healthfirst®
Health Insurance for New Yorkers

Provider Resource Guide

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Introduction

Healthfirst is the largest not-for-profit health insurance company in New York, serving 1.8 million members, including the state's most vulnerable residents. Our products are designed to meet members' needs at all stages of their lives, and include Medicare Advantage and New York State managed care plans including Medicaid.

We are a unique plan in which the foundation of our provider approach is fueled by the heavy collaboration with our partner hospital systems, accessible ancillary network, and community providers. The Healthfirst culture is defined by our members. Our culture aligns with our provider network through financial and quality improvement incentives, using real-time data, and partnering on special initiatives that encourage efficacy, improve healthcare outcomes, and promote health equity throughout our service area.

Our value-based care contracts transfer financial risk to most hospitals and many community providers, allowing them to earn additional compensation for their services, beyond what they would be paid in a fee-for-service system.

For more information on Healthfirst, visit **healthfirst.org**.

Our Mission

At Healthfirst, our mission is to ensure that our members have superior healthcare and satisfaction. We fulfill this promise through our partnerships and, together, will transform the system so that it is accountable for the cost and quality of healthcare for our populations.

Our Vision

Our vision is to treat our members with the same care and attention we would want for our own families.

Our Values

- Members First
- Quality Execution and Continuous Improvement
- Cooperation
- Integrity and Transparency

Community Offices

Healthfirst is truly a health insurance company of the community, serving a diverse geographical footprint. Healthfirst is invested in community offices throughout the New York metro area, including our five boroughs and outer county regions. We are strategically present in high foot traffic locations, and engaged in several community events throughout the year. Members have the opportunity to meet face-to-face with Healthfirst representatives at our member enrollment and information hubs. We are here to service their healthcare access needs and provide answers to questions they may have, including finding an in-network provider, paying their plan premium, and more. Our door is always open.

- **18** community offices across the greater metropolitan area serve as local resources for members and providers
- **21** community offices currently operating as of August 2022
- **6** spoken languages other than English are provided by our Member Services teams based in our offices

To learn more about our community offices, including a list of locations, visit **hfrepdirectory.healthfirst.org/CommunityOffices**.

Community Events

We partner with our communities and providers to participate in and coordinate provider events. Learn more about upcoming events and other Healthfirst news at **healthfirst.org/about-us/newsroom**.

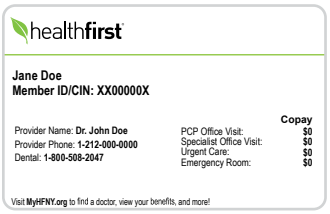
Healthfirst Plans

Healthfirst PHSP Plans

Healthfirst Medicaid Managed Care Plan

Healthfirst has delivered managed healthcare services to the Medicaid-eligible population of New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), and to Nassau, Suffolk, Westchester, Sullivan, Orange, and Rockland counties. We provide a full range of New York State Medicaid benefits under the following government programs:

- Temporary Assistance to Needy Families (TANF)
- Safety Net Assistance (SNA)
- Medicaid Only (MA-HR and MA-ADC)
- Supplemental Security Income (SSI)
- As well as other applicable government programs


healthfirst

Jane Doe
Member ID/CIN: XX00000X

Provider Name: Dr. John Doe
Provider Phone: 1-212-000-0000
Dental: 1-800-508-2047

Copay
PCP Office Visit: $0
Specialist Office Visit: $0
Urgent Care: $0
Emergency Room: $0

Visit MyHFNY.org to find a doctor, view your benefits, and more!

Healthfirst Essential Plans


healthfirst

Essential Plan 1

Member Name
Member ID: 0000000000000

Rx Bin: 004336
Rx PCN: ADV
Rx Group: RX1108

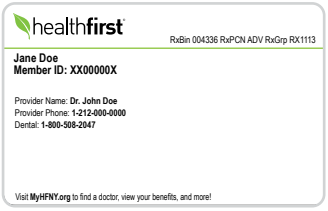
Individual Deductible: $0
Individual MOOP: $2,000

Copay
PCP Office Visit: $15
Specialist Office Visit: $25
Urgent Care: $25
Emergency Room: $75
Inpatient Hospital: $150
Prescriptions: $6/$15/$30

Visit MyHFNY.org to find a doctor, view your benefits, and more!

The Healthfirst Essential Plan provides federally subsidized comprehensive health coverage for eligible individuals. It launched on January 1, 2016, and allows for new enrollment at any point throughout the year. Our Essential Plan improves the continuity of care for people whose income is slightly higher than the Medicaid income limit or who are lawfully present in the United States but do not qualify for Medicaid due to immigration status. The Essential Plan is available on the NY State of Health Marketplace. The Essential Plan's service area consists of New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), Long Island, and Westchester, Orange, Rockland, and Sullivan counties.

Healthfirst Child Health Plus Plan (CHP)


healthfirst

RxBin 004336 RxPCN ADV RxGrp RX1113

Jane Doe
Member ID: XX00000X

Provider Name: Dr. John Doe
Provider Phone: 1-212-000-0000
Dental: 1-800-508-2047

Visit MyHFNY.org to find a doctor, view your benefits, and more!

In March of 1999, Healthfirst implemented the CHP program to provide quality healthcare coverage for the children of uninsured and underinsured families. The CHP program offers healthcare to children under age 19 who are above the Medicaid income levels or who are ineligible for Medicaid because of their immigration status.

Coverage available in CHP provides children with a comprehensive benefit package. The family must be income-eligible for membership and may be responsible for contributing to a premium, based on its income category. The plan's service area consists of New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), Long Island, and Westchester, Orange, Rockland, and Sullivan counties.

