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SECTION 1 - INTRODUCTION

INTRODUCTION TO AFFINITY HEALTH PLAN

Affinity Health Plan (originally known as the Bronx Health Plan) opened for business in early 1987. Our founder had one goal in mind: to offer affordable, high quality health care coverage to needy New Yorkers by working closely with community health centers and other primary care practices. We were the first health plan licensed in New York State to serve public-sector health programs. We have grown from a handful of members in 1987 to more than 280,000 today. Affinity works with more than 40,000 primary care and specialty care providers to ensure our members receive the services they need.

High quality, affordable coverage from Affinity Health Plan: NY State of Health, The Official Health Plan Marketplace is where individuals and families shop for and purchase health insurance. Individuals can enroll via the Marketplace in the Affinity Health Plan product that best meets their needs or the needs of their family:

- **Essential Plan** is a New York State-sponsored program for lower-income people who don’t qualify for Medicaid or Child Health Plus, and which costs much less than other health plans.

- **Medicaid Managed Care** is a New York State-sponsored program for children and adults who meet income, resource, age, and/or disability requirements.

- **Child Health Plus** is a New York State-sponsored program for children under the age of 19 who do not qualify for Medicaid and which provides free or low-cost comprehensive coverage. Almost every child in New York State is eligible — regardless of family income.

- **Health and Recovery Plan (HARP)**, Affinity Health’s Enriched Health Plan, is a managed care product that manages physical health, mental health, and substance use services in an integrated way for adults with significant behavioral health needs (mental health or substance use).

Affinity Health Plan is operational in the Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk and Westchester counties of New York State. For a current listing of programs, eligibility guidelines, and counties of operation, please visit our website at AffinityPlan.org.
Our Mission, Vision and Values

Mission

The mission of Affinity Health Plan is to improve the health and well-being of our members, their families and communities in collaboration with primary care providers.

Vision

Affinity strives to be the health plan of choice for its members and its providers known for assuring access to high quality cost-effective care, for delivering the best customer experience and for having a robust patient-centered health care system.

Values

We recognize and accept the importance of shared personal values in achieving our mission, in increasing personal effectiveness, and in demonstrating our commitment to our members, providers and employees. The values that are most important to us are:

- Commitment to improving health and healthcare
- Integrity and honesty during interactions
- Respecting and caring for people
- Partnership and collaboration with those who share our values and goals
- Pride in our communities, our daily work and our accomplishments
- Promoting constructive change and innovation
- Encouragement and support of personal and organizational achievements

Affinity Health Plan is a Prepaid Health Services Plan (PHSP).

Provider Manual Use and Interpretation

Thank you for joining the Affinity Health Plan network. This provider manual is made available to orient you and your staff on the policies, procedures and expectations related to your network participation.

The provider manual is not intended to alter or modify any benefits to which an Affinity (member) is entitled. To the extent that policies, procedures and expectations are unique to a particular product, they are delineated in the product line sections of this manual. This manual will be amended as our operational policies change.

The most current version of our provider manual is the operative version that providers are required to follow and is always available on our website AffinityPlan.org, where 24-hours a day, seven days a week you can access our provider portal (Affinityportal.AffinityPlan.org) to check member eligibility, claim status, primary care provider (PCP) panel assignment, etc. Provider Portal registration is required and takes only a few minutes to establish access.

For your convenience, a quick reference guide is also included following this manual’s table of contents. If you have any questions that are not addressed in this manual and cannot be answered or resolved through our website, please call our Customer Service at 866.247.5678 or your Provider Account Representative.

We value your contribution to your patients and our members and are dedicated to making your participation a success!
HOW AFFINITY HEALTH PLAN WORKS WITH PROVIDERS AND MEMBERS

Provider Relations Department

The Provider Relations Department is dedicated to fostering strong, long-term partnerships with all contracted providers. This relationship begins with an initial orientation and is followed by continuing education on policies, procedures, and issues that concern healthcare delivery within the guidelines of Affinity Health Plan.

Health Services (UM/CM)

Our Health Services Department assists with pre-authorization requests and works with providers to perform concurrent review for stays extending past the base DRG period. They will also assist with discharge planning. Our case managers assist with long-term patient care and care coordination. Our UM department also arranges for peer-to-peer requests.

Quality Department

The Quality Department evaluates the quality and appropriateness of health care services provided to Affinity Health Plan members. They are directly accountable for HEDIS® data compilation and reporting.

Customer Service Department

In addition to our web tools, Customer Service is available Monday to Friday, 8:30 a.m. to 6:00 p.m. ET for Medicaid, Essential Plan, Enriched Plan, HARP and Child Health Plus; and to help members and respond to questions or concerns regarding their health care coverage. This includes providing information about covered benefits, helping choose or change a primary care provider, orienting members to our plan, and sharing member responsibilities.

Customer Service also solicits feedback from members as to their satisfaction with services provided by Affinity Health Plan. The goal is always to address member concerns or complaints quickly and efficiently.

Claims Department

The Claims Department processes and pays claims for covered services provided in accordance with the provider's contract and with Affinity Health Plan policies and procedures. The claims department also performs follow-up work when there are questions about the accuracy of a claim payment or when a claim is re-submitted with corrected information.
Grievances and Appeals (G&A)

The G&A Department is responsible for all member/provider appeals and state fair hearings. Our G&A Department assists with appeals regarding administrative action from the health plan as well as medical necessity denials.

ASSESSING PROVIDER SATISFACTION

On an annual basis Affinity Health Plan conducts a provider satisfaction survey. The survey includes questions that relate to satisfaction with our utilization management and with authorization processes, administrative policies, network adequacy, the call center, and the Provider Relations Department. The survey results are analyzed and reported in various forums, and actions are taken to address identified opportunities. Affinity Health Plan encourages all providers to participate in the provider satisfaction survey.

HOW TO CONTACT AFFINITY HEALTH PLAN

The easiest and fastest way to access information regarding membership and eligibility, claims information, and primary care physician assignment is through Affinity Health Plan's provider portal at Affinityportal.AffinityPlan.org.

Providers and their staff members can log in using a secure username and password 24-hours a day, seven days a week.

Our Customer Service Department is also available to answer your questions. Customer service representatives (CSRs) can assist with member eligibility questions, claims payment and much more. Call 866.247.5678.

AFFINITY’S BEHAVIORAL, DENTAL, PHARMACY AND VISION PROVIDERS

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Phone Number</th>
<th>Web Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon Health Options - Behavioral Health</td>
<td>888 438-1914</td>
<td>Beaconhealthoptions.com/</td>
</tr>
<tr>
<td>DentaQuest</td>
<td>866.731.8004</td>
<td>Dentaquest.com/</td>
</tr>
<tr>
<td>CVS Caremark Pharmacy</td>
<td>855.722.6228</td>
<td>Caremark.com/</td>
</tr>
<tr>
<td>Superior Vision</td>
<td>866.810.3312</td>
<td>Superiorvision.com/</td>
</tr>
<tr>
<td>Integra Partners</td>
<td>888.729.8818</td>
<td>Accessintegra.com/</td>
</tr>
<tr>
<td>Landmark (EP only)</td>
<td>800.638.4557</td>
<td>Landmarkhealthcare.com/</td>
</tr>
</tbody>
</table>

HOW TO CONTACT eviCore healthcare

Affinity Health Plan has engaged eviCore healthcare (eviCore) to manage the prior authorization program, outpatient high-technology radiology services, non-obstetrical ultrasounds, diagnostic cardiology services, radiation Therapy and therapy services.

<table>
<thead>
<tr>
<th>Authorization Program: Radiology, Cardiology, PT/OT/ST and Radiation Therapy</th>
<th>Phone: 866.242.5615, option 6 evicore.com/</th>
</tr>
</thead>
</table>
Affinity Health Plan’s partnership with eviCore healthcare includes authorization of the following services:

- **Ultrasound**
  For a routine pregnancy, the first two ultrasounds – nuchal translucency (76813) and fetal anatomy survey (76805) – do not require prior authorization. Any additional ultrasounds will require prior authorization.

- **Non-Obstetric Ultrasounds**
  The first ultrasound for any one specific condition (e.g., pelvic ultrasound for pelvic pain, thyroid ultrasound for a thyroid mass, renal ultrasound for hematuria) does not require a prior authorization. Any additional ultrasound for the same condition will require prior authorization.

- **PT/OT/ST**
  Prior authorization is not required for the first six visits within the benefit period. Visit seven and beyond will require prior authorization. Please refer to the specific program benefits for limitations.

- **Sleep Study Supplies**
  Prior authorization is required every three months. Out-of-network services or services rendered by a non-participating physician or provider continue to require prior authorization. Participating Affinity providers must refer to in-network providers and/or render services in in-network facilities.

### OTHER USEFUL NUMBERS

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
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<tbody>
<tr>
<td>New York State (NYS) Child Abuse Hotline</td>
<td>800.342.3720</td>
</tr>
<tr>
<td>Early Intervention Program (EIP) NYS</td>
<td></td>
</tr>
<tr>
<td>Early Childhood Direction Center</td>
<td>518.473.7016 or in</td>
</tr>
<tr>
<td></td>
<td>New York City (NYC) dial 311</td>
</tr>
<tr>
<td></td>
<td>518.486.7462 &amp; TTY: 518.474.5652</td>
</tr>
<tr>
<td>Vaccines for Children (VFC)</td>
<td>800.543.7468 or 800.KID.SHOTS</td>
</tr>
<tr>
<td>Women, Infants and Children Program (WIC)</td>
<td>800.522.5006</td>
</tr>
<tr>
<td>NYS HIV Counseling, Testing and Other Services Hotline</td>
<td>800.541.AIDS (2437) - English</td>
</tr>
<tr>
<td></td>
<td>800.233.SIDA (7432) - Spanish</td>
</tr>
<tr>
<td>NYC Deaf or Hard of Hearing AIDS Hotline</td>
<td>800.421.1220 or dial 711</td>
</tr>
<tr>
<td>NYS Domestic and Sexual Violence Hotline</td>
<td>800.942.6906 (English, Spanish) &amp; multi-language accessibility, Dial 711</td>
</tr>
<tr>
<td></td>
<td>800.621.HOPE (4673), dial 311 or TTY: 866.604.5350</td>
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<tr>
<td>NYC Deaf or Hard of Hearing NYC Hotline</td>
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MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

Members have rights pursuant to federal and state laws and to the applicable program contract. **While enrolled in Affinity Health Plan, member’s healthcare rights are an important part of their participant services.** These rights are summarized below. (Additionally, member rights and responsibilities are outlined in the Affinity Health Plan member handbook provided to all members upon enrollment.)

Throughout your participation, you must allow members to:

- See plan providers, get covered services, and have prescriptions filled within a reasonable period.
- Obtain clear, complete and current information with regard to diagnoses, treatments and prognoses in terms the member can understand. When it is not advisable to give such information to the member, the information must be made available to an appropriate person acting on the member’s behalf.
- Receive information as necessary to give informed consent prior to the start of any procedure or treatment.
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- Receive prompt and reasonable responses to questions and requests, including information about Affinity Health Plan, our services, our practitioners and providers, and about member rights and responsibilities. Information for Medicaid, the Essential Plan, HARP and Child Health Plus is available at AffinityPlan.org 24 hours a day; by calling Customer Service Monday to Friday between 8:30 a.m. and 6:00 p.m. Eastern Time, by fax at 718.794.7804; or by TTY dialing 711.
- Be treated with courtesy, respect, dignity and with protection for privacy including the protection of medical records and personal health information.
- Have their information remain confidential throughout the Affinity Health Plan organization. The following are ways Affinity Health Plan keeps information confidential:
  - Affinity Health Plan staff members are prohibited from discussing confidential information in public places, such as elevators or outside of Affinity Health Plan offices.
  - When discussing confidential information on the telephone, staff members are required to use appropriate safeguards to confirm they are speaking with someone who has the right to the confidential information.
• All electronic transmissions contain limited identifiable information and are protected by encryption when sent outside of the organization.
• Paper documents are stored in secure locked areas and destroyed when no longer needed.
• Participate with practitioners in making decisions about their health care.
• Have a candid discussion with their practitioners or providers about appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage.
• Be given, upon request, full information, and necessary counseling on the availability of known financial resources for their care.
• Share which member support services are available, including whether an interpreter is available.
• Voice complaints or appeals about Affinity Health Plan and the care or services we provide. Complaints may be made by contacting Customer Service at 866.247.5678 (TTY users should call 711) or fax us at 718.536.3358.
• Make recommendations regarding our member rights and policy responsibilities.

Member Responsibilities

Affinity Health Plan members have the responsibility to:
• Supply information (to the extent possible) that Affinity Health Plan and its practitioners and providers need in order to provide care, including notifying the provider of any unexpected changes in their condition as well as past health issues.
• Follow the plans and instructions for care they have agreed to with their practitioners.
• Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
• Assure the financial obligations of their health care are fulfilled as promptly as possible, including premiums, if any, and copayments that the patient may owe for covered services. They must also meet the financial responsibilities that are described in the Evidence of Coverage section.
• Act in a way that supports the care given to others in the provider’s office, and not interfere with the smooth running of their doctor’s office, hospital and other offices.
SECTION 3 – PROVIDER ROLE AND RESPONSIBILITIES

THE PROVIDER'S ROLES AND RESPONSIBILITIES

As a participating provider, you shall:

- Provide services that conform to accepted medical and surgical practice standards in the community. These community standards include, as appropriate, the rules of ethics and conduct as established by medical societies and other such bodies, formal or informal, including governmental agencies, from which physicians seek advice or guidance or to which they are subject for licensing and control.

- Refrain from discriminatory practices, actions or language against any member on the basis of age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, need for health services, or payment.

- Adhere to all laws related to obtaining informed consent for treatment.

- Comply with all laws related to advance directives and provide care and treatment according to the wishes of the member.

- Make reasonable efforts to assure timely and accurate compliance with other mandated reporting requirements, including the following:
  1. Infants and toddlers suspected of having a developmental delay or disability;
  2. Suspected instances of child abuse; and
  3. Additional reporting requirements pursuant to state law and, for contractors operating in New York City, the New York City Health Code.

- Immediately notify Affinity Health Plan's chief medical officer, in writing, if any of the following occurs:
  1. The ability to practice medicine is restricted or impaired in any way, or
  2. The license to practice is revoked, suspended, restricted, requires a practice monitor or is limited in any way, or
  3. Any adverse action is taken, or
  4. An investigation is initiated by any authorized local, state or federal agency, or
  5. Any new or pending malpractice actions, or
  6. Any reduction, restriction or denial of clinical privileges at any hospital, or
  7. Any sanctions by CMS or NYOMIG which have limited or removed provider participation from government programs.

- Comply with all Affinity Health Plan reimbursement, quality assurance, utilization review, referral, complaint/grievance, and all other processes/functions.

- Cooperate and participate in all Affinity Health Plan peer review functions, including quality assurance, utilization review, and administrative and grievance procedures as established by Affinity Health Plan.
• Comply with all final determinations rendered by Affinity Health Plan peer review programs or external third-party reviewers for grievance procedures consistent with the terms and conditions of the provider's agreement with Affinity Health Plan and this provider manual.

• Notify Affinity Health Plan in writing of any change in office address, telephone number or office hours. A minimum of thirty (30) calendar days advance notices is requested.

• Notify Affinity Health Plan at least ninety (90) calendar days in advance, in writing, of any decision to terminate the relationship with Affinity Health Plan or as required by the provider’s agreement with Affinity Health Plan.

• Not under any circumstances, including non-payment by or insolvency of Affinity Health Plan, bill, seek or accept payment from Affinity Health Plan members for covered services with the exception of any applicable copayments.

• Freely communicate with members about all treatment options, regardless of benefit coverage limitations.

• A member requires or requests a service that is not covered or authorized by Affinity Health Plan, and such service is also not covered by the program through which the member is entitled to receive services, the provider is required to:
  1. Inform the member that the member will be personally responsible for all fees related to the service and the estimated fee for the service.
  2. Obtain an executed acknowledgment of financial responsibility from the member prior to the time such services are provided.
  3. Obtain express prior approval from the member and from Affinity Health Plan.

Only if these steps have been taken shall the provider be entitled to bill the member and collect for such services.

• At provider sites where participating providers are sharing office space with non-participating providers, a participating provider must treat Affinity Health Plan members.

• Maintain standards for documentation of medical records and confidentiality for medical records (as per Section 7 of this manual).

• Agree to retain medical records for six (6) years after the date of service(s) rendered to members, and for a minor, three (3) years after majority or six (6) years after the date of the service, whichever is later.

• Maintain appointment availability in accordance with New York State standards (as defined in Section 4 of this manual).

• Maintain 24-hour access in accordance with New York State standards (as defined in Section 4 of this manual). Providers shall notify Affinity Health Plan of any extended coverage arrangements for sick leave, vacation, etc.
• Notify Affinity Health Plan within 180 days if panel is closing.
• Cooperate with all HEDIS® requests on a timely basis.
• Report communicable diseases, immunizations, lead testing, etc. consistent with New York State requirements.

ADDITIONAL HOSPITAL ROLES AND RESPONSIBILITIES
• Provide all contracted services that are within the scope of the facility’s operating certificate.
• Discuss discharge planning with Affinity Health Plan to coordinate the most appropriate care for the member and to ensure services are in place prior to discharge.

RESTRICTED RECIPIENT PROGRAM
The Restricted Recipient Program is a medical review and administrative mechanism that restricts recipients to one or more healthcare providers due to a demonstrated pattern of abusing or misusing the Medicaid program. Restricted recipients are Affinity Health Plan members whose care must be coordinated and authorized through a provider assigned by Affinity Health Plan. This restriction applies to all non-urgent and non-emergent services. Failure to coordinate care with the member’s Affinity Health Plan-assigned provider may result in a denial of services. Restricted recipients are clearly identified when checking member eligibility online.

CULTURAL COMPETENCE
Cultural competence represents the ability to interact effectively with people of different cultures and conditions.

Affinity serves a diverse member population and it is important to our network that providers understand and are prepared for the cultural differentiators and attributes of the members they serve. A culturally competent clinician views all patients as unique individuals and realizes that their experiences, beliefs, values and language affect their perceptions of clinical service delivery, acceptance of a diagnosis and compliance with any treatment plans. 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.
Where possible, professional translators should be used as it may not always be in the individual’s best interest to have a family member act as an interpreter. Individuals may feel uncomfortable discussing personal matters in front of a relative or close friend. In addition, the friend or family member may lack a medical vocabulary or may reinterpret what the patient says with an inaccurate connotation.

In addition to verbal sensitivity, providers should be sensitive to cultural differences when using nonverbal communication. Clinicians must be aware that personal space has different boundaries in different cultures and that simple touches can have different meanings.

**Communication Access**
Communication is an integral part of providing care to a patient. Communication may become an issue if there are barriers based on physical, social, or language limitations. Affinity Health Plan providers may bill translator services using Code T1013. If a translator is not available, a language line or TTY line can be accessed by calling Affinity at 866.247.5678.

**Physical Access**
An accessible examination room has features that make it possible for patients with mobility disabilities, including those who use wheelchairs, to receive appropriate medical care. These features allow the patient to enter the examination room, move around in the room, and utilize the accessible equipment provided. Affinity notes in the provider directory which providers’ offices are handicap accessible. Detailed diagrams can be found at ADA.gov/medicare_mobility_ta/medcare_ta.htm.

