended to indicate the requirement for giving written notice of adverse reimbursement changes to a provider’s contract and allowing the provider to terminate the contract, as follows:
- Senior Health Partners will provide written notice at least 90 days prior to an adverse reimbursement change to the provider contract.

- If the provider objects to the change, he/she may, within thirty days of the date of the notice, give written notice to Senior Health Partners to terminate the contract effective upon the implementation of the reimbursement change.

- Under the law, an adverse reimbursement change is defined as one that "could reasonably be expected to have an adverse impact on the aggregate level of payment to a healthcare professional."

The following are statutory exceptions to the notice requirement:

1) The change is otherwise required by law, regulation or applicable regulatory authority, or is required due to changes in fee schedules, reimbursement methodology or payment policies by the State or Federal government or by the American Medical Association’s Current Procedural Terminology (CPT) Codes, Reporting Guidelines and Conventions; and

2) The change is provided for in the contract between Managed Care Organization (MCO) and the provider or the IPA and the provider through inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

There is no private right of action for a healthcare professional relative to this provision.
Section 6 - Complaints and Appeals

6.1 Complaints

A complaint is any oral or written communication of dissatisfaction given by a member, family/caregiver, friend, provider on behalf of the member made to Senior Health Partners about the care and treatment a member receives from our staff or providers of covered services. Senior Health Partners will try its best to deal with member concerns or issues as quickly as possible.

Senior Health Partners cannot change the way a member receives services or the way they were treated by Senior Health Partner's staff or providers after the member filed a complaint. Interpreter services are also available to members who would like to file a complaint or appeal.

If a member asks you how to file a complaint direct them to: **1-800-633-9717** or to:

Senior Health Partners
Appeals and Complaints Department
PO Box 5166
New York, NY, 10274-5166
or
Fax: 1-646-313-4618

The member will need to provide their name, address, telephone number and the details of the problem.

Members may file a complaint with us orally or in writing. The person who receives their complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send the member a letter telling them that we received their complaint and a description of our review process. We will review their complaint and give a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to the member's health, we will address the complaint within 48 hours after receipt of all necessary information.
2. For all other types of complaints, we will notify the member of our decision within 45 days of receipt of all necessary information, but the process must be completed no later than 60 days of the receipt of the complaint. The review period can be increased up to 14 days if we need more information and the delay is in the member's interest.

If the member is not satisfied with the decision we make concerning their complaint, they may request a second review of their issue by filing a complaint appeal. Complaint appeals must be in writing and must be filed within 60 business days of receipt of our initial decision about their complaint. Once we receive the appeal, we will send a written acknowledgement. All complaint appeals will be conducted by appropriate staff who were not involved in the initial decision.

For standard complaint appeals, we will make the decision within 30 business days after we receive all necessary information. If a delay in making our decision would significantly increase the risk to the member's health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

A report of all complaints is submitted to the Department of Health on a quarterly basis.
6.2 Appeals of Benefit and Service Determination

Below are all the details your patients need when appealing a decision by SHP regarding the benefits and services including timelines and requirements. You may contact your patient’s Primary Care Management Team if you want to assist them in starting an appeal. You must sign and date a statement saying that the member has identified you to assist with filing a Plan Appeal.

Notice of Action – or a written decision about services by Senior Health Partners
A plan "action" includes when Senior Health Partners denies or limits services requested by the member or you (their provider); denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn’t provide timely services; or doesn’t make complaint or appeal determinations within the required timeframes, “actions”. All actions are subject to appeal.

If Senior Health Partners decides to deny or limit services the member requested or decides not to pay for all or part of a covered service, we will send the member a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service, except in cases of:
- Confirmed fraud (when the period is shortened to five (5) days)
- Death (when the notice is mailed by the change date)
- A signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (when the notice is mailed by the change date)
- Admission to an institution making the member ineligible for further services (when the notice is mailed by the change date)
- The member’s address is unknown and mail is returned with no forwarding address
- The member has been accepted for Medicaid services by another jurisdiction (when the notice is mailed by the change date).
- The member’s doctor prescribes a change in the level of their medical care

Any notice we send to the member about an action will:
- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe their right to file an appeal with us (including whether the member may also have a right to the State’s external appeal process);
- Describe how to file an internal appeal and the circumstances under which the member can request that we speed up (expedite) our review of their internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, which must be provided by the member and/or you (their provider) in order for us to render a decision on appeal.