Personal Wellness Plan (PWP)

The Healthfirst Personal Wellness Plan (PWP) is a Health and Recovery Plan (HARP). It is a qualified, specialized, and integrated managed care product for individuals with significant behavioral health needs (serious mental health illness and/or substance use disorders). The plan's service area consists of New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), Long Island, and Westchester, Orange, Rockland, and Sullivan counties.

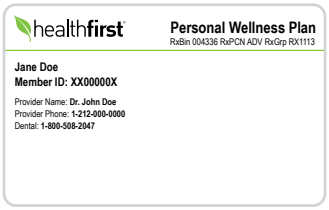
New York State created HARP for managed care plans, service providers, peers, families, and government to work together to help patients prevent chronic health conditions and recover from serious mental illness and substance use disorders.

- Healthfirst focuses on patient-centered integrated care
- Healthfirst manages behavioral health services in conjunction with the medical benefits members presently receive
- Healthfirst works with providers to develop care plans that integrate all member needs and centralize focus on the member as a whole

These benefits include **Behavioral Health Home and Community Based Services (BH-HCBS) for Personal Wellness Plan members**. BH-HCBS provide opportunities for Medicaid beneficiaries with Serious Mental Illness (SMI) and/or Substance Use Disorders (SUD) to receive person-centered, recovery-oriented services in their own community.

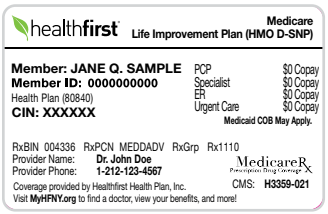
Some Medicaid beneficiaries in HARP are enrolled in health homes and are assigned a care coordinator and a care delivery team that work together with the member to create a care plan to help improve the member's ability to function in the community.

In order to reach success for this population, Healthfirst partners with providers to meet the needs of our membership. This partnership involves sharing data, working as a team, and bringing key components to the development of a recovery plan for the member, allowing for the delivery of effective patient-centered care with the goal of maximizing the quality of life for our member.



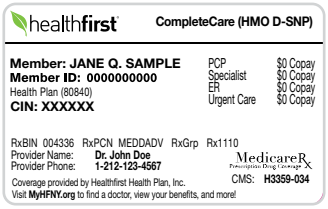
Healthfirst Medicare Advantage Plans

Healthfirst Life Improvement Plan (HMO D-SNP)


healthfirst Medicare Life Improvement Plan (HMO D-SNP)
Member: JANE Q. SAMPLE
Member ID: 0000000000
Health Plan (80840)
CIN: XXXXXX
PCP $0 Copay
Specialist $0 Copay
ER $0 Copay
Urgent Care $0 Copay
Medicaid COB May Apply.
RxBIN 004336 RxPCN MEDDADV RxGrp Rx1110
Provider Name: Dr. John Doe
Provider Phone: 1-212-123-4567
MedicareRx
Coverage provided by Healthfirst Health Plan, Inc.
CMS: H3359-021
Visit MyHFNY.org to find a doctor, view your benefits, and more!

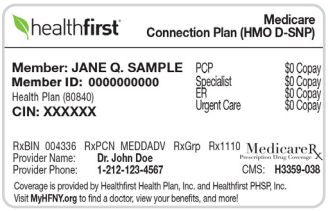
Our Life Improvement Plan is a Dual-Eligible Special Needs Plan (D-SNP) designed specifically for those Medicare beneficiaries who are eligible for both Medicare and full Medicaid. Healthfirst has a Coordination of Benefits Agreement (COBA) with New York State Department of Health (NYSDOH) that provides wraparound Fee-For-Service (FFS) Medicaid benefits and covers member cost sharing. NYSDOH is financially responsible for cost sharing obligations and Medicaid benefits for our Dual-Eligible Beneficiaries. Services New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), and Nassau, Orange, Rockland, Sullivan, and Westchester counties.

Healthfirst CompleteCare (HMO D-SNP)


healthfirst CompleteCare (HMO D-SNP)
Member: JANE Q. SAMPLE
Member ID: 0000000000
Health Plan (80840)
CIN: XXXXXX
PCP $0 Copay
Specialist $0 Copay
ER $0 Copay
Urgent Care $0 Copay
RxBIN 004336 RxPCN MEDDADV RxGrp Rx1110
Provider Name: Dr. John Doe
Provider Phone: 1-212-123-4567
MedicareRx
Coverage provided by Healthfirst Health Plan, Inc.
CMS: H3359-034
Visit MyHFNY.org to find a doctor, view your benefits, and more!

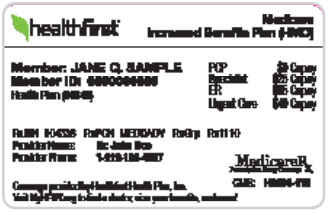
Healthfirst CompleteCare is a $0 cost share, fully integrated Dual-Eligible Special Needs Plan (D-SNP) that combines Medicare and Medicaid benefits with added long-term care services. It is specifically designed for people who are nursing home eligible but who reside in the community at the time of enrollment in CompleteCare. Services New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island),and Nassau, Orange, Rockland, Sullivan, and Westchester counties.

Healthfirst Connection Plan (HMO D-SNP)


healthfirst Medicare Connection Plan (HMO D-SNP)
Member: JANE Q. SAMPLE
Member ID: 0000000000
Health Plan (80840)
CIN: XXXXXX
PCP $0 Copay
Specialist $0 Copay
ER $0 Copay
Urgent Care $0 Copay
RxBIN 004336 RxPCN MEDDADV RxGrp Rx1110
Provider Name: Dr. John Doe
Provider Phone: 1-212-123-4567
MedicareRx
CMS: H3359-038
Coverage is provided by Healthfirst Health Plan, Inc. and Healthfirst PHSP, Inc.
Visit MyHFNY.org to find a doctor, view your benefits, and more!