**Informed Consent**
As a matter of practice, the provider must adhere to all federal and state law requirements for obtaining informed consent for treatment. Properly executed consents must be included in the medical record for all procedures that require informed consent.

**CONFIDENTIALITY**
All Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act of 1996 (45 CFR § 164.501), related to services provided to members shall be confidential pursuant to federal and state laws, rules and regulations. PHI shall be used or disclosed by the provider only for a purpose allowed by or required by federal or state laws, rules, and regulations.

Medical records of children enrolled in foster care programs shall be disclosed to local social service officials in accordance with the New York State Social Service Law.

Medical records of all Affinity Health Plan members shall be confidential and shall only be disclosed to and by the provider’s personnel as necessary to provide medical care and quality, peer, or complaint and appeal review of medical care under the terms of the applicable program contract as required in accordance with applicable laws and regulations.
You Can Help Protect Patient Confidentiality
Protecting a patient’s privacy is an essential part of building a physician/patient relationship. You and your staff can help protect patient confidentiality by following these simple measures:

• Avoid discussing cases where other patients or visitors can hear.
• Ensure voices cannot be heard easily through exam room walls.
• Allow privacy for paying bills and making appointments.
• Make sure computer screens containing patient information are protected from general view.
• Be sure all patient care is provided out of sight and hearing of others, even routine procedures like weighing.
• Have a confidentiality policy for staff to read, enforced, and kept in office personnel files.
• Ask patients to sign an Authorization to Release Information form prior to releasing medical records to anyone. Ensure all patients are provided with your HIPAA policies and procedures.
• Have a protocol for faxing confidential information.
• Ensure patient sign-in sheets are quickly ‘blacked out’ or not used.

New York State Confidentiality Law and HIV

Member Complaints and Grievance Procedures
All Affinity Health Plan providers must respect member rights as outlined in Section 2 of the provider manual. In addition, providers should participate in, and are obligated to cooperate with, the resolution of any member complaint or grievance that arises relating to an Affinity Health Plan member. Any concerns identified by members with Affinity Health Plan, a provider, or any of a provider's personnel with respect to the provision of all services are handled in accordance with Affinity Health Plan complaint and grievance procedures.

Advance Directives
All participating providers are required to comply with all laws related to advance directives and must provide care and treatment according to the wishes of the member. All new Affinity Health Plan members are told of their right to formulate oral or written advance instructions regarding healthcare treatment. The PCP is responsible for verifying if their patients have executed any advance directives. For additional information go to Health.ny.gov/professionals/patients/patient_rights.

Health Care Proxy
A copy of the health care proxy should be kept with the physician, the health care agent, and the person and any other family member(s) or friend(s) that the person chooses.
SECTION 4 – PRIMARY CARE SERVICES

PRIMARY CARE SERVICES

Responsibilities of the Primary Care Provider

Primary care provider (PCP) services include those that are determined by a provider to be necessary and appropriate to promote, preserve and restore optimal health. Affinity Health Plan does not require paper referrals but does require the PCP to coordinate a member's care with other health care providers. The PCP agrees to:

- Coordinate, provide, monitor and supervise the delivery of all healthcare services, including inpatient care, for any member assigned to the PCP.
- Supervise and coordinate medically necessary care not directly delivered.
- Maintain 24/7 telephone coverage. Answering machines must direct to a live voice.
- Comply with all standards of care applicable to PCPs that are described in Affinity’s Quality Assurance Program and are consistent with generally accepted standards of medical practice.
- Conduct Child/Teen Health Program screenings for MMC children and adolescents and behavioral health screenings for all MMC members as appropriate.
- Provide health counseling and advice; conduct baseline and periodic health examinations; diagnose and treat conditions not requiring the services of a specialist; arrange inpatient care, consultations with specialists, and laboratory and radiological services when necessary; coordinate findings of consultants and laboratories; interpret findings to the patient or the patient’s family subject to confidentiality provisions; and maintain a current medical record for the patient.
- Perform behavioral health screenings for all Medicaid members as appropriate.
- Provide periodic assessments and member education, as clinically necessary, including preventive care measures.
- Contact Affinity immediately in the event that you are no longer able to provide services to a member. You must also provide a written notice to the affected Affinity member(s).
- Provide on-call or after-hours coverage or arrange for on-call and after-hours coverage with another PCP who is participating with Affinity Health Plan.
- Coordinate the medical care of members who have sought medical services at emergency rooms, including necessary follow-up care.
- Provide services normally performed in the provider's practice and provide care that conforms to acceptable medical practice standards.
- Contact Affinity Health Plan members who are new to the practice and perform a comprehensive evaluation within sixty (60) days from the date the member appears on the PCP’s roster.
- Utilize the Affinity website or EPACES to check member eligibility and to verify the member’s assignment to the practice.
- Only see members that are assigned to your practice. If a member who is not...
assigned to you requests services, you should direct them to Customer Service to change their PCP to your practice.

- Provide periodic assessments and member education, as clinically necessary, including preventive care measures based upon clinical guidelines.
- Coordinate care for Affinity Health Plan members who require services outside the scope of the provider's practice to appropriate in-network specialists for consultations and/or medical care. A full list of participating providers can be found on the Affinity Health Plan website at Affinityplan.org/Providers/Resources/Pre-Authorization-Codes/Pre-Authorization-Codes.
  
  Note: An Affinity Health Plan PCP who has training in a sub-specialty may be credentialed in that specialty and also participate as a specialist in Affinity Health Plan’s network. Such providers are referred to as dual providers.

- Refer to in-network providers. See Section 17 Authorization for Non-Participating Providers for the Affinity Health Plan policy on referrals to non-participating providers.
- Provide specific and adequate clinical/diagnostic data with each referral to the specialist.
- Admit and refer members to hospitals that participate in Affinity Health Plan’s network, except in emergencies or when it is medically unsafe for the member to go to a participating hospital.
- Maintain medical records that meet the medical record standards enumerated in Section 7 of this manual.
- Send copies of member medical records, reports, treatment summaries and other related documents to Affinity Health Plan and other participating providers upon request.
- Submit encounter reports for capitated services electronically to Affinity Health Plan using the CMS 1500 or UB04 format. Encounter reports must be submitted within ninety (90) calendar days of the encounter and should list the appropriate procedure and diagnosis codes.
- Submit claim forms and encounters for non-capitated services electronically within ninety (90) days of the date of service using appropriate procedure and diagnosis codes.
- Seek compensation for provision of covered services to members solely from Affinity Health Plan except applicable copays and coinsurance.
- Maintain professional credentials and liability insurance acceptable to Affinity Health Plan and in accordance with state regulations.
- Comply with all utilization management (UM) protocols as outlined in this provider manual. For UM procedures, refer to Section 8 Emergency and Inpatient Services, Section 11 Referrals and Authorizations, Section 17 Authorizations for Non-Participating Providers and Section 16 Behavioral Health. Contact Affinity Health Plan’s Health Services Department at 866.247.5678 for authorization.
• Work closely with Affinity Health Plan to resolve any problems, complaints and disputes that may arise between provider, member and Affinity Health Plan.

• Treat members with respect and honor the member's right to know and fully understand his or her diagnosis, the prognosis and expected outcome of the recommended medical or surgical treatment, and his or her right to refuse treatment. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member’s behalf.

• Not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, income level, source of payment or any other basis prohibited by applicable federal, state or local civil rights laws.

• Abide by Affinity Health Plan policies and procedures relating to member complaints, peer review, quality assurance and utilization review.
  1. Member complaints: Refer to Section 2 Member Rights and Section 14 Member Grievances and Complaints.
  2. Peer review: Refer to Section 3 Provider Roles and Responsibilities; Section 9 Provider Credentialing; Section 10 Quality and Provider Performance.
  3. Utilization review: Refer to Section 8 Emergency and Inpatient Services; Section 11 Referrals and Authorizations; Section 17 Authorizations for Non-Participating Providers; and, Appendix A Quick Reference Guide.

• Notify Affinity Health Plan Provider Relations Department of any changes in information included on the provider application, e.g., changes in address or office hours, on-call arrangements, etc.

• Maintain admitting privileges with at least one hospital that participates in Affinity Health Plan’s network.

• Report and participate in the various state-mandated programs, such as reporting of communicable diseases, participation in immunization registries, lead testing and reporting consistent with New York State public health law and New York State regulations.

• Contact Affinity immediately in the event that you are no longer able to provide services to a member. You also must provide a written notice to the affected Affinity member(s).
Provider Initiated PCP Change
In the event that a PCP determines that he/she is unable to provide services to a member, the PCP must make a written request to the Affinity Health Plan Customer Service Department stating the specific problem. To request the removal of a member from a roster, the PCP must show good cause. Some examples of good cause are:

- Fraudulent acts in obtaining services
- Consistent abuse to the PCP or staff
- Violation of documented office policies and protocols

In no event shall the volume of services requested or utilized by the member be considered a valid reason for transfer of a member.

Capitation
If contracted reimbursement is on a capitated basis, payment will be due for all members reflected on the monthly membership list we provide you. We typically issue capitation checks at the beginning of each month, and you do not need to submit invoices/bills for capitation payments. A single monthly check is issued for all members reflected on a membership list, regardless of product line differences. Even if reimbursement for the underlying service is encompassed in capitation, you must submit a claim for the underlying service so that the encounter can be recorded.

Vaccinations
Affinity Medicaid and Child Health Plus require that vaccines be obtained from New York State's Vaccines for Children immunization program. Providers should call 800.KID.SHOTS (800.543.7468) for more information.

Affinity Health Plan will generally pay providers an administration fee for each covered immunization administered by participating providers.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Services through the Child/Teen Health Program (C/THP) and Adolescent Preventive Services
Child/Teen Health Program (C/THP) is a package of early and periodic screening, including inter-periodic screens and diagnostic and treatment services that New York State offers all Medicaid-eligible children under 21 years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The care includes necessary health care, diagnostic services, treatment and other measures (described in §1905[a] of the Social Security Act) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance.
Behavioral Health and Substance Abuse Screening

Beacon Health Options (Affinity Health Plan’s managed behavioral health partner), has developed a toolkit to assist PCPs in the diagnosis and treatment of mental health and substance use disorders. Delivering behavioral health services in a primary care setting can help reduce the stigma and discrimination associated with mental health diagnoses. It’s also more cost-effective to treat common behavioral health disorders in primary care settings.

Primary care settings are also becoming the first line of identification for behavioral health issues and PCPs are the center of care for many patients who have both physical and behavioral health disorders. To supports PCPs, this online toolkit will assist in identifying behavioral health conditions through well-known screening tools and in decision support. Condition-specific fact sheets, as well as other patient-centered information, are included within the toolkit so PCPs can help their patients understand their diagnosis and take the right steps to become and stay healthy.

The conditions included in the toolkit are:

- Alcohol and other drugs
- Anxiety
- ADHD
- Depression, adolescent depression and postpartum depression
- Eating disorders
- OCD
- PTSD
- Schizophrenia

The toolkit also has forms that will allow PCPs to share relevant patient information with other providers, including behavioral health providers, to facilitate better integration of care. Beacon’s PCP toolkit is an excellent resource for PCPs as they diagnose and treat behavioral health conditions. The toolkit can be found on Beacon’s website at Beaconhealthoptions.com/.

Affinity recognizes the crucial role primary care physicians play in the diagnosis and treatment of depression and promotes the use of the patient health questionnaire (known as PHQ-9) as a screening tool to assist its PCPs in identifying Affinity 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 preventative care visit and when alerted to possible signs of depression. A copy of the questionnaire should be kept in the member’s medical records. This tool is not intended to replace a complete mental health evaluation and assessment. PCPs can refer members to behavioral health specialists for a complete evaluation.
Behavioral health services include:

- Medically necessary supervised outpatient withdrawal (OASAS services)
- Outpatient clinic and opioid treatment program (OTP) services (OASAS services)
- Outpatient clinic (OMH services)
- Comprehensive psychiatric emergency program
- Continuing day treatment
- Partial hospitalization
- PROS
- ACT
- Intensive case management/supportive case management
- Health Home care coordination and management
- Inpatient hospital detoxification (OASAS service)
- Inpatient medically supervised inpatient detoxification (OASAS service)
- Inpatient treatment (OASAS service)
- Rehabilitation services for residential SUD treatment supports (OASAS service)
- Inpatient psychiatric services (OMH service)
- Rehabilitation services for residents of community residences

Health Homes
Affinity participates with many Health Homes in its service area. A Health Home is a care coordination model where communication between a member’s caregivers aims to improve member outcomes. A Health Home-based care manager oversees and provides access to all of the services a member needs to assure they stay healthy, out of the emergency room and out of the hospital. Health records are shared (either electronically or by paper) among providers so that there is no duplication of services or so that needed services are provided timely. In concert with Affinity Health Plan, Health Home services are provided through a network of organizations, providers, health plans and community-based organizations. When all the services are considered collectively, they become a virtual "Health Home." Enriched Health members are eligible for Health Home services; it is an elective service so it is the member’s decision if they wish to receive services from a Health Home.

Eligibility for Health Home Services

- One single qualifying condition: HIV/AIDS or a serious mental illness (SMI)
- Two or more chronic conditions such as:
  - Substance abuse
  - Heart disease
  - Diabetes
  - Asthma
  - Hypertension
  - Obesity
Services Office Hours
Under New York State Department of Health guidelines, Affinity Health Plan primary care providers must practice at least two days per week and maintain a minimum of 16 office hours per week at each primary care site.

Appointment Availability
Affinity Health Plan conducts audits of provider demographics, provider appointment availability and 24-hour access and coverage. All participating providers are expected to provide care for their Affinity members within these access standards.

All Affinity Health Plan providers must have an appointment system that meets the following standards for appointment availability for primary care services:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Timeframe Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Care:</strong> Emergency condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person’s bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.</td>
<td>Care must be provided immediately upon presentation at the service delivery site.</td>
</tr>
<tr>
<td><strong>Urgent Care:</strong> Urgent conditions are defined as those illnesses and injuries of a less serious nature than emergencies that require services to prevent a serious deterioration of a member’s health, which cannot be delayed without imposing undue risk to the patient’s well-being, until the patient either returns to the Plan’s service area or until the patient can secure services from his or her primary care physician.</td>
<td>Urgent medical or behavioral problems must be seen within 24 hours of request.</td>
</tr>
<tr>
<td><strong>Non-urgent Sick Visits:</strong> These are visits for symptomatic conditions, which are neither of an emergency nor an urgent nature.</td>
<td>Appointment must be scheduled within 48-72 hours of request as indicated by the nature of the clinical problem.</td>
</tr>
<tr>
<td><strong>Routine Care:</strong> These visits are for routine management of clinical conditions or other follow-up care as is clinically appropriate.</td>
<td>Appointment must be scheduled within four weeks of request.</td>
</tr>
<tr>
<td><strong>Adult Baseline and Routine Physicals</strong></td>
<td>Appointment must be scheduled within 12 weeks of enrollment.</td>
</tr>
<tr>
<td><strong>Well-Child Care Visits</strong></td>
<td>Appointment must be scheduled within four weeks of request.</td>
</tr>
<tr>
<td>Type of Service</td>
<td>Timeframe Standards</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
</tbody>
</table>
| Initial Prenatal Visits: | 1. Appointment must be scheduled within three weeks of request.  
|  | 2. Appointment must be scheduled within two weeks of request.  
|  | 3. Appointment must be scheduled within one week of request.  |
| Initial Newborn Visit to the PCP | Appointment must be scheduled within two weeks of hospital discharge. |
| Initial Family Planning Visits | Appointment must be scheduled within two weeks of request. |
| Non-urgent Referred Specialist Visits | Appointment must be scheduled within four to six weeks of request. |
| In-Plan Behavioral Health or Substance Abuse Follow-up Visits (subsequent to an emergency or inpatient stay) | Appointment must be scheduled within five days or as clinically indicated. |
| In-Plan Non-urgent Behavioral Health or Substance Abuse Visits | Appointment must be scheduled within two weeks of request. |
| Assessments for the purpose of making recommendations regarding ability to perform work when requested by a LDSS | Appointment must be scheduled within 10 days of request for MMC members. |

**Waiting Time Standards**

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

- **Emergency Visits**: Affinity members are to be seen immediately upon presentation at the service delivery site.

- **Urgent Care and Urgent Walk-In Visits**: Affinity members should be seen within one hour of arrival. Please note that prescription refill requests for medications to treat chronic conditions are considered urgent care. It is essential that these medications be dispensed to Affinity members promptly to avoid any lapse in treatment with prescribed pharmaceuticals.

- **Scheduled Appointments**: Affinity members should not be kept waiting for longer than one hour.

- **Non-Urgent Walk-In Visits**: Affinity members with non-urgent care needs should be seen within two hours of arrival or scheduled for an appointment in a timeframe consistent with Affinity's scheduling guidelines.

**Missed Appointments**

Affinity expects providers to follow up with members who miss scheduled appointments. When there is a missed appointment, Affinity providers should follow these guidelines to ensure that Affinity members receive assistance and that compliance with scheduled visits and treatments is maintained.
• At the time an appointment is scheduled, confirm a contact telephone number with the Affinity 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.

24-Hour Telephone Coverage

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

• Regular office hours including days, times and locations

• After-hours telephone number and type of service covering the telephone line (e.g., answering service

• Providers who will be taking after-hours calls

Facilities as well as individual practitioners must conform to the following requirements:

• Affinity member will be provided with a telephone number to use for contacting providers after regular business hours. Telephone operators receiving after-hours calls will be familiar with Affinity and its emergency care policies and procedures, and will have key Affinity telephone numbers available at all times.

• Affinity providers will be contacted and patched directly through to the member, or the provider will be paged and will return the call to the member within 30 minutes.

• Affinity providers must be able to act in accordance with Affinity’s emergency policies and procedures such as notifying Medical Management of emergency care or admissions.

Affinity members must be able to locate an Affinity participating provider or his/her designated covering provider. It is not acceptable to have an outgoing answering machine message that directs members to the emergency room in lieu of appropriate contact with the provider or covering provider. If an answering machine message refers a member to a second phone number, that phone line must be answered by a live voice.

Providers shall notify Affinity Health Plan, in writing, at least thirty (30) calendar days in advance of any change in their office address, telephone number or office hours.

Affinity Health Plan is required to conduct 24-hour access and appointment availability studies of our providers annually (semi-annually in New York City) and submit the results to the New York State Department of Health and to each local Department of Social Services (LDSS). In addition, the New York State Department of Health conducts its own survey.
Required Reporting to Local Department of Health

TB Screening and Diagnosis
PCPs and other providers in the Affinity Health Plan network are expected to report positive TB test results and active cases of TB to the New York City Department of Health (NYCDOH) or local county department of health (CDOH), as required by state and city health codes. In New York City, reports to NYCDOH must include information on HIV+ status, IV drug and other substance abuse, and the status of the case.

Affinity Health Plan also expects the PCP and other providers to cooperate with the NYSDOH or county DOH in identifying case contacts and arranging for providing services and follow-up care. Affinity Health Plan encourages all providers to consult with their respective county health departments on TB treatment and preventive therapy. Information forms for reporting and consultation in New York City can be obtained by calling the TB hotline for physicians at 347.396.7400. For additional information contact the New York State Department of Health at 518.474.7000.