The notice will also inform the member about their right to a State Fair Hearing:
- It will explain the difference between a Plan Appeal and a Fair Hearing;
- It will say that for any denials on or after May 1, 2018, the member must file a Plan Appeal before asking for a Fair Hearing;
- It will explain how to request a Fair Hearing; and
- If we are restricting, reducing, suspending, or terminating an authorized service and the member wants their services to continue, the member must file a Plan Appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

Effective May 1, 2018, if we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell the member about the right to have services continue while we decide on the appeal; how to request
that services be continued; and the circumstances under which the member might have to pay for services if they are continued while we were reviewing the appeal.

**How to file an appeal of a notice of action - information to help your patients**

If the member does not agree with an action that we have taken, the member may appeal. When the member files an appeal, it means that we must look again at the reason for our action to decide if we were correct. The member can file an appeal of an action with the plan orally or in writing. An appeal must be requested within **60 calendar** days.

If a member needs assistance filing an appeal, direct them to Senior Health Partners at **1-800-633-9717** or have them write to

```
Senior Health Partners
Attn: Appeals and Complaints
PO Box 5166
New York, NY 10274-5166
```

The person who receives their appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling the member that we received their appeal, and how we will handle it. We will also include a copy of your case file which includes medical records and other documents used to make the original decision. The appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that the member is appealing.

Please note that the member can appeal any restriction, reduction, suspension, or termination of authorized Consumer Directed Personal Assistance Services (CDPAS) or denial of a request to change CDPAS. If Senior Health Partners denies their appeal, the member is entitled to a fair hearing.

Unless the member asks for an expedited review, we will review their appeal of the action taken by us as a standard appeal and send the member a written decision as quickly as their health condition requires, but no later than **30 days** from the day we receive an appeal. (The review period can be increased up to 14 days if the member requests an extension or we need more information and the delay is in their interest.) During our review the member will have a chance to present their case in person and in writing. The member will also have the chance to look at any of their records that are part of the appeal review.

We will send the member a notice about the decision we made about their appeal that will identify the decision we made and the date we reached that decision. If the member does not receive a response to the Plan Appeal or the decision is late, the member can ask for a Fair Hearing without waiting for the plan's decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while their appeal was pending, we will provide the member with the disputed services as quickly as their health condition requires. In some cases the member may request an “expedited” appeal.

**Continuation of services while an appeal is reviewed**

If the member is appealing a restriction, reduction, suspension or termination of services they are currently authorized to receive, the member must complete the internal appeal process prior to requesting a Fair Hearing. The member can request a Fair Hearing no later than **120 days** from the date on the determination notice.

**How to ask for an expedited/fast review - information to help your patients**

If you (the provider) or the member feels that taking the time for a standard appeal could result in a serious problem to their health or life, the member may ask for an expedited review of their appeal of the action. We will respond to the member with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than **3 business days**.
after we receive their appeal. (The review period can be increased up to 14 days if the member requests an extension or we need more information and the delay is in their interest.).

Beginning May 1, 2018, we will respond to the member with our decision within 72 hours after we receive all necessary information. In no event will the time for issuing our decision be more than **72 hours** after we receive their appeal.

If we do not agree with their request to expedite their appeal, we will make our best efforts to contact the member in person to let the member know that we have denied their request for an expedited appeal and will handle it as a standard appeal. Also, we will send the member a written notice of our decision to deny their request for an expedited appeal within 2 days of receiving their request.

**How to request a state fair hearing after appeal - information to help your patients**

If our decision about their appeal is not totally in their favor, the notice the member receive will explain their right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on their behalf, and for some appeals, their right to request to receive services while the Hearing is pending and how to make the request.

**Note: Beginning May 1, 2018, the member must request a Fair Hearing within 120 calendar days after the date of the Final Adverse determination notice.**

If we deny their appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

The member must exhaust internal appeal rights before requesting a Fair Hearing. The member must request a Fair Hearing within **120 calendar days** of the date we sent the member the notice about our original decision. The member must wait until the Plan decides their appeal and then ask for a Fair Hearing.

To make sure that their services continue pending the appeal, generally the member must request the Fair Hearing AND make it clear that the member wants their services to continue. Some forms may automatically do this for the member, but not all of them, so please read the form carefully. In all cases, the member must make their request within 10 days of the date on the notice, or by the intended effective date of our action (whichever is later).