The Healthfirst Connection Plan is a Dual-Eligible Special Needs Plan (D-SNP) that coordinates coverage for those who are newly Medicare-eligible and enrolled in our Medicaid Managed Care plan pursuant to the CMS default enrollment process. Healthfirst Connection Plan members that do not opt out of the default enrollment receive their Medicare coverage from the Healthfirst Connection Plan and their Medicaid coverage from Healthfirst Medicaid Managed Care. This plan includes Medicare Prescription Drug coverage. Services New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), and Nassau, Orange, Rockland, Sullivan, and Westchester counties.

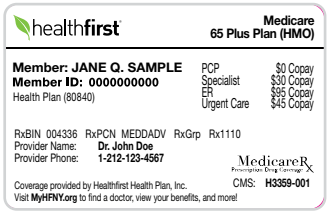
Healthfirst Increased Benefits Plan (HMO)


healthfirst Medicare Increased Benefits Plan (HMO)
Member: JANE Q. SAMPLE
Member ID: 0000000000
Health Plan (80840)
PCP $0 Copay
Specialist $25 Copay
ER $65 Copay
Urgent Care $40 Copay
RxBIN 004336 RxPCN MEDDADV RxGrp Rx1110
Provider Name: Dr. John Doe
Provider Phone: 1-212-123-4567
MedicareRx
CMS: H3359-038

Our Increased Benefits Plan (IBP) is designed for Medicare beneficiaries who qualify for some level of Low Income Subsidy (LIS) for Part D and possibly for some level of assistance in the form of Medicare Savings Programs (MSP) for medical benefits but are not fully dual eligible. Those who qualify for full Extra Help will be eligible for a $0 monthly plan premium, no drug deductible, and lower copays for prescription drugs. Services New York City's five boroughs (the Bronx, Brooklyn,

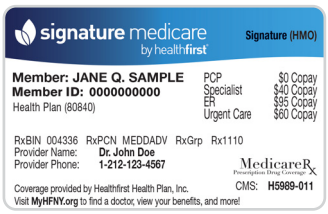
Manhattan, Queens, and Staten Island), and Nassau, Orange, Rockland, Sullivan, and Westchester counties.

Healthfirst 65 Plus Plan (HMO)



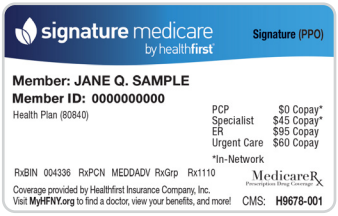
Our 65 Plus plan is designed to be the preferred plan for Medicare beneficiaries who do not qualify for "Extra Help," either in the form of a Low Income Subsidy (LIS) for Part D or of Medicare Savings Programs (MSP) for medical benefits. This plan offers a comprehensive benefit package, including additional benefits not covered by Original Medicare, at a $0 monthly premium, making it a high-value yet affordable choice. Services New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), and Nassau county.

Healthfirst Signature (HMO)



Healthfirst Signature (HMO) is a Medicare Advantage plan that gives members the flexibility to pick benefits that best suit their needs and provides them with a specially trained member services team dedicated to making healthcare easy. It offers the benefits of Original Medicare plus more for a $0 monthly premium. Services New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), and Nassau, Orange, Rockland, Sullivan, and Westchester counties.

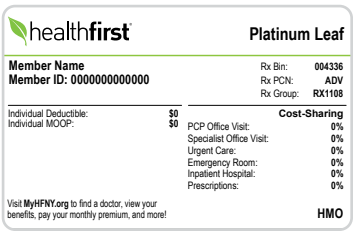
Healthfirst Signature (PPO)



Healthfirst Signature (PPO) is a Medicare Advantage plan that includes all the benefits of Original Medicare, plus dental, vision, hearing, and more, for a $0 monthly premium. This plan provides members with a specially trained member services team dedicated to making healthcare easy. Members have the option of seeing out-of-network providers without a referral and can get care from any doctor or hospital in the U.S. that accepts Medicare. Services New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island) and Nassau county.

Healthfirst Commercial Plans

Healthfirst Leaf and Leaf Premier Plans



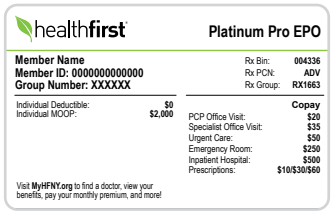
Healthfirst Leaf and Leaf Premier plans are Qualified Health Plans certified by the NY State of Health (NYSOH) Marketplace.

Healthfirst Leaf plans provide essential health benefits, follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements. Healthfirst Leaf Premier plans include the set of essential health benefits and also adult dental and vision care coverage.

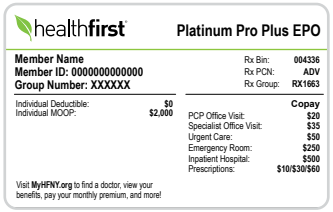
Both Healthfirst Leaf and Leaf Premier plans are offered at different metal levels (Platinum, Gold, Silver, and Bronze), depending on the proportion of healthcare costs that they will cover. Services New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), Long Island, and Westchester county.

Healthfirst Pro EPO and Pro Plus EPO Plans

Healthfirst Pro EPO and Pro Plus EPO plans for small businesses offer commercial, off-exchange health coverage. Healthfirst Pro EPO plans include comprehensive health coverage for small-business owners, their employees, and their families, and cover dental and vision services for individuals below the age of 19.


healthfirst
Platinum Pro EPO
Member Name
Member ID: 0000000000000
Group Number: XXXXXX
Rx Bin: 004336
Rx PCN: ADV
Rx Group: RX1663
Individual Deductible: $0
Individual MOOP: $2,000
Copay
PCP Office Visit: $20
Specialist Office Visit: $35
Urgent Care: $50
Emergency Room: $250
Inpatient Hospital: $500
Prescriptions: $10/$30/$60
Visit MyHFNY.org to find a doctor, view your benefits, pay your monthly premium, and more!