Prevention and Treatment of Sexually Transmitted Diseases
Participating providers shall educate their members about the risk and prevention of sexually transmitted infections and diseases (STIs/STDs). Providers are also responsible for ensuring members are screened and treated for STIs and that cases of STIs are reported to the local public health agency (LPHA). Further, providers shall cooperate in contact investigation, in accordance with existing state and local laws and regulations.

Affinity covers STI diagnostic and treatment services rendered by LPHAs; LPHAs must render such services free of charge pursuant to Public Health Law Section 2304 (l). In addition, Affinity is responsible for coverage of HIV testing provided to an MMC member during an STI/STD related visit at a public health clinic directly operated by an LPHA; such services will be covered by Affinity. If no agreement has been reached, Affinity agrees to reimburse the LPHA for these services at Medicaid fee-for-service rates established by NYSDOH.

Provider Panel Closing
A provider's panel may be closed upon request or upon reaching the maximum members permitted under New York State standards, based on a 40-hour, full-time employment status. Member-to-Provider ratios will be no more than 1,500 Medicaid members for each PCP or 2,400 for a provider practicing in combination with a physician’s assistant. There may be no more than one thousand 1,000 Medicaid members for each nurse practitioner.

A PCP’s panel may also be closed:
- Per PCP request, so long as the PCP has already accepted a minimum of 400 members before closing the panel or as specified in the agreement between the PCP and Affinity
- By Affinity, if at any time the PCP is no longer able to care for additional members

We will notify a PCP prior to closing his/her panel.
When a single PCP reaches the maximum of one thousand five hundred 1,500 members, he/she will receive notification that his/her panel has been closed by Affinity Health Plan. Provider Relations will inform the PCP that they can no longer add additional members to their panel. Similarly, panels will be closed for nurse practitioners when a maximum of one thousand 1,000 members have been enrolled or a provider practicing with a physician’s assistant when a maximum of two thousand four hundred (2,400) members have been enrolled.

Provider Leaves the Network
If a member's health care provider leaves the Affinity Health Plan network of providers, or is terminated for reasons other than imminent harm to member care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the health professional's ability to practice, Affinity Health Plan shall permit the member to continue an ongoing course of treatment with the member's current healthcare provider during a transitional period and upon a previously agreed reimbursement rate that exists in the current agreement. The care shall be authorized by Affinity Health Plan for the transitional period only if the health care provider agrees to accept reimbursement at rates applicable prior to the start of the transitional period as payment in full, to adhere to quality assurance requirements, to provide medical information related to such care, and to adhere to the organization's policies and procedures.

The transitional period shall continue up to ninety (90) calendar days from the date of notice to the member of the provider's disaffiliation from the network or, if the member has entered the second trimester of pregnancy, for a transitional period that includes the provision of postpartum care directly related to the delivery.

New Member
a. If a new member has a life-threatening or degenerative disease or disabling condition, Affinity Health Plan shall allow the new member to continue an ongoing course of treatment with the member's current healthcare provider for a period of up to 60 days effective from the date of enrollment.

b. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery.

c. The transitional period applies only if the healthcare provider agrees to accept reimbursement at rates established by Affinity Health Plan as payment in full, to adhere to the organization's quality assurance requirements, to provide medical information related to such care, and to adhere to the organization's policies and procedures.

In no event shall this requirement be construed to require Affinity Health Plan to provide coverage for benefits not otherwise covered as part of the member’s benefit package with Affinity Health Plan.
Primary Care Provider Selection
In general, Affinity Health Plan prefers that PCPs practice in the areas listed below. Because managed care programs include members with life threatening or disabling and degenerative medical conditions, specialist and sub-specialist providers may function as PCPs when such an action is considered by Affinity Health Plan to be medically appropriate. A member diagnosed as having a life-threatening disease or condition, or a degenerative and disabling disease or condition, either of which requires specialized medical care over a prolonged period of time, is eligible to have a specialist serve as his/her PCP. This is contingent upon the agreement of Affinity Health Plan, the PCP, and the specialist pursuant to a treatment plan.

The following details, in general, the types of providers eligible to serve as PCPs for Affinity members:

- Family practice
- General practice
- General pediatrics
- General internal medicine
- Obstetrics and gynecology (subject to plan and New York State Department of Health qualifications)
- Nurse practitioners may also function as PCPs, subject to their scope of practice limitations under New York State law. Resident physicians may also serve as PCPs, subject to specific guidelines developed by the New York State Department of Health.

Member choosing of a PCP:

- When Affinity Health Plan contacts a new member, Affinity Health Plan must offer the member a choice of at least three (3) PCPs.
- The member has thirty (30) calendar days from the date of enrollment to select a PCP.
- If the member does not select a PCP within thirty (30) calendar days of enrollment, Affinity Health Plan must assign the member to a PCP and inform the member of the assignment.
- The member can call Customer Service if they wish to change the assigned PCP.
- Affinity Health Plan sends PCPs a monthly eligibility roster of plan members who have selected them as their PCP.
- Members may change PCPs by contacting the Customer Service Department and requesting such a change. Changes will be made effective the first day of the following month.
• When making assignments, Affinity Health Plan considers:
  1. The member’s geographic location
  2. Any special health care needs of the member, if known by Affinity Health Plan
  3. Any special language needs of the member, if known by Affinity Health Plan

Medical Residents and Fellows
Only attending physicians and nurse practitioners may be assigned as a member’s PCP. Residents are not credentialed as PCPs or specialists by Affinity Health Plan and therefore may not be assigned as a member’s PCP.

Nurse practitioners may not act as attending preceptors for the resident physicians. Residents are restricted to acting under the supervision of the member’s PCP or by a fully licensed Affinity-credentialed physician. Responsibility for care of the member rests with the attending PCP or specialty provider. An attending PCP may not supervise more than four (4) residents at one time. Members have the right to request an appointment with their assigned PCP and must be informed of this right and the underlying resident/attending physician relationship.
SECTION 5 – SPECIALTY PROVIDER SERVICES

SPECIALTY PROVIDER SERVICES

Participating specialists work in partnership with primary care providers (PCPs) to render appropriate, quality medical care to Affinity Health Plan members. PCPs may refer members to specialists for specific services based on evaluation, diagnosis, and direction of care. Specialists play a critical role by providing efficient care within their area of expertise and within the scope of the PCP’s referral.

Responsibilities of Specialty Care Providers

- Coordinate with the PCP to provide services to Affinity Health Plan members, except in an emergency.
- Provide services consistent with the provider practice specialty and provide care that conforms to accepted medical and surgical practice standards in the community.
- Report findings and recommendations to the referring PCP by telephone and in writing.
- Admit and refer members to hospitals that participate in Affinity Health Plan network, except in emergencies.
- Maintain medical records that meet the medical record standards listed in Sections 3 and 7 of this manual.
- Send copies of member medical records, reports, treatment summaries and other related documents to Affinity Health Plan and other participating providers, upon request.
- Submit claim forms for services electronically within ninety (90) calendar days of the date of service.
- Seek reimbursement only from Affinity Health Plan for covered services. Except for copayments and/or coinsurance, providers may not seek payment from members. The provider may seek compensation for provision of covered services to members solely from Affinity Health Plan.
- Maintain professional credentials and liability insurance acceptable to Affinity Health Plan in accordance with state requirements.
- Accept peer review of professional services provided to Affinity Health Plan members.
- Maintain admitting privileges with at least one hospital that participates in Affinity Health Plan’s network.
• Work closely with Affinity Health Plan to resolve any problems, complaints, and disputes that may arise between the provider, member, and Affinity Health Plan.

• Treat members with respect and honor the patient's right to know and fully understand his or her diagnosis, prognosis and expected outcome of the recommended medical or surgical treatment or medication and his or her right to refuse treatment. When it is not advisable to give such information to the member, the information is to be made available to an appropriate person acting on the member’s behalf.

• Not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, place of residence, health status, income level, source of payment or any other basis prohibited by applicable federal, state, or local civil rights laws.

• Abide by agreements made with Affinity Health Plan as a result of member complaints, peer review, quality assurance and utilization review.

• Immediately notify Affinity Health Plan, in writing, if the provider’s ability to practice medicine is restricted or impaired in any way; if any adverse action is taken; or if an investigation is initiated by any authorized city, state or federal agency, or of any new or pending malpractice actions, or of any reduction, restriction, or denial of clinical privileges at any affiliated hospital. (See Section 3 of this provider manual).

• Immediately notify Affinity Health Plan of any adverse actions or sanctions taken by state agencies and any changes in information included on the provider application, (e.g., changes in address or office hours, malpractice actions, on-call arrangements, etc.).

• Ensure only participating providers can treat Affinity Health Plan members without authorization.

Appointment System
Participating specialists shall abide by the applicable appointment availability standards as defined in Section 4 of this manual.

Verification of Member Eligibility
Prior to providing services at each visit, the provider’s office must verify the member’s current eligibility by either using the integrated voice response (IVR), provider portal, or EPACES. Failure to verify eligibility at the time of service may result in denial of payment for services rendered, as Affinity Health Plan does not pay for services rendered to ineligible members.

To obtain eligibility or status claims, please go to Providers.affinityplan.org to access our online provider portal. You may also call 866.247.5678 to access the IVR.
Services to be rendered
Appropriate evaluation and treatment of a member may require a specialist provider to order certain diagnostic tests. Before rendering services, providers are required to check the list of services requiring prior authorization, which is available at Affinityplan.org/Providers/Resources/Pre-Authorization-Codes/Pre-Authorization-Codes/.

Affinity Health Plan reserves the right to deny reimbursement if, in the opinion of the chief medical officer or medical director, the test performed is not medically necessary. Specialists are encouraged to call the Affinity Health Plan UM Department at 866.247.7822 if they have any questions regarding a particular test.

The specialist is required to provide any relevant documentation with all treatment information to the member’s PCP. It is the specialist's responsibility to coordinate all treatment with the member's PCP in order to ensure effective case management.

If the specialty referral occurs in a hospital-based specialty clinic, it is the responsibility of the hospital to ensure that consultation reports are forwarded to the PCP in a prompt and efficient manner.
SECTION 6 — WOMEN’S HEALTHCARE PROVIDER RESPONSIBILITIES

WOMEN’S HEALTHCARE PROVIDER RESPONSIBILITIES

Access to Obstetrics and Gynecological (OB/GYN) Services

Women do not need a PCP referral to see a network OB/GYN doctor. Women have direct access to in-network mammography as well as to women’s healthcare specialists within the network for women’s routine and preventative health care services. They can have routine checkups (twice a year), follow-up care if there is a problem, and regular care during pregnancy. Women may also have access to services outside of the Affinity network. Members are not required to obtain a referral or authorization to visit an OB/GYN. A complete listing of OB/GYN providers is found in the provider directory.

Preventive Care

Providers are responsible for delivering preventive gynecological services to female members, including but not limited to cervical cancer screening, mammography screening services, annual chlamydia testing for women of child-bearing age, and three doses of HPV vaccine between the ages of nine (9) and thirteen (13). Additionally, providers should treat any gynecological-related clinical condition.

Prenatal Care/Delivery/Postpartum

OB/GYN providers and nurse midwives shall deliver prenatal care to pregnant members according to American College of Obstetricians and Gynecologists (ACOG) standards and New York State's prenatal care standards for managed care plans.

Affinity Health Plan has adopted New York State's 2009 updated prenatal care standards as set forth in Title 10, Part 85.40 of the New York Code, Rules & Regulations. Please refer to Appendix VIII for a description of the Medicaid prenatal standards program for New York State.

OB/GYN providers and nurse midwives shall perform all in-hospital deliveries and provide all subsequent inpatient and outpatient follow-up care.

Providers are responsible for sending records of all treatment and outcomes to the member’s PCP, and for coordinating any follow-up care when necessary.

Appointment Timeframes

Participating OB/GYN and nurse midwives shall schedule appointments with members within three (3) weeks during the first trimester; two (2) weeks during the second trimester; and within one (1) week thereafter, unless the member's condition is urgent, whereby the appointment should be scheduled using appropriate clinical judgment. A postpartum appointment shall be between twenty-one (21) and fifty-six (56) days after delivery.

Maternity Admissions

Pregnancy-related complications admission (ante-partum admissions): When a pregnant
member presents due to a medical condition, e.g., eclampsia, hyperemesis, etc., and delivery is not imminent, the hospital should call the Affinity Health Plan UM Department for authorization for inpatient admission or other treatment unless the patient presents with an emergent condition. In this instance, the hospital should assess and stabilize the member, and then notify the Affinity Health Plan UM Department.

**OB Delivery Information**

The hospital must call the UM Department within two (2) business days after delivery with the following maternal and newborn admission information for authorization and case management:

- Mother's name
- Mother's Medicaid (CIN) number (if applicable), admission date and time
- Delivery method (normal spontaneous, C-section, etc.)
- Newborn information:
  1. Gender
  2. Date of birth
  3. Birth weight
  4. APGAR score
  5. Nursery (NICU, newborn etc.) for newborns admitted to the NICU, please provide the working diagnosis, and the name and telephone number of the physician of primary responsibility
  6. Gestation by week
Transition of Children Placed in Foster Care and New York State Public Health Law Article 29-I
Health Facility Services into Medicaid Managed Care

As part of the Children’s Medicaid System Transformation, effective April 1, 2019, the B2H waiver programs were consolidated under the 1915(c) Children Waiver 2. Effective October 1, 2019, Children’s Waiver Home and Community-Based Services (HCBS) were added to the Medicaid Managed Care (MMC) Plan Benefit Package, and the exemption from mandatory enrollment in MMC for participation in the Children’s Waiver was removed. For more information on the Children’s Medicaid System Transformation visit 

Effective July 1, 2021, children/youth placed in foster care, including those in direct placement foster care and placement in the care of Voluntary Foster Care Agencies (VFCAs) statewide, will be mandatorily enrolled in MMC unless the child/youth is otherwise exempt or excluded from enrollment. Exemptions and exclusions from MMC enrollment are included in the 1115 Medicaid Redesign Team Waiver Special Terms and Conditions.

In alignment with the MMC enrollment of the foster care population in VFCAs, VFCAs may opt to become a licensed healthcare provider facility through New York State Public Health Law (PHL) Article 29-I. This Article allows for the provision of Core Limited Health-Related Services (CLHRS) and Other Limited Health-Related Services (OLHRS), and allows for agreements with Medicaid Managed Care Plans (MMCPs), including Mainstream Medicaid Managed Care and HIV Special Needs Plans, to provide these services to eligible enrolled children/youth. On July 1, 2021, CLHRS and OLHRS will be included in the MMCP benefit package.

Not all VFCAs have elected to become Article 29-I providers. VFCAs who opt out of Article 29-I licensure are not authorized to provide health services and will not be reimbursed for Article 29-I health services through Medicaid Fee For Service (FFS) or MMC. However, children/youth placed in the care of these VFCAs and eligible for Medicaid will be enrolled in an MMCP, unless otherwise exempted or excluded from enrollment.

Scope of Benefits Transitioning to Medicaid Managed Care

A. On July 1, 2021, MMCPs are responsible for providing all benefit package services to enrolled children/youth placed in foster care, promoting continuity of care, and ensuring healthcare services are delivered in a trauma-informed manner and consistent with standards of care recommended for children in foster care. Children/youth often enter foster care without having had access to traditional preventive healthcare services. As a result, children/youth in foster care require increased health monitoring.
B. On July 1, 2021, MMCPs are responsible for covering the following 29-I health facility services\(^8\) for enrollees who are eligible to be served by a 29-I health facility, in accordance with the 29-I billing guidance:

1. Core Limited Health-Related Services (CLHRS) on a per diem basis, inclusive of:
   a. Nursing Services
   b. Skill-Building Licensed Behavioral Health Practitioner (LBHP)
   c. Medicaid Treatment Planning and Discharge Planning
   d. Clinical Consultation/Supervision Services
   e. VFCA Managed Care Liaison/Administration

2. Medically necessary Other Limited Health-Related Services (OLHRS) that the 29-I health facility is authorized by the state to provide may include:
   a. Children and Family Treatment Supports and Services (CFTSS)
      i. Other Licensed Practitioners (OLP)
      ii. Community Psychiatric Supports and Treatment (CPST)
      iii. Psychosocial Rehabilitation (PSR)
      iv. Family Peer Supports and Services (FPSS)
      v. Youth Peer Support and Training (YPST)
      vi. Crisis Intervention (CI)
   b. Children’s Waiver HCBS
      i. Caregiver Family Supports and Services
      ii. Community Advocacy and Support
      iii. Respite (Planned and Crisis)
      iv. Pre-Vocational Services
      v. Supported Employment
      vi. Day Habilitation
      vii. Community Habilitation
      viii. Palliative Care: Bereavement Therapy
      ix. Palliative Care: Expressive Therapy
      x. Palliative Care: Massage Therapy
      xi. Palliative Care: Pain and Symptom Management
      xii. Environmental Modifications
      xiii. Vehicle Modifications
      xiv. Adaptive and Assistive Equipment
      xv. Non-Medical Transportation
   c. Medicaid State Plan services
      i. Screening, diagnosis and treatment services related to physical health, including but not limited to:
         • Ongoing treatment of chronic conditions as specified in treatment plans
         • Diagnosis and treatment related to episodic care for minor ailments, illness or injuries, including sick visits
         • Primary pediatric/adolescent care
         • Immunizations in accordance with NYS or NYC recommended childhood immunization schedule
         • Reproductive health care
ii. Screening, diagnosis and treatment services related to developmental and behavioral health, including:

- Psychiatric consultation, assessment and treatment
- Psychotropic medication treatment
- Developmental screening, testing and treatment
- Psychological screening, testing and treatment
- Smoking/tobacco cessation treatment
- Alcohol and/or drug screening and intervention
- Laboratory tests

OLHRS do not include the following services:

i. Surgical services
ii. Dental services
iii. Orthodontic care
iv. General hospital services including emergency care
v. Birth center services
vi. Emergency intervention for major trauma
vii. Treatment of life-threatening or potentially disabling conditions
viii. Nursing services, skill building activities (provided by LBHPs as described in the Article 29-I VFCA Health Facilities License Guidelines and any subsequent updates)
ix. Medicaid treatment planning and discharge planning, including medical escorts and any clinical consultation and supervision and tasks associated with the 29-I MMCP liaison/administrator in 29-I health facilities. These services are included in the preventive or rehabilitative residential supports of the mandatory CLHRS.

Covered Populations

A. Effective July 1, 2021, children/youth placed in foster care, including those in direct placement foster care and placement in the care of VFCAs statewide, will be mandatorily enrolled in MMC unless the child/youth is otherwise exempt or excluded from enrollment.

B. Effective upon licensure by the state, 29-I health facilities will provide CLHRS and OLHRS to children/youth as described in the Article 29-I VFCA Health Facilities License Guidelines and the 29-I Billing Guidance. Child/youth populations served by 29-I health facilities and covered by the MMCP for CLHRS and/or OLHRS are described and defined in the 29-I billing guidance, including:

1. Children/youth placed in foster care;
2. Babies residing with their parent who are placed in a 29-I health facility and in foster care (8D Babies);
3. Children/youth placed in a 29-I health facility by Committee on Special Education (CSE);
4. Pre-dispositional placed youth; and
5. Children/youth and adults who are discharged from a 29-I health facility. (With limitations. See Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care Version 1.0, Section IX.)