Their benefits will continue until the member withdraws the appeal; the original authorization period for their services ends; or the State Fair Hearing Officer issues a hearing decision that is not in their favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that the member receives the disputed services promptly, and as soon as their health condition requires. Beginning May 1, 2018, we must make sure that the member receives the services no later than 72 hours from the date the plan receives the Fair Hearing decision. If the member received the disputed services while their appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although the member may request to continue services while the member is waiting for their Fair Hearing decision, if their Fair Hearing is not decided in their favor, the member may be responsible for paying for the services that were the subject of the Fair Hearing.

The member can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online Request Form: [http://otda.ny.gov/oah/FHReq.asp](http://otda.ny.gov/oah/FHReq.asp)
- Mail a Printable Request Form:
Senior Health Partners may not act in any manner that restricts a member's right to a fair hearing or influence their decision to pursue a fair hearing.

If we deny their appeal because we determine the service is not medically necessary or is experimental or investigational, the member may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or for New York State. These reviewers are qualified people approved by New York State. The member does not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide the member with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If the member wants an external appeal, the member must file the form with the New York State Department of Financial Services within four months from the date we denied their appeal.

Their external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell the member and us of the final decision within two business days after the decision is made.

The member can get a faster decision if their doctor can say that a delay will cause serious harm to their health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or fewer. The reviewer will tell the member and us the decision right away by phone or fax. Later, a letter will be sent that tells the member the decision.

**The member may ask for both a Fair Hearing and an external appeal.** If the member asks for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that counts.”

We can be reached by calling 1-800-633-9717 or by writing to:

Senior Health Partners  
Attn: Appeals and Complaints  
PO Box 5166  
New York, NY 10274-5166
The person who receives their appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling the member that we received their appeal, and how we will handle it. Their appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan’s initial decision or action that the member is appealing.

Remember that if at any time the member is dissatisfied with how Senior Health Partners has treated the member, or how we have handled their complaint, the member can contact the New York State Department of Health by writing to:

New York State Department of Health
Bureau of Managed Long Term Care
One Commerce Plaza
Room 1620
Albany, New York 12210
1-866-712-7197

The member can also call the Participant Ombudsman called the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about their coverage, complaints, and appeal options. They can help the member manage the appeal process. They can also provide support before the member enrolls in a Managed Long Term Care (MLTC) plan like Senior Health Partners. This support includes unbiased health plan choice counseling and general program-related information. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)
Web: www.icannys.org | Email: ican@cssny.org

Senior Health Partners will cooperate with, and may not inhibit, the ICAN in the exercise of its duties. Appeals are tracked by a formal mechanism.
A report of appeals is submitted to the Department of Health on a quarterly basis.

6.3 Quality Review and Oversight

Records of complaints and appeals are stored, tracked, and reviewed by the Vice President of Clinical Excellence or designee.
Providers may be asked to investigate individual or aggregate complaints and may be asked to define action improvement plans, as necessary.
Results of activities are reported to the Quality Utilization and Management (QUM) Committee to determine ongoing issues, trends, and opportunities for improvement.
Recommendations may also be made to limit a provider’s participation in the network.
The results of the review and analysis are also reported to the Quality Management Committee.
7.1 Quality Assurance, Performance Improvement (QAPI) Plan and Compliance

The goals of the QAPI plan are to systematically monitor, evaluate and improve the quality and appropriateness of care provided or coordinated and to maximize member satisfaction. The following areas are reviewed annually:

- The quality of services provided to members;
- The management of care including availability, access and continuity, and early identification of problems;
- The identification and correction of operational and clinical practice issues;
- Outcomes in clinical and non-clinical areas as appropriate.

The Quality Improvement Committee (QIC), a multidisciplinary group comprised of Healthfirst clinical leadership, staff, and community providers, maintains oversight of the Healthfirst quality program. The QIC’s primary responsibilities are to promote initiatives and programs related to quality management and performance improvement, and ensure that Healthfirst has a rigorous quality oversight process. The Member Advisory Council, one of several sub-committees of the QIC, is a focus group that meets regularly to obtain feedback from members regarding the care and service they receive as Healthfirst members. QIC activities are reported to the Board of Directors.

7.2 Quality Assurance Performance Improvement (QAPI)

An annual work plan is designed to conduct and/or monitor activities in support of the QAPI plan. Activities include a review of clinical operations to comply with regulatory requirements and business and operational goals. Sources of data include record reviews, incidents, hospitalizations and nursing home admission data, high-risk/high-volume utilization data, and other customer service and provider performance data reports. Data is reported to the Quality Improvement Committee (QIC) and its sub-committees as appropriate.