Healthfirst Pro Plus EPO plans include the same benefits as Pro EPO plans, with the addition of vision and dental benefits for adults. Services New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), Long Island, Rockland, and Westchester counties.


healthfirst
Platinum Pro Plus EPO
Member Name
Member ID: 0000000000000
Group Number: XXXXXX
Rx Bin: 004336
Rx PCN: ADV
Rx Group: RX1663
Individual Deductible: $0
Individual MOOP: $2,000
Copay
PCP Office Visit: $20
Specialist Office Visit: $35
Urgent Care: $50
Emergency Room: $250
Inpatient Hospital: $500
Prescriptions: $10/$30/$60
Visit MyHFNY.org to find a doctor, view your benefits, pay your monthly premium, and more!

Healthfirst Total EPO Plans

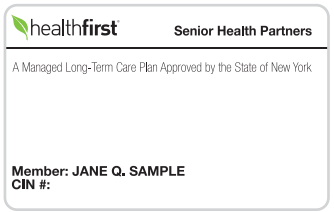
Healthfirst Total EPO plans for individuals offer commercial, off-exchange health coverage. Healthfirst Total EPO plans sold off the NY State of Health (NYSOH) Marketplace to individuals and families include vision and dental benefits for all ages. Services New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island), Long Island, and Rockland and Westchester counties.


healthfirst
Platinum Total EPO
Member Name
Member ID: 0000000000000
Rx Bin: 004336
Rx PCN: ADV
Rx Group: RX1663
Individual Deductible: $0
Copay
PCP Office Visit: $20
Specialist Office Visit: $35
Urgent Care: $50
Emergency Room: $250
Inpatient Hospital: $500
Prescriptions: $10/$30/$60
Visit MyHFNY.org to find a doctor, view your benefits, pay your monthly premium and more!

Healthfirst Long-Term Care Plan

Senior Health Partners (SHP) Managed Long-Term Care (MLTC) Medicaid Plan

SHP is a New York State Managed Long-Term Care Medicaid Plan, capitated by Medicaid, that serves New York City residents 18 years of age and older. Senior Health Partners provides access to services 24 hours a day, 7 days a week, 365 days a year, to ensure that members receive the care they need. Potential members must be qualified for Medicaid, have the ability, at the time of enrollment, of returning to or remaining in their home and community without danger to their health and/or safety, are expected to require at least one Community Based Long-Term Care Service (CBLTCS) for more than 120 days from the effective date of enrollment, and must reside in one of New York City's five boroughs (the Bronx, Brooklyn, Manhattan, Queens, and Staten Island) or in either Nassau or Westchester county.


healthfirst
Senior Health Partners
A Managed Long-Term Care Plan Approved by the State of New York
Member: JANE Q. SAMPLE
CIN #:

Credentialing and Termination

Provider Application Process

Participating providers should contact their Network Account Manager to notify Healthfirst about new providers joining existing practices. Providers who wish to join the network must complete a preliminary application for review. Should the provider be deemed a desirable candidate, they will then be required to complete an application package and to submit the appropriate credentialing documents. For more information, visit **joinhfnetwork.org**.

Credentialing and Re-credentialing Requirements

Providers are initially credentialed through approved delegation agreements with participating hospitals. They are re-credentialed biannually through the same process, or every three (3) years through a review conducted by Healthfirst.

Voluntary Terminations

All providers who wish to terminate their contractual relationship with Healthfirst are bound by the applicable provisions of their Healthfirst agreement.

All providers voluntarily terminating their affiliation with Healthfirst must give 90 days' prior written notice of the termination, or written notice as set forth in the agreement with Healthfirst.

Verbal notification is not sufficient to initiate the termination process.

Online Resources

HFProviders.org

Access all the tools you need to manage your day-to-day practice and deliver services to Healthfirst members.

HFProviderPortal.org

Create your account on our secure provider portal to access patient information and coverage policies, submit and view up-to-date authorization requests, and update your practice information.

Provider Responsibilities

Healthfirst expects participating providers to adhere to the following service guidelines:

- When ordering services for a member, the requesting provider should identify the member as a Healthfirst member and provide the member's Healthfirst Member ID number as well as their own Healthfirst Provider ID number
- Promptly report all findings, clinical reports, test results, and recommendations to the PCP and/or ordering provider in writing, by mail, or by fax
- Consult the Healthfirst Utilization Management staff to obtain required authorization for services
- Collaborate with the member's PCP and Utilization Management staff to ensure continuity of care and appropriate integration of services

Requirements for Primary Care Providers

PCPs are responsible for coordinating all of the care a member receives and are expected to refer members to specialists in the Healthfirst network for care that is outside the scope of primary care. Written referrals are not required for Healthfirst plans.

Because the PCP is the member's first contact with Healthfirst, the PCP is responsible for identifying members with complex or serious medical conditions, assessing those conditions, and recommending members to Care Management for intensive review and follow-up.