To read about the Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care, click on link:

Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care Version 1.0.

For information on the Transition of Children Placed in Foster Care 29-I Health Facility Services Provider Training and a link to Frequently Asked Questions visit https://www.affinityplan.org/Providers/Portal/Portal-Landing/.
SECTION 8 — STANDARDS FOR MEDICAL RECORD DOCUMENTATION

STANDARDS FOR MEDICAL RECORD DOCUMENTATION

Good documentation facilitates communication, coordination, and continuity of care, and promotes the efficiency and effectiveness of treatment.

All Affinity Health Plan participating providers are required to participate in the Affinity Health Plan’s Quality Improvement Program. Providers are obligated by contract to allow inspection of their records, and are expected to meet federal and state regulatory requirements enabling Affinity Health Plan to access and review their records.

“Medical record” means a complete record of care rendered by a provider, including inpatient, outpatient and emergency care, in accordance with all applicable federal, state and local laws, rules and regulations.

Affinity Health Plan’s Medical Record Standards

Affinity Health Plan requires providers maintain members’ medical records in a manner that is current, detailed, organized, and legible facilitating effective and confidential member care and quality review. A separate, distinct medical record is required for each member.

Affinity Health Plan requires that providers have an organized medical record-keeping system. An adequate medical records filing system includes maintenance of confidentiality, procedures for review of diagnostic test results, etc. The following are key items in maintaining an adequate medical records filing system:

- Medical records are stored in a secure location not accessible to members and unauthorized personnel.
- A unique medical record is assigned for each member, identified by a medical record identifier (either name or number) on each page.
- Records are organized with a filing system to ensure easy and timely retrieval upon request by legitimate users.

Content of the Medical Record

Medical records must reflect all services provided directly by the provider, all ancillary services and diagnostic tests ordered, and all diagnostic and therapeutic services for which the member was referred (e.g., Home Health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports). Specific medical record content standards are as follows:

- Each page contains the member’s name and date of birth or ID number;
- The record contains personal and biographical data such as address, telephone numbers, marital status and emergency contacts;
• All entries contain author identification (may be handwritten or written with a unique electronic identifier);

• All entries are dated;

• The record is legible to someone other than the writer;

• Significant illness and medical conditions are indicated on the problem list;

• An appropriate past medical history for patients seen at least three times is contained in the record;

• Medication allergies and adverse reactions are prominently noted in the record;

• Use of cigarettes, alcohol and illicit substances, for those older than 13 years old, are noted;

• The history and physical documents with appropriate information for presenting complaint;

• Diagnostic testing is ordered, as appropriate, and reports are filed in the chart and noted to have been reviewed by the provider;

• Working diagnoses and treatment plans are consistent with findings;

• Follow-up care with a specific time of return visit is noted;

• Unresolved problems from previous visits are addressed in subsequent visits;

• If a consultation is requested, a note from the consultant is in the record;

• Referral specialist records contain evidence of communication with the PCP;

• An immunization record is kept for children; an immunization history is in the record for adults;

• Preventive screening and services, in accordance with standard clinical guidelines, are noted, including education and counseling;

• If appropriate based on the patient’s age, the medical record should document whether the patient has executed an advance directive;

• Documentation that a patient with serious mental disease is also cared for by a behavioral health specialist or that such care has been recommended; and

• Evidence of reporting to the appropriate public health agency when required is documented in the record. Examples of required reporting include lead poisoning and certain communicable diseases.
Retention of Medical Records
 Providers agree to retain medical records for six years after the last date of service or, in the case of a minor, for six years after the patient reaches the age of majority, or the length of time required by applicable law.

Confidentiality
 a. All offices are required to meet and exceed state and federal confidentiality requirements such as HIPPA and must protect confidential information against unauthorized disclosure. Provider offices are to ensure periodic confidentiality training of staff members.

b. Access to medical records is permitted only to those individuals who are part of the team-providing healthcare to the individual. Such information contained in the medical record may be provided to Affinity Health Plan for purposes directly connected with the performance of Affinity Health Plan obligations.

Confidentiality of HIV-Related Information.
 Confidential HIV-related information is any information in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV-related information, concerning whether an individual has been the subject of an HIV-related test, or has an HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual having one or more of such conditions, including information pertaining to such individual’s contacts.

Confidentiality of HIV-related information requires each provider to develop policies and procedures to assure confidentiality of HIV-related information. Policies and procedures must include:

- Initial and annual in-service education of staff and contractors,
- Identification of staff allowed access and limits of access,
- Procedure to limit access to trained staff (including contractors),
- Protocol for secure storage (including electronic storage),
- Procedure for handling requests for HIV-related information, and
- Protocols to protect persons with or suspected of having HIV infection from discrimination.

Providers are also reminded that HIV pre-test counseling with clinical recommendation of testing for all pregnant women is required. The women and their newborns must have access to services for positive management of HIV disease, psychosocial support and case management for medical, social, and addictive services. **(Note: Applicable only to qualified providers of OB/GYN care).**
A Release of Confidential HIV Related Information is a written authorization for disclosure of confidential HIV-related information, which is signed by the protected individual or by a person legally authorized to consent to health care for the individual. A general authorization for the release of health information shall not be construed as a release of confidential HIV-related information, unless such authorization specifically indicates its dual purpose as a general authorization and as an authorization for the release of confidential HIV information. HIV information may not be re-disclosed without a signed HIV release form.

NY Public Health Law § 2782 prohibits persons who obtain confidential HIV-related information in the course of providing any health or social service, or pursuant to a release of confidential HIV information, from disclosing such information, unless a specific exception applies. Exceptions include disclosures to:

- The protected individual or a person authorized pursuant to law to consent to health care for the individual;
- Any person to whom disclosure is authorized pursuant to a release of confidential HIV-related information;
- An agent or employee of a health facility of a health care provider if the agent or employee is permitted to access medical records;
- The health facility of the health care provider;
- The agent or employee who provides health care to the protected individual, or maintains or processes medical records for billing or reimbursement;
- Third party reimbursement entities or their agents to the extent necessary to reimburse health care providers for health services, provided that, where necessary, an otherwise appropriate authorization for such disclosure has been secured by the provider;
- An insurance institution other than a third party reimburse, provided the insurer obtains a dated and written authorization, signed by the subject individual or his or her legal representative, which indicates (1) that health care providers, health facilities, insurance institutions, and other persons are authorized to disclose the information about the protected individual, (2) the nature of the information to be disclosed, and (3) the purpose for which the information is to be disclosed.

A full list of exceptions to the disclosure prohibitions can be found in NY Public Health Law § 2782.

Note that failure to comply with Article 27-F can result in the state pursuing civil penalties of up to $5,000 per occurrence, as well as criminal misdemeanor charges.

To access informed consent and release forms and to learn more about HIV/AIDS-related programs, policies and regulations visit the NYSDOH website at Health.ny.gov/diseases/aids/index.htm/.
For general information and questions about HIV confidentiality, to report a possible violation of Article 27-F, or to get forms to report a possible violation of Article 27-F call the New York State Department of Health HIV Confidentiality Hotline at 800.962.5065.

**MEDICAL RECORD ACCESS**

Access to medical records and/or copies of medical records must be made available, without charge, to other participating providers, consultants or physicians involved with the member’s care and treatment. Copies of medical records must be made available to assist in orderly transfer of medical records if member changes their PCP. Copies of medical records must also be made available upon request, and without charge (unless otherwise noted in a provider’s contract), to Affinity Health Plan (e.g., chief medical officer, quality improvement staff) for quality assurance and utilization review activities. The handling of medical records must comply with all federal and state laws and regulations regarding confidentiality of member records. Copies of medical records must be made accessible to the local Department of Social Services (LDSS), New York State Department of Health, and/or the Centers for Medicare and Medicaid Services (CMS) upon request.
SECTION 9 — EMERGENCY AND INPATIENT SERVICES

EMERGENCY SERVICES
Consistent with federal and state law, an emergency medical condition is defined by using a prudent layperson standard, which is as follows: A medical or behavioral condition, the onset of which is sudden that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a pregnant woman, the health of the woman or her unborn child, or in the case of a behavioral health condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of the person.

Emergency services means health care procedures, treatments or services needed to evaluate or stabilize an emergency medical condition, including psychiatric stabilization and medical detoxification from drugs or alcohol.

Emergency services are not subject to prior approval and may be obtained from a non-participating provider without penalty. Affinity maintains telephone coverage utilizing a toll free 24/7 number answered by a live person at 866.247.5678 to advise members of procedures for accessing services for emergency medical conditions.

PCPs and OB/GYN providers must also provide members with access to a live person 24 hours a day, seven days a week for after-hours emergency consultation and care. If the provider uses an answering machine after-hours, the message must direct the member to a live person.

OBSERVATION SERVICES

Medicaid Guidance

- Hospitals may provide observation services for those patients for whom a diagnosis and a determination concerning admission, discharge or transfer cannot be accomplished within eight hours after presenting in the emergency department (ED), but can reasonably be expected within 48 hours.

- In order to be reimbursed for observation services, a patient must be in observation status for a minimum of eight hours (with clinical justification). This is in addition to any time that the patient spent in the ED prior to receiving observation services.
• Assignment to observation services may be made only through the emergency department.

• A patient may remain in observation for up to 48 hours and then the hospital must determine if the patient is to be admitted, transferred to another hospital, or discharged from the facility.

• Many providers incorrectly assume that when patients stay in the hospital for more than 48 hours, they automatically qualify for inpatient status. If the patient does not meet clinical criteria that require inpatient level of care in accordance with MCG guidelines but could be treated at a lower level of care, this admission may be denied, or only observation services approved.

INPATIENT SERVICES

Medical and Surgical Emergent/Urgent Admissions

Authorization is required for medical and surgical inpatient hospital admissions, following stabilization of the member, if applicable. Affinity Health Plan requires notification of the member’s hospital admission within two business days of an admission through the emergency room. This applies to emergency transfers from one acute care hospital to another when the treating hospital cannot provide the needed care and the patient's clinical status makes it unsafe to wait until the next business day to obtain prior authorization for the transfer from Affinity Health Plan.

Please contact Affinity Health Plan at 866.247.5678. Follow the voice prompts for authorizations to connect to the Utilization Management Department from 8:30 a.m.-5:00 p.m., Monday through Friday. Notifications can be accepted after hours, holidays and weekends. Use the standard toll-free number and follow the voice prompt as noted above.

Behavioral Health Admissions

Affinity requires notification as soon as possible, not to exceed two (2) business days following admission. A Beacon clinician is available to review clinical information, determine medical necessity, and verbally pre-authorize reimbursement for services. Hospital staff, or other providers wishing to provide or arrange for inpatient care are required to call 800.974.6831 prior to the admission of a covered Affinity member to an inpatient unit.

If emergency treatment is required, in an emergency room or crisis intervention service, preauthorization for this service is not required and the provider then must notify Beacon within 24 hours of the emergency treatment and/or admission.
EMERGENCY SERVICES

Emergency services means health care procedures, treatments or services needed to evaluate or stabilize an emergency medical condition, including psychiatric stabilization and medical detoxification from drugs or alcohol. Beacon is committed to ensuring that all members have access to emergency behavioral health services for treatment of emergent and critical healthcare needs. Emergency services are not subject to prior approval.

Notification: Beacon requests all hospitals notify Beacon of emergency behavioral health services provided to members in order to facilitate proper arrangements for follow-up care, for case management and for coordination with Affinity to address medical case management needs.

Inpatient Admissions (non-emergent)

Affinity Health Plan follows state guidelines for timeliness of utilization management (UM) decisions. In situations where initial inpatient authorization requests are not accompanied by sufficient clinical documentation, Affinity Health Plan will contact the facility to request the necessary information at least two times. If Affinity Health Plan is unable to obtain the information within 72 hours of receipt of the initial request, the inpatient admission will be subject to denial for lack of sufficient clinical information. All authorization requests and supporting clinical information should be faxed to Affinity UM at 718.794.7822. If situations dictate a verbal request, a phone call to UM at 888.543.9074 can be made; however, in most cases, clinical information will also need to be faxed.

Transfer of an Affinity Health Plan Member to Another Hospital

Prior authorization from Affinity Health Plan is required to transfer a member from one hospital to another. Affinity Health Plan will not authorize transfers unless:

- The facility that the patient is in cannot provide the care and services the patient’s medical condition requires; and
- The member’s attending provider has authorized the transfer; and
- A physician at the receiving facility has accepted the patient and the accepting facility has acquired and authorization; and
- All statutory and regulatory requirements for the transfer of a member from one institution to another are met.

The Affinity Health Plan UM Department can assist in arranging for pre-authorized transportation for approved transfers, if necessary.

Transfer to a non-participating facility requires prior authorization and will only be approved, if needed care is not available at a participating facility.
The receiving institution is under the same obligation to notify Affinity Health Plan with clinical information so that concurrent review can take place.

**Concurrent Review**
In order for Affinity Health Plan to track and monitor the care of our members who have been hospitalized, Affinity Health Plan conducts concurrent review on selected patient hospitalizations, typically those members whose lengths of stay exceed the base DRG length of stay. Affinity Health Plan will contact the hospital’s utilization department to request clinical information in support of the patient’s need for continued hospitalization. Failure to submit the requested information may result in an adverse determination.

The purpose of the concurrent review is to:

1. Ensure the level of service provided is consistent with the need for continued hospitalization,
2. Assist in the coordination of services after discharge, and
3. Monitor the quality of care provided in the acute care setting as part of the Affinity Health Plan quality assurance program. On occasion, a member of the Affinity Health Plan’s Utilization Management staff may visit the hospital to review the chart for either quality or utilization purposes.

We will make a decision and notify the member and the provider by phone and in writing:

- Within one (1) business day of receipt of necessary information.
- For MMC, as quickly as the member’s condition requires and a) within one (1) business day of receipt of necessary information, but no more than three (3) business days of an expedited authorization request; or b) in all other cases, within one (1) business days of receipt of necessary information, but no more than fourteen (14) days of the request.
SECTION 10 — PROVIDER CREDENTIALING

PROVIDER CREDENTIALING

Consistent with New York Department of Health Recommended Guidelines for Credentialing Criteria, Affinity credentials participating providers on a periodic basis (not less than once every three years). This process includes, but is not limited to, primary verification of training and experience. Each healthcare professional must be credentialed by Affinity prior to rendering services to members.

It is the applicant’s responsibility to supply all requested documentation in a form satisfactory to the credentials committee. Either the Affinity Health Plan Provider Application or the CAQH Universal Credentialing Data Source Form is required, in addition to applicable credentialing documents/certifications. Applications lacking supporting documentation shall not be considered by the Committee.

It is your responsibility to ensure that we have the correct address to contact when re-credentialing is due. If you fail to re-credential, your network participation will be terminated and any claims processed may be recouped.

Our credentialing/re-credentialing processes are overseen by our chief medical officer and our credentialing committee. These parties review credentialing information and make recommendations. We will complete credentialing activities and notify providers within 60 days of receiving a completed application. Our notification to providers will inform them if they are credentialed, if additional time is needed, or if we do not need additional providers. If additional time is needed, we notify the provider as soon as possible, but no more than 60 days from our receipt of the application.

You must immediately notify us in writing if any of the following occur:

- Your ability to practice medicine is restricted or impaired in any way.
- An investigation is initiated by any authorized agency.
- A new or pending malpractice action(s) is initiated.
- Your clinical privileges at any hospital have been reduced, restricted, or denied.
- Any other adverse action that reasonably relates to your credentialing.

You are also responsible for ensuring that all ancillary staff a) are appropriately licensed, registered or certified in their field; b) practice in accordance with all applicable laws and regulations; c) are appropriately supervised; and d) do not exceed those responsibilities set forth in applicable New York State laws and regulations for such practices.
Provider Rights

The provider has the right to:

- Review information submitted to support his/her credentialing application – this includes information from outside sources. However, Affinity does not need to disclose references, recommendations or peer-review protected information.

- Correct erroneous information. In the event that Affinity Health Plan Credentialing discovers inconsistent information in the application/reapplicant, an associate will reach out to the provider for correct information with a request for a response within 15 business days. In the event that the practitioner discovers incorrect information in the application/reapplicant after exercising the above right, the practitioner may then contact Affinity Health Plan Credentialing via a letter or email and request that the application/reapplicant be updated. Affinity Health Plan will process and document receipt of the corrected information in the file within 15 business days.

- Receive the status of their credentialing or recredentialing application upon request. Affinity Health Plan will share what documentation is outstanding to complete the application/reapplicant and/or will inform the provider when the application/reapplicant will be reviewed by the Affinity Health Plan Credentialing Committee (CR). Affinity Health Plan will respond to the practitioner’s request by phone or via email.

Confidentiality

All credentialing documents or other written information developed or collected during the approval processes are maintained in strict confidence. Except with authorization, or as required by law, information contained in these records will not be disclosed to any person not directly involved in the credentialing process.

Credentialing of Ancillary Staff Working in a Participating Provider’s Office

Ancillary staff working in a participating provider’s office and providing care to Affinity Health Plan members must also be credentialed by Affinity Health Plan. It is the responsibility of the participating provider to notify Affinity Health Plan when any of the following professionals are hired/contracted to provide services:

- Nurse practitioners
- Physical therapists/occupational therapists/speech therapists
- Certified nurse midwives
- Physician assistants
OMH-Licensed/OASAS-Certified Behavioral Health Providers and HCBS Providers

Affinity Health Plan will accept state-issued HCBS providers, OMH and OASAS-certified providers with OMH and OASAS licenses and certifications in place of any credentialing process for individual employees, subcontractors or agents of such providers.

The contract shall collect and will accept program integrity-related information as part of the licensing and certification process. Affinity Health Plan requires that such providers not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicaid program.

PROVIDER SUSPENSION

Policy Statement

Affinity Health Plan may elect to suspend providers who have been charged and/or arrested until final resolution of the charges, or that are subject to an OPMC or other regulatory agency investigation/action. Providers who are suspended are excluded from participation in all Affinity Health Plan’s programs.

PROVIDER TERMINATION

Affinity reserves the right to suspend or terminate a provider’s contract immediately, with written notice to follow, under the following circumstances:

- Final disciplinary action is taken by a governmental regulatory agency that impairs the provider’s ability to practice.
- There is a determination of fraud.
- There is an imminent harm to patient care.

Affinity will make good faith effort to notify all affected members of the termination of a provider contract within 30 days of notice of termination by plan or provider. Please see Section 9 of the provider manual for a detailed description of the provider termination process.

Terminating Network Participation

Providers that are sanctioned by the DOH’s Medicaid Program will be excluded from participation in Affinity’s Medicaid panel.

Your network participation may be terminated pursuant to the terms of your provider agreement. We will not terminate (or refuse to renew) your agreement solely because you have:

- Advocated on behalf of a member;
- Filed a complaint against Affinity;
- Appealed an Affinity decision;
• Provided information or filed a report pursuant to PHL § 4406-c regarding prohibitions by plans; or

• Requested a hearing or review.

We will not terminate the agreement of a participating healthcare professional without providing a written explanation of the reason for the proposed termination and an opportunity for a review or hearing as described below. Notwithstanding the foregoing, a provider terminated due to imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other government agency that impairs the healthcare professional’s ability to practice is not eligible for a hearing or a review. Regarding the latter, we will immediately remove any provider from the Affinity network who is unable to provide health care services due to a final disciplinary action.