7.3 Licensed Home Care Service Agency Quality Reports

Healthfirst evaluates the quality of Licensed Home Care Services Agencies using their Overall Quality Rating (OQR), a numerical score on a scale of 1.0 to 5.0 that summarizes the provider’s weighted average performance on select quality and satisfaction measures. The measures are informed by NYS MLTC Quality Incentive Measures and CMS Stars measures which are updated on a yearly basis. A list of the quality measures used for OQR calculation(s) is provided via the HQIP for LHCSAs Program Guide supplied to all participating providers.

The Healthfirst Quality Incentive Program for Licensed Home Care Services Agencies (HQIP for LHCSAs) program helps Healthfirst gauge the quality and experience of care provided to our members. Healthfirst MLTC membership is used to determine eligibility for the HQIP for LHCSAs. The HQIP for LHCSAs program is open to LHCSAs that serve at least 150 Senior Health Partners (SHP) members. Eligibility for this program is at the sole discretion of Healthfirst. LHCSAs that meet the requirements for participation in the HQIP for LHCSAs program receive monthly reports summarizing their performance on the measures included in the program. A sample of the domains LHCSA’s are evaluated on is outlined below:

- Quality: MLTC Quality Incentive Measures identified by NYSDOH and calculated from the Uniform Assessment System for New York (UAS-NY).
- Satisfaction: Select measures obtained from the Healthfirst Member Satisfaction Survey, which is a proxy for the IPRO survey utilized by NYSDOH and substantiated grievances filed by Healthfirst members.
- Efficiency: (Potentially Avoidable Hospitalizations) A PAH is an inpatient hospitalization that might have been avoided if proper outpatient care was received in a timely fashion. The hospitalization is
identified as potentially avoidable if the primary diagnosis is any one of the following conditions: heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection.

Medication Adherence: Measures designed by CMS to assess the adherence to medications prescribed for chronic conditions.

Healthfirst reserves the right to suspend or rescind provider eligibility for HQIP for LHCSAs for any reason, including agency attendance to program trainings and performance meetings. Quality ratings will be used internally to evaluate performance across the network. Healthfirst will set a minimum threshold on an annual basis and a notification will be sent to providers falling below that threshold. LHCSAs whose performance is consistently below minimum thresholds may be subject to certain actions including, but not limited to, suspension from the Healthfirst Quality Incentive Program and network.

7.4 How Licensed Home Health Agencies are Evaluated

Healthfirst uses standardized and evidence-based tools to evaluate the quality of a Licensed Home Care Services Agency's (LHCSA) care for our members. Healthfirst evaluates the quality of agencies using their Overall Quality Rating (OQR), a numerical score on a scale of 1.0 to 5.0 that summarizes the agency's weighted average performance on select quality measures. The quality measures used to determine OQR (as well as their cut points and target rates) are informed by the New York State Department of Health (NYS DOH) Managed Long Term Care (MLTC) Quality Incentive Program, which is updated on a yearly basis. Healthfirst's detailed methodology for calculating OQR is available upon request. Note that evaluation of an agency against a quality measure is contingent on the agency meeting the minimum membership size for that measure.

Where eligible, agencies are evaluated on the following domains for quality:

- Uniform Assessment System for New York (UAS-NY), including select quality and functioning measures obtained from UAS-NY reassessments completed by members
- Member Satisfaction, including select measures obtained from the Healthfirst Member Satisfaction Survey, which is a proxy for the NYS DOH IPRO survey
- Substantiated Member Complaints, including select measures obtained from Healthfirst’s Appeals and Complaints department capturing substantiated same-day and standard complaints filed by members during the program year

Healthfirst will review agency OQRs throughout the program year (July-June), and share this information with eligible agencies on a quarterly basis. Eligible agencies will also have access to their quality data and OQRs through Healthfirst reporting tools. Reports detailing the final performance of all eligible agencies will be available in September following the end of the program.

Healthfirst will factor agency OQRs in new member agency assignment decisions, where LHCSAs with higher OQRs will be given more weight and consideration. Healthfirst will also engage eligible agencies falling at or below the Minimum Quality Rating (MQR) for the LHCSA network. Agencies will only be evaluated against the MQR if they have enough valid quality measures that they can be evaluated on. Agencies will be notified if they are below the MQR and additional support resources will be furnished to support OQR improvement. For agencies consistently falling below the MQR, Healthfirst may take other actions deemed necessary, including but not limited to:

- Reduction or discontinuation of Healthfirst member assignment to agency
- Reduction or discontinuation of quality incentive bonus payments/deductions
- Removal from the Healthfirst network

For additional information, please email QualityRatings@healthfirst.org
8.1 Senior Health Partners Provider Partnership

Senior Health Partners views and works with each vendor as a partner in care. Senior Health Partners staff works with providers to ensure that the right services are provided in the right place for the right amount of time based on a member’s needs. Selected providers also participate in quality improvement and other initiatives designed to maximize member outcomes and satisfaction. When providers identify clients they feel will both qualify for and benefit from the unique services Senior Health Partners provides, we ask that you contact us. The following section details the instructions and form to be used for making a referral to Senior Health Partners.

