



Senior Health Partners

Provider Manual

Table of Contents

- Table of Contents..... 1

- Section 1 - Introduction..... 3**
 - 1.1 Welcome Network Provider Letter..... 3
 - 1.2 Introduction to Senior Health Partners 4

- Section 2 - Members..... 5**
 - 2.1 How to Identify a Senior Health Partners Member..... 5
 - 2.3 Member Co-payments 5
 - 2.4 Non-English Speaking Members 5
 - 2.5 Impaired Members 5

- Section 3 - Care Management Teams 7**
 - 3.1 Care Management 7
 - 3.2 Coordination of Services 7
 - 3.2 a Sample Service Plan Letter (Page 2) 10
 - 3.2 b Sample Service Plan Update Letter (Page 1) 11
 - 3.2 b Sample Service Plan Update Letter (Page 2) 12
 - 3.4 Assessments of Members 13
 - 4.4 Provider Rights and Responsibilities and Dual Eligible Members 15
 - 4.5 a Notice of Privacy Practices 16
 - 4.8 Network Evaluation..... 16
 - 5.1 a Claims Submission Procedures 17
 - 5.1b Requests for Review and Reconsideration of a Claim 18
 - 5.3 Fraud Waste and Abuse..... 19

- 5.4 The Compliance Policy 19**
 - 5.4a Definitions 19**
 - 5.7 Provider External Appeals – Effective January 1, 2010..... 27
 - 6.1 Complaints 36
 - 6.2 Appeals of Benefit/Service Determination..... 36
 - 6.3 Complaints 41
 - 6.4 Quality Review and Oversight 41

Section 7 - Quality Assurance, Performance Improvement, and Compliance

..... **42**

7.1 Quality Assurance, Performance Improvement (QAPI) Plan and Compliance 42

7.2 Quality Assurance Performance Improvement (QAPI) 42

8.2 Instructions for Providers to Make Referrals 43

Section 1 - Introduction

1.1 Welcome Network Provider Letter

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:
 - Nursing services in the home
 - Therapies in the home
 - Home health aide services
 - Personal care services in the home
 - Adult day health care
 - Private duty nursing
 - 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 BACK

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.**

3.2 a Sample Service Plan Letter (Page 2)

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>>

3.2 b Sample Service Plan Update Letter (Page 1)

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_mmmm_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>>

3.2 b Sample Service Plan Update Letter (Page 2)

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.

3.4 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.

4.4 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
- g) Constructive feedback on performance and utilization

4.5 a Notice of Privacy Practices

4.8 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.

5.1 a Claims Submission Procedures

Submitting Claims Electronically

Senior Health Partners uses the Change Healthcare clearinghouse for all electronic claims. Claims submitted electronically on the CMS 1500 and UB 04 receive a status report indicating which claims were accepted, which were rejected, and/or which are pending, and the amount paid on the claim once it has been finalized. Claims submitted electronically must include:

1. Senior Health Partners' Payer ID Number 80141
2. Complete Senior Health Partners Member's CIN ID number
3. A National Provider Identifier (NPI) should reside in:
 - 837 Professional (CMS)-Loop 2310B Rendering Provider Secondary ID, Segment/Element NM109. NM 108 must qualify with an XX (NPI)
 - 837 Institutional (UB04)-Loop 201 AA Billing Provider, Segment/Element NM 109. NM 108 must qualify with an XX (NPI)

To sign up for electronic billing, providers must contact their software vendor and request that their Senior Health Partners claims be submitted through Change Healthcare. Providers can also direct their current clearinghouse to forward claims to Change Healthcare. Please contact Change Healthcare at 1-800-845-6592 for information on how to set up electronic billing.

If you have any questions regarding claims issues, please call 1-877-737-2693. Representatives are available Monday to Friday, 9am–5pm.

Submitting Paper Claims

All paper claims should be submitted to:

Senior Health Partners Claim Department
P.O. Box 958439
Lake Mary, FL 32795-8439

All paper claims should include the National Provider Identifier (NPI) as well as the Senior Health Partners-assigned Provider ID Number (the latter is not required for electronic claims). The Senior Health Partners Provider ID is a unique provider number for each practice site.

Timely Claim Submission

In-network providers must file claims within 180 days of the date of service. Out-of-network providers must file claims according to Medicare fee-for-service rules.

Authorizations: All Senior Health Partners network providers and out-of-network providers will receive an authorization for covered services EXCEPT FOR dentistry, optometry, audiology, and podiatry. Except for emergency services and treatment of urgent medical conditions, providers are required to obtain authorizations prior to providing services to Senior Health Partners members, whether or not a Senior Health Partners provider referred the member. Contact Senior Health Partners' Care Management Team at 1-212-324-2600 for questions related to care management and service authorizations.

Billing Senior Health Partners

All payments for services provided to Senior Health Partners members constitute payment in full. **Providers may not balance-bill members for the difference between their actual charges and the reimbursed amounts; any such billing is a violation of the provider's contract with Senior Health Partners and of applicable New York State Law.** Where appropriate, Senior Health Partners will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.

Reference: Tab 3 – Sample Blank HCFA Form 1500

5.1b 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
 - R059/RPT-11 Report (insurance Carrier Rejection report) or Change Healthcare Vision "Claim for Review" / "Claim Summary Report"
 - 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**.

5.3 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).

5.4 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.*”

5.4a 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

31 U.S.C. §§ 3729–3733

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., 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/menuegft.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 MRRC 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

5.7 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:**

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: _____

Phone Number: (_____) _____

Fax Number: (_____) _____

Designee E-mail (if you want contact by e-mail): _____

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:(_____)_____

Provider E-mail (if you want contact by e-mail): _____

Provider Signature: _____

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 Medicus, 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; 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>

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 tthe 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/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>
- Mail a Printable Request Form:

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings

Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

- Fax a Printable Request Form: (518) 473-6735
- Request by Telephone:

Standard Fair Hearing line – 1 (800) 342-3334
Emergency Fair Hearing line – 1 (800) 205-0110
TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:

New York City
14 Boerum Place, 1st Floor
Brooklyn, New York 11201

Albany
40 North Pearl Street, 15th Floor
Albany, New York 12243

For more information on how to request a Fair Hearing, please visit: <http://otda.ny.gov/hearings/request/>

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 Complaints

- A complaint can be written or verbal.
- A complaint can be filed by the member, or by a family/caregiver, friend or provider on behalf of the member.
- A complaint can be made about a Senior Health Partners employee or provider.
- Provider complaints are included in the Provider Report Card Process.

6.4 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.

Section 7 - Quality Assurance, Performance Improvement, and Compliance

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.

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