Coordination of Care and Services

PCPs are responsible for:

- Coordinating primary and specialty care, ancillary services, and other covered healthcare services, and for collaborating with Healthfirst case managers and other providers involved in the member's care
- Arranging for behavioral health services through the Healthfirst Behavioral Care Unit or the member's designated behavioral healthcare management organization
- Arranging for transportation services, as needed, to ensure that members are able to access healthcare services

Clinical Care

PCPs should:

- Provide first-line primary, preventive, inpatient, and urgent care, or arrange for care, as appropriate, to manage conditions outside the scope of primary care
- Identify Healthfirst members with complex or serious medical conditions—assessing those conditions through appropriate diagnostic procedures—and contact the Healthfirst Care Management staff to collaborate on treatment plans and follow-up
- Provide Healthfirst members with education on the appropriate use of healthcare services, personal health behavior, health risks, preventing STDs, preventing HIV/AIDS, and achieving and maintaining optimal physical and mental health

Preventive Care

PCPs should:

- Provide or arrange for all appropriate screenings and preventive care, including immunizations and well-child visits; tuberculosis screening, diagnosis, and treatment; lead screening for children and appropriate dental care; HIV testing and counseling; mammography screening, colorectal cancer screening, cervical cancer screening, and HbA1c testing
- Maintain compliance with established preventive care standards and clinical practice guidelines adopted by Healthfirst
- Adhere to the New York State Child Teen Health Program (C/THP) Guidelines and Guidelines for Adolescent Preventive Services (GAPS)
- Participate in the Healthfirst Clinical Quality programs designed to improve care for members

Primary Care Panels and Member Enrollment Rosters

Healthfirst members select a PCP at the time of enrollment. PCPs can receive enrollment rosters indicating the Healthfirst members assigned to their panel each month by logging in to the secure Provider Portal at **HFProviderPortal.org** and requesting access under the Healthfirst Reports section.

The enrollment roster contains demographic information for each member in the provider's panel and also reflects the Healthfirst plan the member is enrolled in.

In an effort to engage new members for an appointment, providers should make regular checks to their rosters for new members assigned to their panel.

Behavioral Health Screenings

Healthfirst recognizes the crucial role primary care physicians play in the diagnosis and treatment of depression and promotes the use of the Patient Health Questionnaire (PHQ-9) as a screening tool to assist its PCPs in identifying Healthfirst members with symptoms of depression who may be appropriate candidates for consultation or referral to a Behavioral Health Specialist.

The PHQ-9 should be used at the baseline appointment, at the annual preventive care visit, and when the PCP is alerted to possible signs of depression. A copy of the questionnaire should be kept in the member's medical record. This tool is not intended to replace a complete mental health evaluation and assessment.

Encounter Data and Bill-Aboves

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

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

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

Office Hours for Primary Care Providers

Each Medicaid and CHP PCP must practice at least two (2) days per week and maintain a minimum of 16 office hours per week at each primary care site.

PCPs must also ensure that their patients have 24-hour access to them. This entails having a 24-hour live voice system in place for after-hours calls that can be returned by either the PCP or a covering provider.

HIV Specialist PCPs working at academic institutions may have some flexibility with this requirement. Medicare and commercial providers must maintain a minimum of 10 office hours per week at each primary care site.

Providers who care for the homeless population are not required to maintain a minimum of 16 office hours per week at each primary care site.

Updating Provider Profile

Providers are responsible for contacting Healthfirst to report any changes in their practice. It is essential that Healthfirst maintain an accurate provider database in order to ensure proper payment of claims and capitation, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our members. Changes and updates should be submitted at least thirty days before the effective date. **Any changes to the following list of items should be reported to Healthfirst via our electronic Demographic Change Form, found on our secure Provider Portal at HFProviderPortal.org. Once you have logged in to your account, click on Demographic Changes and complete the electronic Demographic Change Form.**

Changes can also be faxed to Healthfirst at 1-646-313-4634/Attn: Demographic Update Request. These should be submitted with a fax cover sheet that includes full contact information, along with a comprehensive request on the provider or group letterhead that includes the provider's license number and identifies the practice record for update. Any supporting documentation (such as a W-9 form or a board certificate) should be faxed with these requests.

- Update in the provider or group name and tax ID number (W-9 required)
- Update in provider/group practice address, zip code, telephone, or fax number (full practice information required)
- Update in the provider/group billing address (W-9 required)
- Update in the member age limits for service at the practice (if applicable)
- Update in NY license, such as a new number, revocation, or suspension (new certificate or information on action required, if applicable)
- Closure of a provider panel (reason for panel closure)
- Update in hospital affiliation (copy of current and active hospital privileges)
- Update or addition of specialty (copy of board certificate or appropriate education information)
- Update in practice's office hours
- Update in provider's board eligibility/board certification status
- Update in participation status
- Update in NY Medicaid Number (if applicable)
- Update in National Provider Identification Number (if applicable)
- Update in wheelchair accessibility
- Update in covering provider
- Update in languages spoken in the provider's office

Access and Availability

Access & Appointment Availability Standards

Healthfirst maintains provider access, visit scheduling, and waiting time standards that comply with New York State requirements. Healthfirst and the NYSDOH actively monitor adherence to these standards.

Healthfirst conducts audits of provider appointment availability, office waiting times, and 24-hour access and coverage.

All participating providers are expected to provide care for their Healthfirst members within these access guidelines.

24-Hour Coverage

Participating primary care providers must be accessible 24 hours a day, 7 days a week throughout the year, either directly or through back-up coverage arrangements with other Healthfirst participating providers. Each provider must have an on-call coverage plan, acceptable to Healthfirst, that outlines the following information:

- Regular office hours, including days, times, and locations
- After-hours telephone number and type of service covering the telephone line (e.g., answering service)
- Providers who will be taking after-hours calls
- Telephone operators receiving after-hours calls will be familiar with Healthfirst and its emergency care policies and procedures
- The Healthfirst provider will be contacted and patched directly through to the member, or the provider will be paged and will return the member's call in fewer than 30 minutes

It is not acceptable to have an outgoing answering machine message that directs members to the ER.

If an answering machine message refers a member to a second phone number, that phone line must be answered by a live voice.

Waiting Time Standards

In addition to access and scheduling standards, Healthfirst providers are expected to adhere to site-of-care waiting time standards. They are as follows:

- Emergency Visits: Members are to be seen immediately upon presentation
- Urgent Care and Urgent Walk-in Visits: Members should be seen within one (1) hour of arrival
- Scheduled Appointments: Members should not be kept waiting for longer than one (1) hour
- Non-Urgent Walk-in Visits: Members with non-urgent care needs should be seen within two (2) hours of arrival

Please note that prescription refill requests for medications to treat chronic conditions are considered urgent care. It is essential that these medications be dispensed to members promptly to avoid any lapse in treatment.