Termination of a hospital’s agreement may be subject to cooling-off period requirements set forth in PHL § 4406-c.

Providers who are excluded or terminated by the State Department of Health (SDOH) Medicaid Program will be excluded from participation in Affinity Health Plan’s network of providers.

**Hearing Processes and Procedures**

**Definitions:**

• Healthcare professional: a person licensed, registered or certified pursuant to Title 8 of New York’s Education Law.

• Quality concerns: concerns regarding the healthcare professional’s competence or professional conduct which adversely affect or could adversely affect the health or welfare of an Affinity Health Plan member or any other patient of a healthcare professional.

• Clinical privileges: the ability to furnish medical care to persons enrolled in Affinity Health Plan, as determined by Affinity Health Plan.

• Members: any subscriber, member, patient, designated representative or, where appropriate, prospective member of Affinity Health Plan.

**Applicability**

The hearing procedure is available in the following circumstance:

• When Affinity Health Plan proposes to terminate a participating healthcare professional’s contract with Affinity Health Plan prior to the termination date of the contract.
The hearing procedure is not available in any other circumstances, including but not limited to the following:

- An initial denial of a healthcare professional’s application for clinical privileges.
- When Affinity Health Plan decides not to renew a healthcare professional’s contract.
- When the termination involves imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional’s ability to practice.

Procedure
When Affinity Health Plan receives information that raises quality concerns regarding a healthcare professional who has been granted network participation, it will initiate a review and a notation will be placed in the healthcare professional’s record. Review will also be initiated when Affinity Health Plan decides to terminate a healthcare professional, except where the decision to terminate involves imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional’s ability to practice.

If the results of the review indicate that action is required which involves a hearing, the healthcare professional will be notified in writing regarding the proposed action. Such notice shall include the following:

- The proposed action
- The reasons for the proposed action
- A statement that the healthcare professional has the right to request a hearing or review, at the professional’s discretion, before a panel appointed by Affinity Health Plan
- The time limit, not less than 30 calendar days, for requesting a hearing
- A statement that the hearing will be held within 30 calendar days after the date the hearing request is received
- A summary of the hearing rights

If the healthcare professional does not request a hearing within thirty (30) calendar days of the date of the notice, the proposed action will be final, not subject to arbitration or review by a court of law, and the provider will have no additional appeal rights. If a hearing request is received, the health care professional will be apprised, in writing, of the place, time, and date of the hearing and provided a list of the witnesses expected to testify at the hearing on behalf of Affinity Health Plan. The health care professional will also be told that the failure to appear at the hearing will not delay a decision by the hearing panel. Hearing dates and times may be granted at the discretion of Affinity Health Plan, but within thirty (30) days of the health care professional’s request for a hearing.
The hearing panel shall be comprised of at least three (3) persons appointed by Affinity Health Plan. At least one member of the panel will be a clinical peer in the same discipline and the same or similar specialty as the healthcare professional under review. The hearing panel may consist of more than three (3) persons, provided, however, that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel. The hearing panel shall be comprised of a majority of individuals who are clinical peers in the same discipline and the same or similar specialty as the healthcare professional under review.

The healthcare professional shall have the following rights at the hearing:

- The right to call, examine and cross-examine witnesses.
- The right to present evidence that is deemed relevant by the hearing panel.
- (The determination of relevancy shall be determined solely by the panel.)
- The right to submit a written statement at the close of the hearing.

After the hearing panel has convened, deliberated and rendered a decision, it will notify the healthcare professional, in writing, of the decision not more than fifteen (15) business days after its adjournment. The notification will include a statement of the basis for the decision. Decisions will include one of the following and will be provided in writing to the health care professional: reinstatement; provisional reinstatement with conditions set forth by the MCO, or termination. The decision of the hearing panel is final, and it is not subject to arbitration or review by a court of law.

A decision by the hearing panel to terminate a healthcare professional shall be effective not less than thirty (30) calendar days after the receipt by the healthcare professional of the hearing panel’s decision. In no event will the termination be effective earlier than sixty (60) calendar days from the receipt of the initial notice of termination provided to the healthcare professional. The date of receipt will be presumed to be five (5) calendar days from the date of the initial notice.

Unless the decision to terminate the healthcare professional involves imminent harm to patient care, a determination of fraud, or final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional’s ability to practice, Affinity Health Plan would consider allowing a member to continue an ongoing course of treatment with the professional as outlined in Section 4 Primary Care Services.

The healthcare professional’s record will be noted with the appropriate status determination and all hearing correspondence.

When the decision of the hearing panel will adversely affect the network participation of a healthcare professional for a period longer than 30 calendar days, Affinity Health Plan must notify the New York State Board of Medical Examiners within 15 calendar days from the date the adverse action was taken. Other regulatory and accrediting agencies will be notified as required.
Subject to the due process rights described above, Affinity Health Plan reserves the right to terminate the participation status of any participating provider, without cause, upon ninety (90) calendar day's prior written notice delivered to the provider, or as otherwise required under the terms of the provider contract.

In the event that a provider's license, certification or registration is restricted, revoked, surrendered or suspended by any state in which he or she may hold a license, the provider may be terminated without the right to an appeal. In addition, such action may be taken should restrictions, suspension, revocation or termination occur for the provider:

- Malpractice coverage
- DEA registration
- Medicaid privileges - qualified and approved

A provider terminated due to a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the healthcare professional's ability to practice is not eligible for a hearing or a review, and such termination shall not be subject to arbitration.

**Affinity Health Plan’s Duty to Report**

Affinity Health Plan is legally obligated to report to the appropriate professional disciplinary agency within thirty (30) calendar days of the occurrence of any of the following:

1. Termination of a healthcare provider for reasons relating to alleged mental or physical impairment, misconduct or impairment of member safety or welfare.

2. Voluntary or involuntary termination of a contract or employment, or other affiliation, to avoid the imposition of disciplinary measures.

3. Termination of a healthcare provider contract, in the case of a determination of fraud, or in a case of imminent harm to a member's health.

4. Sanctioned list.

5. Loss of hospital privileges.
QUALITY MANAGEMENT PROGRAM AND PLAN

Affinity Health Plan is committed to providing members with access to quality care and services. A comprehensive Quality Improvement Program provides a management structure for continuously monitoring, evaluating and improving administrative operations, access and the provision of quality care and services. The Quality Committee (QC) for the Board of Directors has authority for oversight of the Quality Management Program. Representatives with clinical backgrounds participate in the QC as well as on the Credentialing/Re-credentialing and the Pharmacy and Therapeutics Committees. A Clinical Affairs Committee is comprised of network practitioners who give input into provider and member health education materials, clinical and preventive health guidelines, quality improvement initiatives, and policies and procedures that may impact providers.

Annually, a quality improvement plan is approved by the QC which establishes the content of the Quality Program for the year. Each year, the plan encompasses, at minimum, work in the following areas:

- Member satisfaction
- Provider satisfaction
- Member complaints
- Adherence to medical record documentation standards
- Compliance with clinical treatment, preventive health, and public health guidelines
- Clinical quality improvement studies
- SDOH Quality Assurance Reporting Requirements (QARR®)
- CMS reporting requirements (including HEDIS®, HOS, CAHPS)

Our program and plan are evaluated annually, and the output of the evaluation informs the development of the coming year’s program and plan. Providers are encouraged to incorporate Affinity Health Plan network performance improvement initiatives into their quality management programs and improvement plans.
A. PROVIDER PERFORMANCE INDICATORS

As part of our efforts to improve quality, we periodically conduct performance review studies in conjunction with our Clinical Affairs Committee. Claim, encounter, and complaint data are among the information maintained by Affinity to evaluate the performance/practice of healthcare professionals.

Any profiling data used to evaluate the performance or practice of a healthcare professional shall be measured against stated criteria and an appropriate group of healthcare professionals serving a comparable patient population. In these circumstances, each healthcare professional shall be given the opportunity to discuss the unique nature of the healthcare professional's patient population, which may have a bearing on the healthcare professional's profile, and to work cooperatively with Affinity Health Plan to improve performance.

Affinity Health Plan is required to provide information used to evaluate the performance of providers and any profiling data. We also make available on a periodic basis, and upon the request of a healthcare professional, the information, profiling data and analysis used to evaluate the provider’s performance. It is important to note that the staff at Affinity Health Plan is committed to working in partnership with providers in order to assure that quality care is delivered to members. Compliance reports are used as a way to provide feedback, as well as to educate and identify areas for improvement.

In addition, Affinity Health Plan has several programs that focus on preventive health and management of certain chronic conditions. Affinity Health Plan encourages providers to refer members to work with the staff of those programs. Currently, the programs available are in Case Management (medical and behavioral health).

The care delivered to members by providers is reported on an annual basis to the State Department of Health (SDOH) through the Quality Assurance Reporting Requirements (QARR®) and to the National Committee on Quality Assurance (NCQA) through the Healthcare Effectiveness Data and Information Set (HEDIS®). Quality is measured using encounter/claim data that may be supplemented by medical record reviews to determine the percentage of members receiving preventive care and care for certain chronic diseases and services. Additional studies and medical record reviews are initiated by the SDOH throughout the year targeting specific areas such as prenatal care.

QARR®/HEDIS® measures are also used in the overall performance evaluation of a practice. Minimum performance standards and requirements of QARR®/HEDIS® are described in the Quality Incentive Program (QIP) brochure.

In addition to QARR® and HEDIS®-based measures, Affinity Health Plan can gather provider and practitioner specified data on measures from consumer satisfaction surveys, health outcome tools, access and availability surveys, member complaints, and internal quality of care. Affinity Health Plan also routinely reviews medical records to determine
provider and practitioner compliance with medical record documentation, preventive health, clinical condition and public health guidelines.

Performance measurement results in these areas will also be made available and, where appropriate, will be included in the provider’s file for consideration during the re-credentialing process. Where provider or practitioner performance consistently falls below an expected threshold or fails to meet the standard of care, improvement plans will be requested. Plan completion will be monitored. Copies of plan documentation shall be retained in the provider’s or practitioner’s contracting and credentialing folder. Providers and practitioners who fail to complete an action plan and/or fail to improve performance sufficiently will be forwarded to the Credentialing Committee for further review and action.

Provider Quality Incentive Program
Affinity offers an annual provider quality incentive program to ensure that providers understand the HEDIS®/QARR® program and are aware of the necessary methods/requirements for demonstrating that care meets the National Committee on Quality Assurances standards. The Quality Incentive Program identifies the measures that Affinity and their providers will jointly focus on throughout the measurement year in order to position Affinity as a high-performing quality plan with NYSDOH and CMS. Affinity’s performance on select NCQA/CMS quality measures is used to determine its ranking among similar plans in the industry. This ranking impacts the Plan’s annual quality incentive award reimbursement which, in turn, assists in supporting the funding of quality programs developed by our providers. The quality ranking also assists a health plan in positioning themselves within the healthcare market and is a consideration by a member when choosing a plan. The annual provider incentive program is introduced at the onset of each measurement year.

Member Wellness Incentive Program
Affinity’s wellness/incentive program focuses on achieving better health outcomes for its members. Annually, the Quality Management Department identifies wellness measures that align with the annual HEDIS®/QARR® or condition-specific risk areas to design a comprehensive program. Members can earn gift cards for completing annual wellness exams, preventive screenings and other important medical services that address their chronic care needs. The incentives are selected based on the needs of the overall Affinity membership and are aligned with the HEDIS®/QARR® performance measures used by NYS/CMS/NCQA to evaluate Affinity and other managed care plans annually. The Plan uses information annually to identify those wellness incentive initiatives that can have a direct impact on the HEDIS®/QARR® results in the measurement year. The Quality Management Department reserves the opportunity to adjust the need to offer specific wellness incentives throughout the year, based on the overall Plan performance and established quality goals.

B. INCIDENTS AND QUALITY OF CARE REFERRALS AND COMPLAINTS

Member complaints about the quality of care received are forwarded by the Affinity Health Plan Customer Service Department to the Quality Management Department for investigation and resolution. Providers will often be asked to respond to these complaints and to submit the
medical record timely. When a complaint is substantiated, a copy of the resolution letter and any requests for provider action plans will be forwarded to the re-credentialing file.

Providers are asked to report to Affinity Health Plan any adverse events or incidents involving our members. The Affinity Health Plan clinical staff can also internally refer for investigation concerns about the quality of care rendered or questions of adverse events or incidents. These can include:

- Unplanned admission and readmissions
- Unexpected medical, surgical and behavioral health treatment complications
- Failure/delay in addressing abnormal results causing adverse outcome or delaying appropriate treatment
- Medication/pharmacy usage concerns or errors
- Unexpected death or injury
- Questions of abuse or neglect of members

For Medicaid, serious reportable incidents (SRIs) which are defined as any situation in which the participant experiences a perceived or actual threat to his/her health and welfare or to his/her ability to remain in the community. For more information please refer to Health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_10/sri_reporting.htm.

The Office of Mental Health (OMH) has created the New York State Incident Management and Reporting System (NIMRS) which is a secure, web-based, quality management tool used by OMH providers to report incidents in accordance with Part 524 of the NYS Rules and Regulations. NIMRS features a report generator that can be used to examine trends, providing risk management staff the ability to make program changes and better the quality of the lives of the individuals served. This tool can be found at OMH.ny.gov/omhweb/dqm/bqi/nimrs/index.html.

For a listing of NIMRS definitions and severity ratings please visit OMH.ny.gov/omhweb/dqm/bqi/nimrs/forms/DefSevRat.pdf.

Providers will often be asked to respond to these complaints and to submit the medical record timely. When a concern, adverse event or incident is substantiated, a copy of the resolution letter and any requests for provider action plans will be forwarded to the re-credentialing file. Where more immediate question of risk to one or more members exists, immediate peer review or administrative intervention may be requested. Where there is a question of significant departure from the standard of care or a serious medical issue or error, the matter will be immediately forward to the Credentialing Committee for consideration of action.

C. QUALITY IMPROVEMENT STUDIES

Affinity Health Plan is required to conduct quality improvement studies annually for each of its product lines. Study topics can be mandated by NYSDOH and CMS, or can be selected by the
Plan. Providers and practitioners are required to participate in these studies as requested. Participation often includes time-sensitive submission of medical record information on selected members.

D. CLINICAL PRACTICE GUIDELINES

Our Quality Improvement Program incorporates practice guidelines consistent with current standards of care, and our decisions for utilization review, member education, coverage of services, and other areas follow these guidelines. The guidelines include, but are not limited to, the following conditions:

- Acute tuberculosis treatment
- Adolescent health care
- Adult health maintenance
- Asthma management
- Behavioral health (e.g., depression, anxiety, etc.)
- Breastfeeding promotion
- Cardiac health
- Chronic obstructive pulmonary disease (COPD)
- Depression screening, diagnosis and treatment
- Diabetes care
- Domestic violence identification
- Fall Prevention
- Geriatric assessment
- Hepatitis C
- HIV/AIDS
- Latent tuberculosis infection: targeted screening and management
- Pediatric anemia: algorithm for Work-Up
- Pediatric health maintenance (e.g., Child/Teen Health Program [CTHP])
- Pediatric preventive services: periodicity schedule
- Postpartum depression screening, diagnosis and treatment
- Prenatal care
- Preventive health guidelines for children and adults
- Sexually transmitted infection screening and treatment
- Smoking cessation
- Syphilis screening

Further details of our Quality Management program and quality assurance-related provider responsibilities are available on our web site at AffinityPlan.org.

Contact the Quality Management staff to learn about the various clinical performance improvement initiatives and primary care incentive programs. Where Affinity’s performance as a plan is less than the statewide average or another standard as defined by the New York State Department of Health, we will develop and implement a plan for improvement.
SECTION 12 — REFERRALS AND PRIOR AUTHORIZATIONS

REFERRAL PROCESS

Primary Care Provider (PCP) Referrals Within Plan Network

PCPs may refer members to any specialists or ancillary providers within the Affinity network. Referral forms are not required when a PCP requests that a member be evaluated and/or treated by a specialist or ancillary provider. Members are advised to visit their PCP for specialty care, except for services that members may access directly.

Referral forms are not required. However, it is important that a PCP document the reason for the referral in a member’s record, as well as the name of the specialist or ancillary provider. In lieu of a referral form, it is suggested, but not required, that the PCP write a prescription or note to the member to present to the specialist. This will assist the specialist in understanding the source of the referral and why the member was referred. It is equally important that the specialist document the source and the reason of the request in the member’s record. For those services for which members may not self-refer, **PCPs have the responsibility to identify specialist providers within the Affinity network for each instance when such services are determined to be medically necessary for the member.** Subject to any applicable appeal right, Affinity reserves the right to recoup the cost of services rendered by a non-participating provider from the Affinity referring provider.

Primary care providers are responsible for coordinating all of the care a member receives and are expected to refer members to specialists in the Affinity network for care that is outside of the scope of primary care. Because the PCP is the member’s first contact with Affinity, the PCP is responsible for identifying members with complex or serious medical conditions, assessing those conditions and recommending them in Care Management for intensive services.

PCPs are responsible for coordinating primary and specialty care, ancillary services and other covered healthcare services and collaborating with Affinity case managers and other providers involved in the member’s care.

Arrange behavioral health services through the Affinity Behavioral Care Unit or the member’s designated behavioral healthcare management organization.

Arrange for transportation services, as needed, to ensure that members are able to access healthcare services.

Affinity Health Plan does not cover care provided by non-participating providers, except for urgent/emergent care, without prior authorization. Please refer to Section 17 for more information.
Access to Specialty Care

Affinity Health Plan communicates to members that it isn’t necessary to see their PCP before seeking care for the following services: (i.e., members are advised to seek care directly from providers of these services.)

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Benefit</th>
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| Behavioral health services and alcohol and substance abuse services | Members may self-refer to a participating behavioral health provider or substance abuse provider for one visit per year for evaluations or be referred by a clinical case manager at Affinity Health Plan for office visits. Members are informed of this benefit at the time of enrollment.  
Except in an emergency, all referrals to the following types of service require an Affinity Health Plan prior authorization: inpatient, residential, partial hospitalization, intensive outpatient, day treatment, psychological testing, and neuropsychological testing. Behavioral health providers should contact Beacon to obtain prior authorization. For emergency situations, the provider should treat the patient and notify Beacon as soon as practical but no later than 48 hours or the next business day. |
| Dental services                                    | Members may self-refer to dental providers within the dental network of Affinity Health Plan. Contact Affinity Health Plan at 866.247.5678 for Medicaid, Essential Plan, HARP, and Child Health Plus Plans. Members can also contact DentaQuest directly at 866.731.8004. |
| Eye care/vision services                           | Members may self-refer to vision providers within the vision network of Affinity Health Plan. Contact Affinity Health Plan at 866.247.5678 for Medicaid, Essential Plan, HARP, and Child Health Plus. Members can also contact Superior Vision directly at 866.810.3312. Contact lenses are provided if medically necessary and prior-authorized (a referral is required for specialty consultation or treatment by an ophthalmologist). |
| Obstetrics and gynecology                          | Members may self-refer to a participating Affinity Health Plan provider for primary and preventive obstetric and gynecological services, and for unrestricted services for care related to pregnancy. |
| TB diagnosis and treatment                         | Members may self-refer for the diagnosis and treatment of TB by public health agency facilities. |
General Information

In order to determine medical necessity, clinical information is needed. Affinity Health Plan will make up to three (3) attempts to obtain necessary clinical information from the facility. Once all of the clinical information needed to determine medical necessity is received, an authorization number will be assigned, and the facility will be notified.