8.2 Instructions for Providers to Make Referrals

A referral to Senior Health Partners is a phone call away:

- Call Intake Team at 1-212-360-0067 or 1-866-585-9280
- Fax Senior Health Partners’ Referral Form to: 1-212-360-1121
- Email Senior Health Partners’ Referral Form to: Referrals@Healthfirst.org

Upon referral, the intake assessment begins.

Relationship Coordinator

- Contacts client within 24–48 business hours to schedule a home visit
- Schedules home visit appointments for the Enrollment Specialists and Assessment Nurses

Enrollment Medicaid Specialist

- Conducts home visit, with significant other present
- Explains covered and coordinated services, answers all questions
- Obtains client authorization for a nurse assessment
- Refers client in need of new Medicaid to the Enrollment Medicaid Specialist Team
- **Completes/submits new Medicaid application for client**
- Completes recertification application, as needed

Assessment Nurses

- Conduct a functional, performance, environmental, and cognitive assessment
- Prepare an initial plan of care with client/family input
- Communicate/confirm with Primary Care Provider (medications, diagnosis, and recommended plan of care), as needed
- Obtain client voluntarily signed Enrollment Agreement Attestation

Marketing

- Communicate the outcome to referring source
Healthfirst CompleteCare (HMO SNP) (MAP), Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan) and Senior Health Partners (MLTC) Referral Form

Please fill in all requested information below and fax your referral to 1-212-360-1121. To contact us or to receive more information, call 1-866-585-9280, Monday to Friday, 8:30am–8pm.

PLEASE NOTE: This form should not be filled out for anyone joining a long-term care plan for the first time nor for anyone who has not been in a plan for 45 days or longer. Those individuals should contact New York Medicaid Choice for an evaluation and enrollment guidance. Call 1-800-505-5678, Monday to Friday, 8:30am–8pm, and Saturday, 10am–6pm.

REFERRAL SOURCE INFORMATION

Date: ___________ Name: ___________________________ Job Title: ___________________________

Referring Agency/Organization: ___________________________

Tel: __________________ Fax: ___________________ Email: ___________________________

Address: __________________ City: ___________ State: ______ Zip: _______

CLIENT/PROSPECT INFORMATION

INTERESTED IN: ☐ MAP ☐ FIDA ☐ MLTC

Name: __________________ ___________ Last Initial ___________ First

Address: __________________ Street Number ___________ Apt. # ___________ City ___________ State ______ Zip Code _______

Tel: ___________________________ *Date of Birth: ___________________________ *Must be 21 for MLTC and FIDA

Primary Care Provider: __________________

Primary Language: ☐ English ☐ Spanish ☐ Other: _____________________ Female ☐ Male ☐

Emergency Contact Name: __________________ ___________ Last ___________ First Relationship __________________

Tel: ________________________ (H) ____________________ (W) ____________________ (C) __________________

*Medicaid No. ___________________ Medicare No. __________________ Do you have ESRD? ☐ Yes ☐ No

*If no Medicaid, does client want to apply? ☐ Yes ☐ No

Current services in the home? ☐ Yes ☐ No If yes, provide the name of the vendor: __________________________

REFERRAL SOURCE ATTESTATION

I, __________________________, attest that the client was informed of the referral and agrees to receive more information about the MAP, FIDA, and/or MLTC program.

_________________________________________ Date __________________________

TO ALL LICENSED HOME CARE AGENCIES:

If this client is presently receiving services from a Certified Home Health Care Agency (CHHA), the Licensed Home Care Agency attests that the CHHA has been notified that this client is being referred to Healthfirst CompleteCare (HMO SNP) (MAP), Healthfirst AbsoluteCare FIDA Plan (Medicare-Medicaid Plan) or Senior Health Partners (MLTC) regarding potential enrollment.

_________________________________________ Date __________________________

Signature

All information will be kept confidential. NYSDOH Approved 09132016

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