Missed Appointments

Healthfirst expects providers to follow up with members who miss scheduled appointments. When there is a missed appointment, providers should follow the guidelines below to ensure that members receive assistance and that compliance with scheduled visits and treatments is maintained:

- At the time an appointment is scheduled, confirm an appropriate contact telephone number with the member
- If the member does not keep the scheduled appointment, document the occurrence in the member's medical record and attempt to contact the member by telephone
- To encourage member compliance and minimize the occurrence of "no shows," provide a return appointment card to each member for the next scheduled appointment

Cultural Competence

Cultural competence represents the ability to interact effectively with people of different cultures, conditions, and socioeconomic backgrounds.

Healthfirst services a diverse member population, and it is important that our network providers understand and are prepared for the cultural context of the communities they service.

Healthfirst providers must exercise sensitivity on religious, ethnic, and socioeconomic cultural differences of the members they serve.

People with disabilities face barriers to care at provider sites. So it is important to maintain a culturally competent practice and to address:

- Physical Barriers
- Communication Barriers
- Perception Barriers and Lack of Training

Linguistic Competency

Providers must ensure that services and information about treatment are provided in a manner consistent with the member's ability to understand what is being communicated. Members of different racial, ethnic, and religious backgrounds, as well as individuals with disabilities, should receive information in a comprehensible manner that is responsive to their specific needs.

If foreign-language barriers exist, a family member, friend, or healthcare professional who speaks the same language as the member may be used (at the member's discretion) as a translator.

If a member has hearing, cognitive, or visual impairments, appropriate methods for communication—sign language materials, braille, large print, audio tapes, or simple language for medical forms and instructions—should be made available.

Physical Accessibility

ADA Guidance for Physical Accessibility

In keeping with the guidelines of the Americans with Disabilities Act (ADA), accessibility of doctors' offices, clinics, and other healthcare providers is essential in providing medical care to people with disabilities. All medical, behavioral, and community- and facility-based Long Term Services & Support (LTSS) network providers should be knowledgeable about and adhere to the physical accessibility standards as defined by the U.S. Department of Justice ADA guidance for providers, in the following areas:

- Providing reasonable accommodations—sign materials, braille, large print, audio tapes, or simple language for medical forms and instructions—to those with hearing, vision, cognitive, and psychiatric disabilities
- Utilizing furniture that meets the needs of all participants, including those with physical and non-physical disabilities. Ensure there are no obstructions in pathways that would inhibit free movement and that pathways are navigable, safe, and accessible
- Utilizing clear signage and directional text or symbols (e.g., colored arrows) throughout facilities

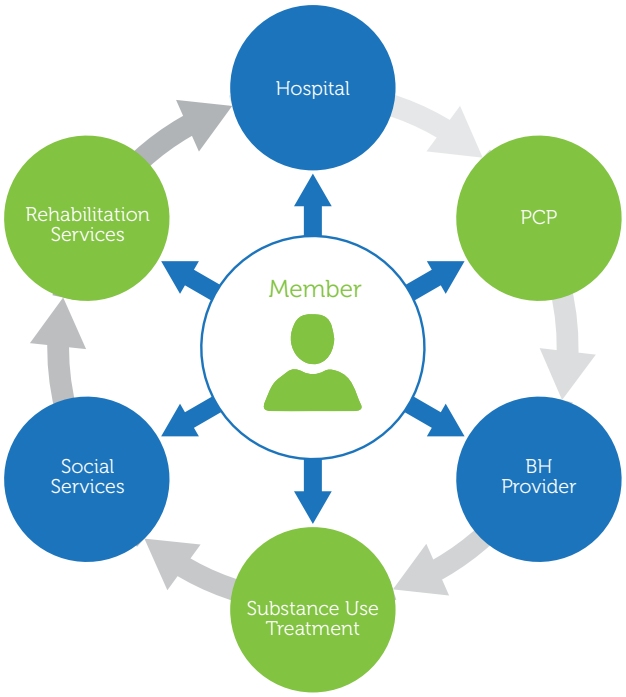
Benefits of Cultural Competency

- **Expand your patient base by providing more culturally and linguistically appropriate care to a wider diversity of patients**
- **Deliver a higher quality of care to help your patients meet their healthcare goals, while honoring and respecting their cultural beliefs and practices**
- **Decrease clinical errors that may arise due to cultural and linguistic differences in communication and differences in health literacy**

Model of Care

The Core Team may include:

- Member or Member Representative
- Healthfirst Care Manager (telephonic)
- Healthfirst Care Coordinator (telephonic)
- Healthfirst Behavioral Health Care Manager
- Primary Care Provider (PCP)
- Primary Behavioral Health Clinician
- Therapist (as indicated)



Other Potential Team Members:

- Specialty Care Physicians
- Home Care Nurses
- Residence Managers
- Social Workers
- Peers
- Other Caregivers
- Family and Community Supports

Special Needs Plan (SNP) Model of Care (MOC)

What is a Special Needs Plan?

Congress created Special Needs Plans (SNPs) in the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries.

Three types of SNPs exist, each designed for a specific group:

- C-SNP — for individuals with severe or chronic conditions
- I-SNP — for individuals who are institutionalized or eligible for nursing home care
- D-SNP — for dual-eligible individuals

What is MOC Delivery for SNPs?

SNP MOC delivery methodology provides primary, specialty, and acute care services, as well as Medicaid long-term care services (under certain plans), through an Interdisciplinary Care Team (ICT) approach.