PLEASE NOTE: When an authorization is requested, we will provide a number as a reference only. Having a number does not mean approval. You must receive notification from Affinity that the authorization is approved. You will be notified both verbally and in writing of both approvals and denials.

Affinity Health Plan’s UM Department is staffed to provide authorization by fax submissions at 718.794.7822 from 8:30 a.m. to 5:00 p.m., Monday through Friday except holidays. For non-urgent services, requests received after business hours (5:00 p.m.) will be processed the next business day. For urgent situations that cannot wait until the next business day, call 866.242.5615 for urgent access. If you need general assistance you may also call our UM Department at 866.242.5615.

Services Requiring Prior Authorization

For a list of prior authorization codes, visit https://www.affinityplan.org/Providers/Resources/Pre-Authorization-Codes/Pre-Authorization-Codes/

- Referral requirements for behavioral health Providers - see Section 21 of Beacon’s provider manual.

- Outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, outpatient radiation therapy services and physical therapy services, for all products, require prior authorization from eviCore. For a complete list of procedures that require prior authorization from eviCore healthcare, visit eviCore.com/resources/healthplan/affinity-health-plan.

Provider Notice - Service Billed Does Not Match Service Authorized

When the service billed does not match the previously approved authorization, your claim will be denied for a lack of authorization with a message “Claim information is inconsistent with pre-certified/authorized services.” In the event that the service performed is different than the service initially authorized, Affinity Health Plan recommends that you submit a request to update your authorization request prior to submitting the corresponding claim. Doing this will prevent the claim from being denied and avoid the activation of the appeal process and its associated timelines. Explanation/Denial code: N54: Claim information is inconsistent with pre-certified/authorized services.

The fax number to submit a request for authorization update prior to submitting your claim is 718.794.7822.
Once claim has been denied, you cannot request the authorization update. The claim will require an appeal to be mailed to Complaints, Grievance and Appeals. The Appeals mailing address is:

Affinity Health Plan
Attention: CGA
1776 Eastchester Road
Bronx, NY 10461

**Pharmacy Services Requiring Prior Authorization**

Members who have CHP, HARP, EP, and NY Medicaid Managed Care have prescription drug coverage through Affinity Health Plan.

The Affinity Health Plan formulary or preferred drug list is located online at AffinityPlan.org/en-us/providers/pharmacyservices.aspx.

Any medication being administered within the provider’s office or outpatient setting should be reviewed for authorization status against the medical authorization grid found at AffinityPlan.org/uploadedFiles/Affinityv3/Providers/Support/Files/Pharmacy/Current%20Authorization%20Status%20for%20Medical%20Benefit%20Drugs.pdf.

**ELECTRONIC PRESCRIBING AND AUTHORIZATIONS**

You are encouraged to prescribe electronically and submit electronic authorizations requests. These options are available through our pharmacy benefits manager, CVS Caremark. Regarding electronic authorization requests, you will be able to answer required criteria and after submission, if the authorization cannot be approved immediately, you will get a response back electronically following review by a clinician. Even with electronic authorization, you will still get a fax notice so that you can easily update your patient chart. Allscripts®, ePrescribe®, and NaviNet® are among the systems currently supported; new systems are constantly being added. If your electronic prescribing tool does not support electronic authorization, a portal version is available. To learn more or to get started, visit Caremark.com/epa.

A list of participating pharmacies, our formularies, coverage rules (e.g., step therapy, quantity limits, etc.) and drug specific authorization forms can be found on our web site at AffinityPlan.org.

Pharmacies may dispense only items found in our formulary. The formulary differs by product line and some formulary agents require prior authorization. The member’s PCP or participating specialist may request exceptions through our PBM by calling 855.722.6228 and for prior authorizations by calling 877.432.6793.
Pharmacy Appeals
In the event that prior authorization coverage for a member is denied, an appeal can be made within 60 days of the initial denial by calling 888.543.9069 (choose option 1 for pharmacy appeals) or by having the provider fax clinical chart notes and a letter of medical necessity to 718.536.3383.

Buy and Bill Authorization Requests
It is the policy of Affinity Health Plan to require prior authorization for medical claims for medications listed on our website via the Medical Benefit Utilization Grid when these agents are being administered in an office or clinic setting. To see the list of applicable drugs and additional considerations, visit AffinityPlan.org/Providers/Support/Pharmacy/Pharmacy/ and choose “Medical Benefit Utilization Management Drugs” section and open the “Current Authorization Status for Medical Benefit Drugs” document.

NYS Medicaid covers some pharmaceuticals and injectable on a fee-for-service basis at the member’s local retail pharmacy. The pharmacy will bill Medicaid directly for these drugs. The NYS Medicaid Program requires prior authorization for certain drugs not on the preferred drug list. For a list of preferred medications and those requiring prior authorization please refer to NewYork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

Dual providers who wish to provide specialty services (beyond the scope of services included in the primary care capitation or as a "bill above" described earlier in this manual) to their own Affinity Health Plan patient must obtain an authorization from Affinity Health Plan UM Department at 888.543.9074 prior to providing specialty services, unless the provider is credentialed as a dual provider with Affinity Health Plan. The authorization number and taxonomy code should be included on the bill for specialty services.

A Specialist as the PCP
An enrollee diagnosed as having a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time is eligible for a specialist to serve as the member’s PCP.

Requires agreement of PCP, MCO, specialist, pursuant to a treatment plan.

Referral to Specialty Care Centers
Should the member present with a life-threatening disease or condition or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, the member is eligible for a referral to an accredited or designated specialty care center with expertise in the condition. The decision to make
such referrals is made by Affinity Health Plan's chief medical officer or designee after consultation with the member's PCP. In no event shall Affinity Health Plan be required to permit a member to elect to use a non-participating specialty care center, unless Affinity Health Plan does not have an appropriate specialty care center within the network.

Degenerative and disabling is defined as any chronic or acute disease entity that, despite appropriate medical intervention, will destroy the body's integrity leading to the patient's dependence on others for activities of daily living (ADL) and eventually to death.

Life threatening is defined as a situation in which the patient's medical condition is such that any delay in treatment would result in the patient's death.

RECIPIENT RESTRICTION PROGRAM

The Recipient Restriction Program (RRP) is a medical review and administrative mechanism whereby selected members with a demonstrated pattern of overutilization or misusing services may be restricted to one or more providers. The objectives of the RRP include:

a. Reducing the cost and inappropriate utilization of health care resulting from patterns of member abuse or misuse of services, and

b. Providing members with coordinated medical services, thus improving the quality of their care.

We restrict access to non-emergent covered services only. We do not restrict access to emergency services or deny coverage of emergency services based upon a member being in the RRP. When a restriction has been imposed, the member will be permitted to access only certain covered services through one or more Affinity-selected providers (RRP provider(s)), except when the member has been referred to an alternate provider authorized by Affinity or the RRP provider.

If a restricted member sees a provider outside of his/her restriction, the associated claim will be denied. As a participating provider you agree to cooperate with us in the management and care of members in the RRP program. Also, as a participating provider you will receive notification when one of your members has been added to the Affinity Health Plan RRP.

PRIOR AUTHORIZATION PROCESS

The purpose for prior authorization is to:

- Give providers eligibility information based on Affinity Health Plan’s currently available data. Confirm that a given service is a covered benefit under Affinity Health Plan.

- Allow Affinity Health Plan to evaluate the medical necessity and appropriateness of the proposed treatment.
• Provide appropriate authorization to allow reimbursement to the provider for treatment.

• Enable the clinical staff to track the member’s care and coordinate services where necessary.

Process to Obtain Prior Authorization

Procedures requiring prior authorization by Affinity Health Plan are listed on the authorization grid in Appendix 1. The prior authorization request must be generated by an Affinity Health Plan provider and authorized by Affinity Health Plan’s UM Department. For scheduled procedures, we recommend that a request be sent at least five (5) calendar days before the anticipated date of service.

The following information will be required to process a service for prior authorization:

• Member name/date of birth

• Member’s Affinity Health Plan ID number

• Ordering provider’s name, servicing provider’s name and hospital/ambulatory center name if indicated

• Tax identification number

• IPA affiliation, if applicable

• ICD-10 diagnosis

• Code Current Procedural Terminology (CPT) codes of the procedure, surgery, or service being requested

• Anticipated date and time of procedure

• Necessary clinical information supporting need for procedure, surgery, or service

The Medical director may request additional information.

Provider service authorization requests can be faxed correspondingly:

• 781.994.7600 for medical

• 718.896.1784 for behavioral health

• 855.633.7673 for pharmacy

• 800-540-2406 for eviCore
## Authorization Processing Timeframes

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Type of Communication</th>
<th>Receiver of Communication</th>
<th>Total Process Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service (prospective non-urgent)</td>
<td>Telephone and in writing within three business day of receipt of information to make decision, not to exceed 14 days from request</td>
<td>Member, designee and practitioner/provider</td>
<td>Three business days not to exceed 14 days from receipt of all necessary information</td>
</tr>
<tr>
<td>Pre-service (prospective) expedited</td>
<td>Telephone and in writing within 72 hours from receipt of necessary information</td>
<td>Member, designee and practitioner/provider</td>
<td>72 hours from receipt of necessary information</td>
</tr>
<tr>
<td>Concurrent/Extension of Care</td>
<td>Telephone and in writing within one business day of receipt of request with necessary information, not more than 14 days after request for information</td>
<td>Member or designee, which may be satisfied by notice to the provider</td>
<td>One business day not to exceed 14 days from receipt of necessary information</td>
</tr>
<tr>
<td>Concurrent/Extension of Care Expedited (all inpatient)</td>
<td>Telephone within one business day but not more than three business days from date of request with necessary information (for Home Health services following a hospital stay, within 72 hours of receipt of necessary info.)</td>
<td>Practitioner/provider and/or member/designee</td>
<td>One business day not to exceed three business days from receipt of necessary information</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Written notice within 30 calendar days of receipt of information to make decision (no calls required)</td>
<td>Member, designee and practitioner/provider</td>
<td>30 calendar days from receipt of all necessary information</td>
</tr>
<tr>
<td>Reconsideration</td>
<td>Must occur within one business day of receipt of request which includes all necessary information for prospective, and concurrent determinations</td>
<td>Practitioner/provider</td>
<td>One business day of receipt of request and all necessary information</td>
</tr>
</tbody>
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Additional Information
For Medicaid, expedited and standard review timeframes for pre-authorization and concurrent review may be extended by an additional fourteen (14) days if:

- The member, designee or provider requests an extension. or
- We demonstrate there is a need for more information, and the extension is in the member’s interest. Notice of extension to member will be made.

An expedited review must be conducted when Affinity Health Plan or the provider indicates that delay would seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum functions. Members have the right to request an expedited review. If Affinity Health Plan denies the member's request for an expedited review, Affinity Health Plan will notify the member that the request will be handled under standard review timeframes.

Service Authorization Request Determination and Notification
All cases are evaluated for the appropriate level of care and medical necessity based on the clinical findings and plan of care submitted to Affinity Health Plan. All cases are reviewed using nationally accepted guidelines (e.g., Milliman Care Guidelines (MCG), American Society of Addiction Medicine (ASAM), CMS National, and local coverage determinations) or guidelines developed by Affinity Health Plan. Any case not meeting guidelines will be reviewed by the chief medical officer or designee.

All cases are evaluated for the appropriate level of care and medical necessity. Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic or congenital condition, injury or disability.

Affinity Health Plan will provide the member (or their designee) and provider with verbal (telephonic) and written notification of the determination regarding the requested service, procedure or surgery.

- Approved authorizations: Notification will include a description of the service and/or number of visits along with the date(s) of service/approval timeframe.
- Adverse determinations: If an Affinity medical director concludes, after review of all information submitted, that the service is not medically necessary or the level of care is not appropriate for the member's condition, a denial notice will be issued in accordance with Article 49 of the NYS Public Health Law and CMS guidelines in Chapter 13, Grievances, Organization Determinations and Appeals.
- Denials: Issued when the clinical information submitted is insufficient to make a utilization determination — this includes the lack of response to information or
updates on patient status.

- Reconsideration of adverse determination: When an adverse determination is rendered without provider input, the provider has the right to reconsideration. The reconsideration shall occur within one business day of receipt of the request and shall be conducted by the member’s health care provider and the clinical peer reviewer making the initial determination.
  - Exception: Retrospective reviews that result in an adverse determination are not eligible for reconsideration.

Affinity Health Plan must send a notice of determination on the date review timeframes expire. If Affinity Health Plan fails to make a determination within the applicable time periods prescribed in this section, it shall be deemed a reversal of the adverse determination.

Each notice of final adverse determination will be in writing, dated, and will include:

- The reasons for the determination, including the clinical rationale, if any.
- Instructions on how to initiate internal appeals (standard and expedited appeals) and eligibility for external appeals.
- Notice of the availability, upon request of the member or the member’s designee, of the clinical review criteria relied upon to make the determination.
- What, if any, additional necessary information must be provided to, or obtained by,
- Affinity in order to render a decision on the appeal.
- A description of action to be taken.
- A statement that Affinity Health Plan will not retaliate or take discriminatory action if appeal is filed.
- The process and timeframe for filing/reviewing appeals, including the member’s right to request an expedited review.
- The member’s right to contact the DOH, with the 800 number, regarding his/her complaint.
- A fair hearing notice review including aid to continue rights. A fair hearing may not be initiated unless an appeal has been filed with the Plan.
- Statement that notice is available in other languages and formats for special needs and how to access these formats.
Reversal of Prior-authorized Treatment
Affinity Health Plan may reverse a prior-authorized treatment, service or procedure on retrospective review pursuant to section 4905(5) of PHL when:

a. relevant medical information presented to Affinity Health Plan or utilization review agent upon retrospective review is materially different from the information that was presented during the prior-authorization review; and

b. the information existed at the time of the prior-authorization review but was withheld or not made available; and

c. Affinity Health Plan was not aware of the existence of the information at the time of the prior-authorization review; and

d. had they been aware of the information, the treatment, service, or procedure being requested would not have been authorized.

Financial Incentives
Affinity Health Plan is committed to providing members with the best and most appropriate care possible. Utilization Management (UM) decisions are based only on the appropriateness of care and existence of coverage. At no time does Affinity Health Plan directly or indirectly reward practitioners or other individuals for issuing denials of coverage, service or care.

There are no financial incentives offered or compensation rewarded to individuals, as UM decision makers, to encourage underutilization of services.

Provider Request for Clinical Criteria
Providers may request a copy of the clinical criteria used to render a Utilization Management decision, free of charge. Providers are notified of their right to obtain clinical criteria.

a. Utilization Management notifications (adverse determinations) include an appeal rights attachment.

b. The provider portal or provider bulletin requests can be submitted by calling 866.247.5678 and speaking with a call center representative. The applicable clinical criteria will be mailed to the requesting provider within 15 business days.
SECTION 13A — BILLING, CLAIMS, AND PAYMENTS

CAPITATION
If contracted reimbursement is on a capitated basis, payment will be due for all members reflected on the monthly membership list we provide you. We typically issue capitation checks at the beginning of each month, and you do not need to submit invoices/bills for capitation payments. A single monthly check is issued for all members reflected on a membership list, regardless of product line differences. **Even if reimbursement for the underlying service is encompassed in capitation, you must submit a claim for the underlying service (see list below) so that the encounter can be recorded.**

CLAIMS
Fee-for-service claims will be processed in a manner consistent with New York Prompt Payment Law (INS § 3224-a). We will pay the lesser of billed charges and contracted rates, unless payment is a global rate or underlying services were otherwise “bundled” for reimbursement purposes.

Submission of Claims
You are encouraged to submit claims electronically. Physicians' offices should submit a CMS-1500 claim form; hospitals should submit a UB 04 claim form (acceptable bills for ambulatory surgery, emergency room and ancillary services include a CMS-1500 or UB 04 form). Submissions may also be made via electronic claim 837I for physicians or 837 for hospitals. In order to be payable, the claim must be submitted in a timely manner. For participating providers, the deadline for claim submission is the greater of 90 days from the date of service/discharge, and such other deadline set forth in the participation agreement. All claims must fully be documented by providing all information requested, including:

- Member name
- Date of birth
- Member ID #
- Authorization #
- All valid diagnosis codes by number
- Present on admission (POA) indicator
- Date(s) of service
- Place of service
- Quantity/units
- Valid procedure code (CPT and HCPC)
- Charges
- Treating physician's name, address, telephone number
- National provider identifier (NPI)
- Coordination of benefits (COB) information
- Federal Tax Identification Number (TIN)
### SECTION 13A – BILLING, CLAIMS, AND PAYMENTS

<table>
<thead>
<tr>
<th>Electronic Billing (837I/837P)</th>
<th>Paper Claims (CMS-1500 and UB 04)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Payer ID #: 13334</td>
<td>Submit to: Affinity Health Plan</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 981726</td>
</tr>
<tr>
<td></td>
<td>El Paso, Texas 79998-1726</td>
</tr>
</tbody>
</table>

For additional information on claim submission, contact your provider relations representative at ProviderRelations@affinityplan.org.

For electronic guidance visit

AffinityPlan.org/Providers/Publications-and-Training/EDI-Information/EDI-Information/.
SECTION 13B — RECONSIDERATIONS

If a provider disagrees with the payment determination, the provider can ask for a request for reconsideration. Claim reconsiderations must be submitted within sixty (60) days of the remittance advice for that claim. If Affinity Health Plan does not receive a request for a reconsideration claim within sixty (60) days of the remittance advice for that claim, the provider shall be deemed to have waived all rights to assert that the claim was processed incorrectly.

Reconsideration Address:

Affinity Health Plan
Attn: Claims
P.O. Box 812, Gracie Station
New York, NY 10028

Please provide the following information on your request when submitting a request for reconsideration:

- Claim number
- Member name
- Member ID
- Date of service
- Procedure code
- Total charges
- Provider name
- National provider identifier
- Tax identification number
- Name of requestor
- Requestor’s contact information (e.g., telephone number and address) and a thorough summary of what is being requested

Corrected/Voided Claims

A corrected claim is a replacement of a previously submitted claim (not limited to changes or corrections to charges, procedure codes, dates of service or member information, etc.) A corrected claim is not an inquiry or an appeal. Do not submit a corrected claim to the claim reconsideration address above. This will cause a delay. Corrected and voided claims can be submitted via paper or electronically on CMS or EDI complaint formats.

If a corrected claim is submitted on paper, please mail to the following address:

Affinity Health Plan
P.O. Box 981726
El Paso, TX 79998-1726
SECTION 13 – PART 1 – BILLING AND CLAIMS SUBMISSIONS GUIDELINES

CAPITATION
If contracted reimbursement is on a capitated basis, payment will be due for all members reflected on the monthly membership list we provide you. We typically issue capitation checks at the beginning of each month, and you do not need to submit invoices/bills for capitation payments. A single monthly check is issued for all members reflected on a membership list, regardless of product line differences. **Even if reimbursement for the underlying service is encompassed in capitation, you must submit a claim for the underlying service (see below) so that the encounter can be recorded.**

Instructions for Submitting Claims
The physician’s office should prepare and electronically submit a CMS-1500 claim form. Hospitals should prepare and electronically submit a UB-04 claim form unless contracted differently. Fee-for-service claims will be processed in a manner consistent with New York Prompt Payment Law (INS § 3224-a). We will pay the lesser of billed charges and contracted rates, unless payment is a global rate or underlying services were otherwise “bundled” for reimbursement purposes.