The MOC strives to meet the specialized needs of its members and to optimize their health outcomes by using evidence-based practices with an appropriate network of providers and specialists.

Healthfirst SNPs are:

- Life Improvement Plan (LIP) – D-SNP
- CompleteCare – Fully Integrated D-SNP with LTC services
- Connection Plan (D-SNP)

How Does it Work?

SNPs improve care for beneficiaries with special needs through interdisciplinary coordination and continuity of care, referred to as a MOC.

Healthfirst's MOC supports service delivery for members through facilitation of access to needed resources and quality care, including:

- Coordination of care through a central point of contact
- Monitoring transitions through the timely coordination of care plans to ensure vulnerable SNP populations do not receive fragmented care, thereby reducing readmissions
- Preventive health, medical, mental health, social services, and added-value services

The Interdisciplinary Care Team (ICT)

The ICT is the group of caregivers who take part in the development and implementation of a comprehensive Interdisciplinary Care Plan (ICP) or Person-Centered Service Plan (PCSP) for each member. Members of the team could be PCPs, RNs, behavioral health professionals, home care aides, specialists, therapists, family members, and anyone who is involved in performing duties to manage the member's care.

The ICT should work together and communicate with each other to ensure the member's ICP is effective. Membership of this team is defined by a Healthfirst Care Manager, based on the member's initial and ongoing health assessments and on conversations with the member and the member's PCP.

The ICT approach—to provide each member with an individualized comprehensive care plan—maximizes the member's functional potential and quality of life.

The ICT ensures integration of the member's medical, behavioral health, community-based or facility-based long-term services and supports (LTSS), and social needs.

The ICT will be based on a member's specific preferences and needs, and will deliver services with respect to linguistic and cultural competence, and dignity.

ICT Responsibilities

Each ICT member is responsible for:

- Actively participating in the ICT service planning and care management process
- Attending meetings, whether in person or by means of real-time, two-way communication (telephone or videoconference)
- Regularly informing the ICT of the medical, functional, and psychosocial conditions of the member
- Remaining alert to pertinent input from other team members and caregivers
- Documenting changes in a member's condition in the Person-Centered Service Plan (PCSP) or ICP
- The ICT as a whole is responsible for making coverage determinations as part of service planning
- After the first ICT meeting, the team must convene routinely, but not more than six months from the previous meeting
- These meetings may occur more frequently, since the ICT must reconvene after a reassessment due to a qualifying trigger event (hospitalization, change in health status, etc.)
- ICT participants must operate within their professional scope of practice appropriate for responding to and meeting the member's needs and complying with the state and federal licensure and credentialing requirements
- When a care decision is required to be made by a provider with a certain licensure and/or certification, the ultimate decision always rests with the appropriately licensed or certified treating participants of the ICT

Authorizations

General Requirements

Other than for emergency care, providers must obtain prior authorization from Utilization Management for all Healthfirst plans for acute inpatient admissions; selected outpatient procedures and services, including certain ancillary services; and all out-of-network care. Prior authorization may be requested by the member's PCP or specialist who is caring for this member.

Required Information for Prior Authorization:

- Member's name and Healthfirst Member ID number
- Attending/requesting provider's name and telephone number
- PCP's name (if not the attending/requesting provider)
- Diagnosis and ICD Code Version
- Procedure(s) and CPT Code(s) and procedure date(s)
- Services requested and proposed treatment plan
- Medical documentation to demonstrate medical necessity

For inpatient admissions: hospital/facility name, expected date of service, and expected length of stay.

Important Points on Authorizations:

- Our Online Authorization Request tool is intuitive and easy to navigate. It lets you request authorizations without the need to call or fax Healthfirst. To access the Online Authorization Request tool, log in to the Secure Healthfirst Provider Portal at HFProviderPortal.org. You will need your username and password to log in. If you do not have an account, you must create one to access the secure portal. Once logged in, click on the "Online Authorization Request" tab
- When requesting authorizations, the requesting provider should supply their Healthfirst provider ID, NPI, or Tax ID number and the Member ID number for which services are being requested, along with all supporting clinical documentation. Authorization requests can be submitted via the Online Authorization Request tool available via HFProviderPortal.org, Provider Services intake phone line, or the Utilization Management fax line
- The Utilization Management team will make a decision on the services, based on medical necessity, utilizing nationally accepted standards of practice guidelines and within the timeframes set forth by state and federal regulations
- Providers will be notified of the authorization determination via phone/fax and/or letter
- Providers should contact the Utilization Management team three days before the expiration of the authorization to request additional services and must submit supporting clinical documentation

Authorization Resources:

- Provider site: HFProviders.org — Authorization tools require login
- Healthfirst: Utilization Management – 1-888-394-4327, Fax: 1-646-313-4603
- DentaQuest: Dental Services – 1-800-341-8478
- American Specialty Health (ASH) Chiropractic Services – 1-800-972-4226
- Davis Vision: Eye Examinations/Vision Care/Glasses – 1-800-773-2847
- Superior Vision: Cataract/Cosmetic Eye Surgeries – 1-888-273-2121
- eviCore: Radiology and Radiation Therapy Authorizations – 1-877-773-6964
- OrthoNet: PT/OT/ST Therapy Services – 1-844-641-5629
  Pain Management, Spinal Surgery, and Podiatry procedures performed in an outpatient setting or ASC – 1-844-504-8091
- CVS/Caremark: Specialty Pharmacy – 1-866-814-5506
- Pharmacy Services: Medicaid – 1-877-433-7643; Medicare – 1-855-344-0930

Claims, Appeals, EFT, ERA, and Virtual Card by VPay

Providers must submit claims for reimbursement of services delivered. These claims also serve as encounter data for services rendered under a capitation arrangement. **Providers should never bill Healthfirst members for covered services.**

Timely Filing: Clean claims must be submitted within **180 days** of the date of service.