Timely Filing
All claims must be submitted to Affinity Health Plan within the timeframes specified by your Affinity Health Plan provider contract. Claims for services provided to Medicaid and CHP members must be submitted within 90 days from the date of service/discharge. Acceptable reasons for a claim to be submitted late are litigation, primary insurance processing delays, retro-active eligibility determination, and rejection of the original claim for reason(s) other than timely filing. Late claims that are submitted must be accompanied by proof of prior billing to another insurance carrier or a letter that specifies an acceptable reason for the delay.

Electronic Claim Submissions (837 – Health Care Claims)
Affinity Health Plan recommends using the electronic data interchange (EDI) system for claims submission. Electronic claims submissions can help reduce administrative and operating costs, expedite the claim process and reduce errors.

Affinity Health Plan accepts claims originating from clearinghouses. Please contact your preferred clearinghouse to confirm that they will forward your submitted claims to Affinity Health Plan.

If you have further questions about beginning to submit claims electronically to Affinity Health Plan, please contact your provider relations representative at ProviderRelations@affinityplan.org.

For **medical claims** for Medicaid, Child Health Plus and Essential Plan members:
Affinity's payer ID is 13334

For **behavioral health claims** for all members: Affinity's payer ID is 43324 and our plan ID (SBR03) is 0009

Electronic Remittance Advice (835 – Health Care Claim Payment/Advice)
Affinity Health Plan offers secure electronic delivery of remittance advice. You may receive these either through your claims clearinghouse or directly from Affinity Health Plan.

For clearinghouse delivery, please contact your clearinghouse for availability.

If you would like to receive the HIPAA-mandated 835 electronic remittance advice directly from Affinity Health Plan, please complete the Affinity Health Plan e-commerce request form located at Secure.affinityplan.org/era/Default.aspx.

**Eligibility Inquiries (270/271 – Eligibility, Coverage or Benefit Inquiry/Information)**

Affinity Health Plan offers secure responses to eligibility inquiries.

Eligibility benefit inquiries/responses provide information on covered individual eligibility, coverage verification, and patient liability (deductible, copayment, and coinsurance). You may receive these either through your claims clearinghouse or directly from Affinity Health Plan.

For clearinghouse delivery, please contact your clearinghouse for availability. Eligibility information is also available online at AffinityPlan.org.

**Response Reports**

- 277 report is the electronic claim acknowledgement in X12 format.
- 999 report acknowledges the receipt of claims and whether the transaction is in compliance with HIPAA requirements.
- RPT report is used by Affinity Health Plan to give further information, in a non X12 format, on the status of submitted claims (837 transactions).

**Affinity Health Plan Claims Editing Software**

Affinity Health Plan uses various claims editing software to automatically review and edit health care claims submitted by physicians and facilities.

**Ancillary Providers**

For submitting claims electronically refer to Section 12.1. Providers must submit claims for home healthcare services; durable medical equipment (DME); respiratory care; and physical, occupational and speech therapies on a CMS-1500 or UB-04 claim form within ninety (90) calendar days of the date of service.
Coordination of Benefits (COB)

Affinity Health Plan will coordinate the benefits with the other carrier(s) when other coverage exists to ensure that Affinity Health Plan liability does not exceed more than 100% of Affinity Health Plan allowable expenses. This effort involves coordinating coverage and benefits for illnesses, injuries and accidents covered by:

- personal automobile coverage
- workers’ compensation
- Veteran's Administration
- no-fault
- other health insurance

Plans Payments Involving COB

In the event a claim is initially filed with Affinity Health Plan for which another carrier is determined to be the primary payer, the provider will be notified on a remittance advice to file with the primary insurer.

All participating providers agree to provide Affinity Health Plan with the necessary information for the collection and coordination of benefits when a member has other coverage. The provider will be required to:

- Determine if there is duplicate coverage for the service provided;
- Recover the value of services rendered to the extent such services are provided by any other payer; and
- File the claim with Affinity Health Plan along with the primary carrier's explanation of benefits (EOB) attached for reconsideration within ninety (90) calendar days of receiving the primary carrier's explanation of benefits.

Affinity Health Plan will coordinate benefits up to Affinity Health Plan’s allowable as secondary payer. Affinity Health Plan is not responsible for payment of benefits determined to be the responsibility of another primary insurer.

Payments and Reimbursements

Affinity Health Plan reimburses providers for services that are billed correctly to Affinity Health Plan. Clean claims are paid within the guidelines stipulated by section 3224-a of the New York State Insurance Law.

Payments to Primary Care Providers

Each PCP or group with a capitation agreement will receive capitation payments for enrolled members. Capitation payments are made at the beginning of each month. All encounter data must be submitted to Affinity Health Plan and adhere to all industry standard coding guidelines.
Payments to Specialty Providers
Each specialist provider will receive a payment reflecting payment for covered services provided to eligible members and correctly billed to Affinity Health Plan. The payment may be made payable to the individual provider or to a designated medical or professional group. Multiple specialty providers should submit a taxonomy code when submitting claim forms.

NOTE:
Any changes in a provider's status, address, corporate name, or other changes should be reported to Affinity Health Plan immediately to ensure prompt and accurate reimbursement.

Remittance Advice
Electronic remittance advice and 835 are available. A remittance advice should be obtained by logging onto the online provider portal at AffinityPlan.org.

For providers who need assistance obtaining their ID/password, please contact your provider relations representative for assistance.

The remittance advice identifies which members and services are covered by a particular check. Claims are listed in alphabetical order according to the member's last name. Each item in the listing includes the following:

- Affinity Health Plan claim number as assigned by Affinity Health Plan
- Member's name
- Member's Affinity Health Plan ID number
- Provider's name
- Date of service
- Procedure code
- Patient account number
- Denied amount
- Allowed amount

The remittance advice should be examined to reconcile payments from Affinity Health Plan with accounts receivable records.

Electronic Funds Transfer (EFT)
Providers can request to receive payments electronically. Please contact your account manager for information.

Affinity Health Plan Claim Inquiry
Once a confirmation is received, a provider may go online and check the status of claims submitted, at any time, by visiting Providers.affinityplan.org and viewing the provider portal payment status. You can also contact the provider call center at 866.247.5678. Monday through Friday, 8:30 a.m. to 5:00 p.m.
Stop Payment and Reissue of Checks
For a stop payment or a check reissue, send a request in writing to:

Affinity Health Plan
Attn: Finance Department
Metro Center Atrium
1776 Eastchester Road
Bronx, NY 10461

The written request must have the following information:

- The contact person and phone number
- Verification of the correct remittance address for the check
- Who the check was made payable to, if known

Please note that if the check has been cashed, an additional Affidavit form will need to be obtained, signed, and notarized.

Please note that if the check has been cashed, an additional affidavit form will need to be obtained, signed and notarized.

Claim Denials for Invoice
In some cases, Affinity Health Plan will deny a claim because a copy of the manufacturer’s invoice is required for claims processing (see paragraph below). Providers may send a copy of the unaltered invoice via fax or mail to the contact information below.

Please be sure to include the member’s name and ID, as well as the claim number associated with the invoice request and mail to:

Affinity Health Plan
Attn: Claims
P O Box 812, Gracie Station
New York, NY 10028

Claims Requiring Manufacturer's Invoice
Claims that require a manufacturer’s invoice for payment consideration (e.g., by report (BR) procedure) must be submitted with the following required information in order to be validated as an acceptable invoice:

- Manufacturer’s name
- Provider’s name
- Item with description
- Acquisition cost on the invoice
- Invoice date

Some examples of unacceptable invoices include altered manufacturer’s invoice, purchase orders, sales orders, order confirmations packing slips and delivery receipts.

Any claim received by Affinity Health Plan that requires an invoice and is missing an invoice, missing a required element (noted above), or is submitted with an unacceptable invoice may be denied.
Electronic Submission of Corrected Claims
When submitting a corrected claim electronically, the original claim number must be noted on the corrected claim, and the claim frequency type code must be a seven (replacement of prior claim). Please go to Affinity Health Plan’s website for additional information. Note that corrected claims must be submitted within sixty (60) days of receiving the remittance advice.

Quick Guide to Claims Processing

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| Where do I direct billing questions?                                     | Medicaid, Essential Plan, HARP and Child Health Plus: 866.247.5678  
Medicare: 877.234.4499                                                                                                                                 |
| Where do I submit paper claims?                                         | Medicaid, Essential Plan, HARP and Child Health Plus: Affinity Health Plan  
P.O. Box 981726  
El Paso, Texas 79998-1726                                                                                                                                 |
| Which forms may be used for billing?                                    | Refer to the Affinity Health Plan website at AffinityPlan.org for information about submitting claims electronically  
Professional: CMS 1500  
Facility: UB-04                                                                                                                                     |
| Which patient identifier(s) should be used?                             | Medicaid Number (CIN) or  
Affinity Health Plan Identification Number                                                                                                                                 |
| What is the time frame for submitting the claim?                        | Ninety (90) days                                                                                                                                 |
| What is the time frame for payment of a completed and clean claim?      | Thirty (30) days after receipt of a clean claim submitted electronically  
Forty-Five (45) days after receipt of a clean claim submitted via paper (in accordance with NY Insurance Law Section 3224-a) |
| How do I check on the status of a claim?                                | To check claim status visit the provider portal at AffinityPlan.org                                                                                     |
| To whom do I direct a claims inquiry?                                   | Medicaid, Essential Plan, HARP and Child Health Plus: 866.247.5678                                                                                     |
| What is the process if you believe a claim has been underpaid or you wish to submit a corrected claim? | Submit claim reconsideration request with supporting documentation within sixty (60) days of the remittance advice for the claim at issue.  
Submit reconsideration requests to: Affinity Health Plan  
P. O. Box 812, Gracie Station  
New York, NY 10028                                                                                     |

The billing guidelines contained within this section adhere to industry standards as defined by the Center for Medicare and Medicaid Services (CMS); the National Correct Coding Initiative (NCCI); the National Coverage Determinations (NCD) and Local Coverage Determinations (LCD); the American Medical Association's (AMA) Current Procedural Terminology Manual (CPT-4); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases 10th Revision (ICD10) Clinical Modification.
SECTION 13 PART 2 – BILLING AND CLAIMS SUBMISSION GUIDELINES

GENERAL CLAIMS AND BILLING GUIDELINES

Claims are processed Monday through Friday and clean claims are scheduled to be paid in accordance with New York State Insurance Law § 3224-a. A clean claim is a claim for healthcare services that contains all of the data elements required by Affinity Health Plan to process and adjudicate the claim including, but not limited to, all the data elements contained on a CMS-1500 form and UB-04 Form. The following data elements are required for a claim to be considered a clean claim:

<table>
<thead>
<tr>
<th>CMS-1500 and UB-04 Data Elements</th>
<th>CMS-1500</th>
<th>UB-04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member name</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Member date of birth</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Member sex</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Member address</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Affinity Health Plan member ID number</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Coordination of benefits (COB)/other insured’s information</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Date(s) of service</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Authorization number</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>ICD-diagnosis code(s), valid and coded to the appropriate digit</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>ICD-procedure code(s) (if applicable)</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>CPT-4 procedure code(s)</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>HCPCS code(s)</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Service code modifier (if applicable)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Place of service</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Service units</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Charges per service and total charges</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Provider name</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Provider address/phone number</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>National provider identifier (NPI)</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Tax ID number</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Affinity Health Plan provider number – for paper claims only</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Affinity Health Plan payer ID number – for EDI claims only</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Hospital/facility name and address</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Type of bill</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Admission date and type</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Patient discharge status code</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>CMS-1500 and UB-04 Data Elements</td>
<td>CMS-1500</td>
<td>UB-04</td>
</tr>
<tr>
<td>----------------------------------</td>
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<td>-------</td>
</tr>
<tr>
<td>Condition code(s)</td>
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</tr>
<tr>
<td>Occurrence codes and dates</td>
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<td>x</td>
</tr>
<tr>
<td>Value code(s)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td><strong>CMS-1500 and UB-04 Data Elements</strong></td>
<td><strong>CMS-1500</strong></td>
<td><strong>UB-04</strong></td>
</tr>
<tr>
<td>Revenue code(s) and corresponding CPT/HCPCS codes (outpatient services)</td>
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<td>x</td>
</tr>
<tr>
<td>Principal, admitting and other ICD-10 diagnosis codes</td>
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<td>x</td>
</tr>
<tr>
<td>Present on admission (POA) indicator (if applicable)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Attending physician name and NPI</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
Suggestions to Expedite Claims

Please follow the guidelines below when completing and submitting claim forms in order to expedite your reimbursement for services rendered. Claims that do not contain all required data elements may be returned or denied.

- Have correct and complete information on the claim form.
- Verify member eligibility.
- Do not submit duplicate claims. Initiate an inquiry if payment is not received within sixty (60) days after billing date.
- Provide coordination of benefits (COB) information before claim is filed.
- Include your NPI and TIN on all claims submitted.
- Electronic submission is the best way to expedite claims (refer to Section 12.1 in this manual). However, if you must submit paper claims, please mail claims routinely throughout the month. Doing so will assure faster turnaround on a consistent basis.
- For the submission of paper claims, please use the appropriate P.O. Box. See Section 12.2 in this manual for a listing of P.O. boxes.
- Complete a single claim form for each patient encounter.
- Submit a separate claim form for each provider and for each site where services were rendered.
- For services that require authorization, you must ensure you have obtained an authorization.

For your convenience, please note the following applicable service code places:

<table>
<thead>
<tr>
<th>Location Description</th>
<th>Location Description</th>
<th>Location Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pharmacy</td>
<td>20 Urgent Care Facility</td>
<td>51 Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td>2 Telehealth</td>
<td>21 Inpatient Hospital</td>
<td>52 Psychiatric Facility Partial Hospitalization</td>
</tr>
<tr>
<td>3 School</td>
<td>22 Outpatient Hospital (Effective 1/1/16: Defined as on Campus-Outpatient Hospital)</td>
<td>53 Community Mental Health Center</td>
</tr>
<tr>
<td>4 Homeless Shelter</td>
<td>23 Emergency Room – Hospital</td>
<td>54 Intermediate Care Facility/Mentally Retarded</td>
</tr>
<tr>
<td>5 Indian Health Service Free-standing Facility</td>
<td>24 Ambulatory Surgical Center</td>
<td>55 Residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>6 Indian Health Service Provider-based Facility</td>
<td>25 Birthing Center</td>
<td>56 Psychiatric Residential Treatment Center</td>
</tr>
<tr>
<td>7 Tribal 638 Free-standing Facility</td>
<td>26 Military Treatment Facility</td>
<td>57 Non-residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>8 Tribal 638 Provider-based Facility</td>
<td>31 Skilled Nursing Facility</td>
<td>60 Mass immunization setting, such as a public health center</td>
</tr>
<tr>
<td>9 Office</td>
<td>32 Nursing Facility</td>
<td>61 Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>10 Patient’s Home</td>
<td>33 Custodial Care Facility</td>
<td>62 Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>11 Assisted Living Facility</td>
<td>34 Hospice</td>
<td>63 End Stage Renal Disease Treatment Facility</td>
</tr>
<tr>
<td>12 Residence with shared living areas (Group Home)</td>
<td>41 Ambulance-Land</td>
<td>71 State or Local Public Health Clinic</td>
</tr>
<tr>
<td>13 Mobile Unit</td>
<td>42 Ambulance Air or Water</td>
<td>72 Rural Health Clinic</td>
</tr>
<tr>
<td>14 Walk-in Retail Health Clinic</td>
<td>43 Independent Clinic</td>
<td>81 Independent Laboratory</td>
</tr>
<tr>
<td>15 Off Campus - Outpatient Hospital</td>
<td>50 Federally Qualified Health Center</td>
<td>99 Other place of service</td>
</tr>
</tbody>
</table>
Supplemental Claim Documentation

- Hysterectomies claims for Medicaid must include a copy of the consent form. A copy of the consent form can be found at Health.ny.gov/health_care/medicaid/publications/docs/lcss/lcss-3113.pdf
- Any services defined as “by report” must be submitted with an invoice to assist with adjudication and payment.
- Supplies, drugs, and DME claims must include an unaltered manufacturer's invoice for HCPC codes that require a by report.

Be sure to attach the appropriate documentation to the claims.

NON-LIABILITY OF MEMBERS

NOTE:
You may not bill members for services covered by Affinity, except for applicable copayments, coinsurance or deductibles. You must advise members prior to initiating service when a particular service is not covered by Affinity and state the cost of the service. Non-compliance will result in termination of your participation agreement.

Copayments may be collected at the time of service. However, providers should not bill members for any cost-sharing amounts until after the remittance advice (RA) is received.

CODING AND BILLING REQUIREMENTS

Billing with the appropriate procedure and diagnosis codes expedites processing and speeds payment for services. It is important that providers code to the highest level of specificity based on the diagnoses of their patients.

CMS-1500

When completing field 21 of the CMS-1500 claim form, if more than one diagnosis is appropriate, list all the diagnoses that affect the treatment received, including any disease being managed by the provider.

UB-04

To group diagnoses into the proper DRG, CMS needs to capture a present on admission (POA) indicator for all claims involving inpatient admissions to general acute care hospitals. Use the UB-04 data specifications manual and the ICD-10-CM official guidelines for coding and reporting to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim forms UB-04 and 837 Institutional.

Multiple Specialty Providers

It is important for providers with multiple specialties to submit the appropriate taxonomy code when submitting claim forms. This will ensure accurate payment and the appropriate application of cost-sharing when appropriate.

National Correct Coding Initiative Edits

The Center for Medicare & Medicaid Service (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate claim payment. These policies are based on coding.
conventions defined in the American Medical Association’s (AMA) CPT Manual, national and local coverage determinations (NCD and LCD), coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. These standards set the coding requirements that all plans and providers must follow in order to secure reimbursement for all lines of business. Claims that are found to be noncompliant with these guidelines may be returned, partially denied, and/or denied.

Please visit the sites below for additional information:
NCCI Edits - CMS.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
AMA - AMA-assn.org/ama
NCD - CMS.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx
LCD - CMS.gov/medicare-coverage-database/indexes/lcd-state-index.aspx

**Evaluation and Management (E&M) Codes**
According to the CPT manual and the CMS guidelines for evaluation and management (E&M) codes, the level of service for E&M codes is based primarily on the extent of history obtained, the extent of examination performed, and the complexity of medical decision making.

Additional reporting issues include counseling and/or coordination of care, the nature of presenting problems(s), and the duration of face-to-face time spent with the patient and/or family. It is imperative that providers bill the appropriate level of E&M to avoid unnecessary claim edits or claim denials.

**Anesthesia Modifiers**
In accordance with the Centers for Medicare & Medicaid Services (CMS) coding guidelines, anesthesiology claims for patients must include the appropriate modifier(s), in the correct positions, in order to qualify for payment by Affinity Health Plan.

For Medicaid claims: When a CRNA is employed by an anesthesiologist, modifier QK should not be used. The anesthesia CPT code should be billed without a modifier under the NPI of the anesthesiologist or anesthesia group.