Claims can be submitted on paper by sending to:

Healthfirst Claims Department
P.O. Box 958438
Lake Mary, FL 32795-8438

OR submit claims electronically and enjoy the following benefits:

- **Faster submission of claims**
- **Faster tracking of claims**
- **Improved cash forecasting and cash flow**

Grace Period Impact to Leaf Plan Providers

Members who receive advance premium tax credit (APTC) subsidies are entitled to a 90-day premium payment grace period.

Claims submitted during days 31–90 of the member's grace period will not be subject to prompt pay provisions until the member pays their premium in full.

Providers are not permitted to balance-bill members during days 31–90 of their grace period. If the member's premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract.

If the member premium is not paid in full by the end of the grace period, claims incurred during days 31–90 of the grace period will be denied.

Electronic Claims

Claims submitted electronically must include:

- Healthfirst Payor ID Number 80141
- Member ID Number
- Provider Name
- Tax ID Number
- Facility NPI Number (if applicable)
- Provider Billing Address
- The Authorization Number
- Valid Procedure Code(s)
- Rate Code/Value Code (if applicable)
- Valid Diagnosis Codes (appropriate ICD-10 version for DOS after 10/1/2015)
- Procedure Code Modifiers (as needed)
- Units of Service
- And for Physician and Outpatient Administered Drugs, the Corresponding NDC Code, NDC Metric Unit, and Unit of Measure (if applicable)

Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Benefits

- The electronic exchange or transfer of money from one account to another, which reduces mailing costs overall — no stuffing of envelopes and no printing
- The electronic payments are sent much faster every week
- ERAs are processed electronically
- EFT/ERA is safe, secure, and efficient
- EFT money is available right away with direct deposit to a checking account
- No lost checks

Virtual Card by VPay Payment

Healthfirst is in the process of transitioning providers to an electronic mode of payment instead of reimbursing through paper checks. We would like all of our providers to sign up for EFT/ERA as the preferred choice of reimbursement or receive payments in the form of Virtual Card by VPay.

Benefits of Virtual Card include:

- **Faster payments:** Virtual Card is delivered via fax, so you will receive payments much quicker than you would with mailed checks
- **Easier reconciliation:** All past Explanation of Payments (EOP) and payment details are stored for you on on the Healthfirst Provider Portal for easy access and reconciliation
- **No bank deposits:** Electronic delivery will deposit your funds directly into your merchant account
- **Fraud protection:** Virtual Card eliminates the risk of fraud. VPay guarantees the delivery of funds to your account, regardless of any fraudulent attempt to process Virtual Card

Reviews and Reconsiderations

Corrected Claims: Corrected claims must be marked "corrected" and should be submitted within 180 days of the date of service. All corrected claims must include the original Healthfirst claim number being corrected. For electronic corrected claim submission, the claim frequency type code must be a 7.

These requests may be submitted electronically through your clearinghouse or mailed to:

Healthfirst Correspondence Department
P.O. Box 958438
Lake Mary, FL 32795-8438

Reviews and Reconsiderations: Requests must be made in writing, with supporting documentation:

- **Request within 90 days from the paid date on Explanation of Payment (EOP)**
- **Requests are accepted through the Healthfirst secure Provider Portal or may be mailed to:**

Healthfirst Correspondence Unit
P.O. Box 958438
Lake Mary, FL 32795-8438

- **Appeal the outcome of a review and reconsideration in writing, with supporting documentation, within 60 days from the date listed on the reconsideration letter and send to:**

Provider Claims Appeals
P.O. Box 958431
Lake Mary, FL 32795-8431

Compliance

First Tier, Downstream and Related Entities (FDRs) and Affiliate Definitions

First Tier Entity: Any provider or facility directly contracted with Healthfirst who provides services to Medicare enrollees in the Medicare Advantage or Part D program.

Downstream Entity: Any provider or entity that has a written agreement with a First Tier Entity and that provides services to Medicare enrollees in the Medicare Advantage or Part D program.

Related Entity: Any entity that is related to a Medicare Advantage Organization (MAO) or Part D sponsor by common ownership or control and that:

- **Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation**
- **Furnishes services to Medicare enrollees under an oral or written agreement; or**
- **Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period**

Affiliate: An affiliate is a person, provider, or entity who provides care, services, or supplies under the Medicaid program, or a person who submits claims for care, services, or supplies for or on behalf of another person or provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

Compliance Requirements

Healthfirst requires each First Tier Entity and Affiliate to complete an annual Compliance Attestation to confirm compliance with the following requirements:

- Reporting of fraudulent, wasteful, and abusive activities
- The policy listed in section 3.3 of the Healthfirst Provider Manual and all applicable federal and state regulations on:
    - Standards of conduct and effective compliance policies
    - OIG and GSA exclusion screening

This attestation can be completed online at **HealthfirstFDR.org**. In addition, First Tier Entities are responsible for ensuring that their downstream and related entities are in compliance with this policy and with applicable federal and state statutes and regulations.

Reporting Potential Fraud, Waste, and Abuse

There are three ways to report Fraud, Waste, or Abuse to Healthfirst:

- Confidential Healthfirst Hotline: 1-877-879-9137
- Confidential Healthfirst Website: hfcompliance.ethicspoint.com
- Confidential Healthfirst Email: compliance@healthfirst.org

All Healthfirst vendors, providers, and First Tier, Downstream and Related Entities (FDRs) are expected to bring any alleged inappropriate activity which involves Healthfirst to our attention.

Healthfirst maintains a strict policy of **zero tolerance** toward fraud, waste, and abuse and other inappropriate activities.

If you have any questions or need additional information, please contact your Network Account Manager, or call Provider Services at 1-888-801-1660, Monday to Friday, 8:30am–5:30pm

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, “Healthfirst”).