**Billing Requirements for Assistant Surgeon & Surgical Assist Claims**
Participating surgeons may utilize the services of an assistant surgeon when the complexity of the surgical procedure deems it appropriate. An assistant surgeon is only permitted when the service is recognized as allowing an assist. When multiple complex surgeries are being performed, the surgeon can be the primary surgeon on some of the surgeries and the assist on others. These services can be billed on the same claim.

A surgeon may not assist on his/her own surgery.

**Assistant surgeon performed by a physician:**
- Modifier 80, 81, or 82 should be used.
  - The assistant surgeon should be billed on a separate CMS-1500 claim form.
  - When multiple complex surgeries are being performed, the assistant surgeon can assist on some of the surgeries and the primary surgeon on others. These services can be billed on the same claim (they will be identified as different CPT codes).
These modifiers must be billed by a physician. They cannot be billed by a physician assistant (PA), a nurse practitioner (NP) or a clinical nurse specialist.

**Surgical assist performed by a PA, an NP or other qualified health professionals:**
- Must be billed by the physician. Claims submitted by the PA, NP, or clinical nurse specialist will be denied.
- Modifier AS should be used.
- Only one claim line should be billed with the surgical CPT code and AS modifier.

**Well Care and Sick Visit Billing**
- To receive the credit for our child and adolescent well visit quality incentives, the provider must bill a preventive medicine code (99381-99397).
- In the event that two separately identifiable services are provided on the same day, a sick visit and a well care visit, and both services are documented in the medical record, providers should bill for both using modifier 25.

**Obstetric Delivery Billing Requirements**
All obstetric deliveries will require the use of a modifier or condition code to identify the gestational age of the fetus as of the date of the delivery. Failure to provide a modifier/condition code with the obstetric delivery procedure codes listed below will result in the claim being denied.

**Practitioner Claims**
Medicaid claims submitted by practitioners for obstetric delivery procedure codes 59400, 59409, 59514, 59612 and 59620 will require a modifier.

**All Obstetrical Deliveries**
Deliveries prior to, at, or after 39 weeks gestation, require the use of a modifier (U7, U8 or U9). Practitioner claims for obstetric deliveries that fail to include a U7, U8 or U9 modifier on a claim, as appropriate, will result in denial of the claim.

- **U7:** delivery less than 39 weeks for medical necessity
- **U8:** delivery less than 39 weeks electively
- **U9:** delivery 39 weeks or greater

Consistent with Medicaid policy, a payment reduction will be applied on elective deliveries less than 39 weeks without medical indication.

**Modifiers 52, 53, 73, 74 and Reimbursement Rate**
Claims received by Affinity Health Plan in 2018 and forward, billed with modifier 52, 53, 73 or 74, containing a date of service in 2017 and forward, will have the following reimbursement reduction applied to the claim:

- **Modifier 52 – Reduced Services**  
  Reimbursement: 50% of base rate
  Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances, the service provided can be identified by its usual CPT code and the addition of modifier 52.

- **Modifier 53 – Discontinued Procedure**  
  Reimbursement: 50% of base rate
Under certain circumstances, the physician or other qualified healthcare professional may elect to terminate a surgical or diagnostic procedure. Due to the extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance is reported by adding modifier 53 to the CPT code reported for the discontinued procedure.

Modifier 73 – Discontinued Out-Patient Hospital/Reimbursement: 50% of base rate

Ambulatory Surgery Center (ASC) Procedure
Prior to Administration of Anesthesia
Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient’s surgical preparation, but prior to the administration of anesthesia. The intended procedure that is prepared for but cancelled can be reported by the usual procedure code with the addition of modifier 73.

Modifier 74 – Discontinued Out-Patient Hospital/ Reimbursement: 50% of base rate

Ambulatory surgery Center (ASC) Procedure
after Administration of Anesthesia
Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate the surgical or diagnostic procedure after the administration of anesthesia. Under these circumstances, the procedure started but terminated can be reported with its usual procedure code and the addition of modifier 74.

Hospital Claims
Medicaid fee-for-service claims submitted by hospitals for obstetric deliveries: ICD 10 procedure codes 10900ZC, 10903ZC, 10904ZC, 10907ZC, 10908ZC, 0U7C7ZZ, 3E0P7GC, 10D00Z0, 10D00Z1, and 10D00Z2 will require a condition code when a C-section or induction of labor occurs. Hospital claims for obstetric deliveries must include one of the following conditioning codes: (Failure to include one of the two modifiers below on a claim will result in denial of the claim.)

- 81: C-sections or inductions performed at less than 39 weeks gestation for medical necessity. If reported with an acceptable diagnosis, the claim will be paid in full. For this condition code, diagnosis code 650 or O80 (normal delivery) will be considered an acceptable diagnosis code, when reported as the primary diagnosis code and the claim will be paid in full.

- 82: C-sections or inductions performed at less than thirty-nine (39) weeks gestation electively. If reported without an acceptable primary diagnosis code, the claim payment will be reduced.

- 83: C-sections or inductions performed at 39 weeks gestation or greater. If reported, this claim will be paid in full.

Reference for obstetrics delivery billing can be found at Emedny.org/ProviderManuals/communications/OBSTETRICAL_DELIVERIES_PRIOR_TO_39_WEEKS_GESTATION.pdf.
Immunization Administration Processing Guidelines

VFC (Vaccine for Children) Program:
- Applicable for Medicaid line of business
- Applicable for Child Health Plus line of business
- Immunizations that are covered by the VFC will not have a reimbursement rate

Vaccine Administration Codes/Fees:
Affinity Health Plan will reimburse the administrative fee for an immunization separately from the immunization code per Medicaid billing guidelines. Affinity Health Plan will pay one administration fee per immunization.

Drug Code Billing Requirements
In order to comply with Section 6002 of the 2005 Federal Deficit Reduction Act (DRA), providers submitting drug codes administered in an office based or ambulatory setting must include the 11-digit National Drug Code (NDC) number, the NDC dispensing quantity and the NDC unit of measure. NDC information can be obtained from the drug invoice and/or package information. Claims that are missing this required information will be rejected.

Coverage of Medical Language Interpreter Services
As a result of recently adopted regulation, Title 10 NYCRR, Part 86-1.45 and the approval of the State Plan Amendment (SPA) 12-028 by CMS, reimbursement is now available for language assistant services provided in hospital inpatient settings, retroactive to September 1, 2012. The rate of payment is set at $11.00 for one unit of service up to a maximum of two billable units of service per patient per day.

The medical language interpreter services will also be reimbursed by Medicaid Managed Care in accordance with rates established in provider agreements or, for out-of network providers, at negotiated rates.

Patients with limited English proficiency shall be defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with healthcare providers and their staff.

The need for medical language interpreter services must be documented in the medical record and must be provided during a medical visit by a third-party interpreter who is either employed by or contracts with the Medicaid provider. These services may be provided either face-to-face or by telephone. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI).

Reimbursement of medical language interpreter services is payable with HCPCS procedure code:
**HCPCS Procedure Code** | **Units** | **Description**
--- | --- | ---
T1013 | 1 | Includes a minimum of eight and up to 22 minutes of medical language interpreter services
T1013 | 2 | Includes 23 or more minutes of medical language interpreter services

Reference for coverage of medical language services in hospital inpatient settings can be found at Emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf and at Health.ny.gov/health_care/medicaid/program/update/2017/feb17_mu.pdf.

**Locum Tenens**

If a *locum tenens* physician is needed for the traditional “holding one’s place” type of scenario (e.g., coverage for vacations, illness/medical leave, continuing education, etc.), providers may bill for *locum tenens* professional fees using the absent physician’s billing information as long as the following conditions are met:

- The regular physician is unavailable to provide the visit services.
- The patient has arranged or seeks to receive services from the regular physician.
- The locum tenens provider is paid for services on a per diem or similar fee-for-time basis.
- The substitute physician does not provide services to members for a continuous period of 60 days or more.

If these conditions are met, providers may bill for *locum tenens* professional services using the absent provider’s NPI number in box 24 of the CMS-1500. Providers must also use modifier Q6 (services furnished by a *locum tenens* physician) in box 24d for each line item on the claim provided by a *locum tenens*.

Reference for CMS guidelines for *locum tenens* arrangements can be found at CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3774CP.pdf.
SECTION 14 — GRIEVANCES, ORGANIZATION DETERMINATIONS, APPEALS

PROVIDER APPEALS

This section deals with appeals from two kinds of denials: (a) denials for lack of medical necessity, discussed in Part I below, and (b) administrative denials discussed in Part II later on. If providers disagree with a denial made by Affinity Health Plan due to lack of medical necessity or an administrative denial, providers shall follow the process set forth in this section.

Part I - Denial of Services for Lack of Medical Necessity

Affinity Health Plan will not reimburse treatment that is not medically necessary. Decisions denying claims for medical necessity (e.g., clinical denials) are made only by Affinity Health Plan’s chief medical officer or a medical director. Providers, members or the member’s designee shall appeal Affinity Health Plan’s decisions regarding the medical necessity of treatment as described below if they disagree with a denial based on lack of medical necessity.

If Affinity Health Plan requires additional information to conduct a standard internal appeal, then Affinity Health Plan shall notify the provider, in writing, within fifteen (15) business days of receipt of the appeal, requesting the additional information needed.

Appealing a Determination Based on Medical Necessity

Standard Appeals

If Affinity Health Plan denies a request for services based on lack of medical necessity, the provider, member or member’s designee may appeal the denial if they disagree with the denial.

The appeal must be submitted within sixty (60) days after the initial adverse determination. The denial letters are sent to the provider and to the member, and contain instructions regarding request for appeals. A provider shall file an appeal for a retrospective denial if they disagree with the denial.

An appeal is initiated by contacting Affinity Health Plan’s Appeals and Grievances Department either in writing, by telephone or fax. Appeals also can be submitted electronically via the provider portal under the authorization tab. Verbal appeals shall be followed up by a signed written appeal. Affinity Health Plan strongly advises that all appeals be made in writing and include the following documentation:

- The member’s medical records;
- An appeal or a summary of the treatment prepared by the provider’s utilization management department;
- A copy of the original denial letter from Affinity Health Plan; and
- Specific rationale/support as to why the decision should be overturned.
All appeals for medical necessity shall be forwarded to:

Affinity Health Plan
Attn: CGA Unit
1776 Eastchester Road
Bronx, NY 10461
Phone: 888.543.9069
Fax: 718.536.3358
If the original denial letter is not available, the appeal should indicate the dates of service at issue, the member's name and the member's Affinity Health Plan ID number. Although this documentation may be forwarded following the filing of the appeal, Affinity Health Plan may deny the appeal if such written documentation is not provided and Affinity Health Plan, in its own discretion, is unable to assess the basis for the appeal. Please note the complete medical record is not required, only pertinent sections that support the appeal. If the entire record is provided, please tab or mark the section the provider is requesting Affinity review. It is very important that the reason why the appeal is being requested is clear to Affinity and why Affinity should overturn the denial.

Affinity Health Plan will acknowledge the initiation of an appeal in writing within fifteen (15) calendar days after receiving the appeal and will respond to the appeal. If we require information necessary to conduct a standard internal appeal, we will notify the member and the provider, in writing, within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, we will request the missing information, in writing, within five (5) business days of receipt of the partial information.

For Medicaid, Affinity Health Plan will issue a standard medical necessity appeal determination as fast as the member’s condition requires, and no later than 30 calendar days from when the plan receives the appeal. This time may be extended for up to fourteen (14) calendar days upon member or provider request, or if Affinity Health Plan concludes that more information is needed, and an extension of time is in the best interest of the member and notifies the member accordingly.

Members or their designees may also present evidence to support their appeals in person or in writing.

Affinity Health Plan’s written determination regarding the appeal will be mailed to the member, the member’s designee and the provider within two business days of the determination of the appeal. Affinity Health Plan will indicate the reasons for its decision and, if the appeal is denied, the clinical rationale for upholding the clinical denial. The written notice of determination includes a notice of the member’s right to an external appeal and a description of the external appeal process, if applicable (see section below on External Appeals), as well as the member’s right to request a fair hearing, if applicable. Members must exhaust the plan appeal before requesting a fair hearing.

Each notice of the final adverse determination will be in writing, dated, and will include:

- a. The basis and clinical rationale for the determination
- b. The words “final adverse determination”
- c. Affinity Health Plan contact person and phone number
- d. Member coverage type
- e. Name and address of UR agent, contact person and phone number
- f. Health service that was denied, including facility/provider and developer/manufacturer of service as available
- g. Statement that member may be eligible for external appeal and timeframes for
h. Clear statement in bold that member or member’s designee has four months from the final adverse determination to request an external appeal. Providers acting on their own behalf have 60 calendar days to request an external appeal.

i. Standard description of external appeals process attached

For Medicaid, the notice will also include:

j. Summary of appeal and date filed

k. Date appeal process was completed

l. Description of member’s fair hearing rights if not included with initial denial

m. Right of member to complain to the Department of Health at any time via Health.ny.gov/professionals/doctors/conduct/file_a_complaint.htm

n. Statement that notice is available in other languages and formats for special needs, as well as an explanation regarding how to access these formats

Expedited and standard appeals will be conducted by a clinical peer reviewer, provided that any such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

The physician reviewing the appeal will be different from the physician or medical director who first reviewed and determined that the treatment was not medically necessary. If the appeal determination is adverse (denial upheld) it is considered a final adverse determination (FAD).

If Affinity Health Plan fails to make a determination within the applicable time periods, it shall be deemed to be a reversal of the original adverse determination.

Affinity Health Plan and the member may jointly agree to waive the internal appeal process. If this occurs, Affinity Health Plan will provide a written letter to the member within 24 hours of the waiver agreement, setting forth the information necessary for the member to file an external appeal.

If Affinity Health Plan and the member agree to waive the internal appeal process, no additional internal appeals are available. However, providers may seek to file an external appeal pursuant to the process described below.

**Expedited Appeals**

A provider, member or member’s designee may seek an expedited appeal in the event of the following:

- If Affinity Health Plan determines that continued or extended health care services, procedures or treatments, or additional services for a member undergoing a continued course of treatment prescribed by a healthcare provider are not medically necessary.

- If the provider believes an immediate appeal is necessary, provided that the initial determination regarding a lack of medical necessity was not retrospective (for example, appeals of elective admissions or surgeries).
• For MMC members, we will issue a notice whether or not the expedited appeal request was honored or denied. If we deny the request, we will provide notice by phone, immediately followed by written notice in two (2) days; the review will take place according to standard timeframes.

If we require information necessary to conduct an expedited appeal, we will immediately notify the member and the provider by telephone or fax to identify and request the necessary information, followed by written notification. A clinical peer reviewer must be available within one (1) business day.

An expedited appeal will be decided within:
• 72 hours of receipt of necessary information.
• For MMC, as fast as the member’s condition requires and within 72 hours of receipt of necessary information but no more than 72 hours of receipt of appeal.

The 14-day extension does not apply to expedited appeals. Written notice of a final adverse determination concerning an expedited medical necessity appeal will be transmitted to the member within 24 hours of rendering the determination. For MMC, we will make reasonable efforts to provide a verbal notice to the member and provider at the time the determination is made. Expedited appeals not resolved to the satisfaction of the appealing party may be re-appealed via the standard appeal process or through the external appeal process.

External Appeals
Pursuant to Article 49 of the New York State Public Health Law, an external appeal process is available through the New York State Department of Financial Services. The time period to file an external appeal is within four months from the receipt of the final adverse determination (FAD) of the first level appeal. Providers acting on their own behalf shall file external appeals within 60 calendar days. The external appeal decision will be rendered in 30 calendar days and within 72 hours for an expedited external appeal. External appeal decisions are final and shall not be subject to arbitration or further review by a court of law. The application to request an external appeal will accompany the FAD.

In order to qualify for an external appeal, in addition to the time frames above, the following circumstances must be met:
• The service or treatment was denied as medically unnecessary, experimental/investigational, or an out-of-network service or referral.
• The appeal is for a service or procedure that was otherwise covered under the member’s contract with Affinity Health Plan.
• Affinity rendered a final adverse determination with respect to such healthcare service.
• The member has exhausted the internal utilization review process, unless a waiver is signed by the member and agreed to by Affinity.
Processes for External Appeals

Experimental/Investigational

- The member has had coverage of a healthcare service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on the basis that such service is experimental or investigational. The denial was upheld on appeal, or both Affinity and the member have jointly agreed to waive any internal appeal.

- To appeal an experimental/investigational, clinical trial, or out-of-network service or out-of-network referral 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 and recommended the patient's treatment. For an appeal involving a rare disease, a physician must meet the above requirements, but need not be the patient's treating physician.

- To appeal to an experimental/investigational denial, the member’s attending physician must attest that 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 healthcare plan and the member's physician must have recommended either a health service or procedure (including a pharmaceutical product within the meaning of PHL Section 4900(5)(b)(B), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure or, in the case of a rare disease, based on the physician’s certification and such other evidence as the member, the member’s designee or the member’s attending physician may present, that the requested health service or procedure is likely to benefit the member in the treatment of the member’s rare disease and that such benefit to the member outweighs the risks of such health service or procedure; or c) a clinical trial for which the member is eligible (any physician certification provided under this section shall include a statement of the evidence relied upon by the physician certifying his or her recommendation).

- The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for our determination that the health service or procedure is experimental or investigational.

- To appeal a clinical trial denial for which the member is eligible, the member’s physician must attest that a) there exists a clinical trial that is open; b) the patient is eligible to participate; and c) the patient has or will likely be accepted. The clinical trial must be a peer-reviewed study plan (phases 3 or 4) which has been reviewed and approved by a qualified institutional review board, and approved by a) one of the National Institutes of Health (NIH), or an NIH cooperative group or center; or b) the Food and Drug Administration in the form of an investigational new drug exemption; or c) the federal Department of Veteran Affairs; or d) a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants; or e) an institutional review board of a facility which has multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.
Out-of-Network Alternate Treatment

- To appeal an out-of-network referral denial, the physician must attest that the out-of-network health service is materially different from the alternate in-network service recommended by the health plan, and that based on two documents of medical and scientific evidence it is likely to be more clinically beneficial than the alternate in-network health services and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health services. The out-of-network provider’s name, address, training and experience must be included.

- To appeal an out-of-network denial to a non-participating provider, the physician must certify that the participating provider recommended by Affinity Health Plan does not have the appropriate training and experience to meet the member’s healthcare needs, and recommends a non-participating provider with the appropriate training and experience to meet the member’s particular healthcare needs who is able to provide the requested healthcare service.

Rare Disease

- To appeal a rare disease treatment denial, a physician other than the member’s treating physician must attest that the patient has a rare disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service; and that 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 service. The physician must also attest that he/she does not have a material financial or professional relationship with the provider of the service AND (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 the provision of the service requires approval of an institutional review board, include or attach the approval.

A member may request an external appeal by:

1. Calling the Department of Financial Services at 800.400.8882
2. Going to the Department of Financial Services’ website (DFS.ny.gov) and downloading the application at DFS.ny.gov/complaints/file_external_appeal
3. Contacting Affinity Health Plan at 866.247.5678 regarding Medicaid, Essential Plan, HARP and Child Health Plus. Customer Service will mail or fax the application to the member.

An application for external appeals can be found in this section and is also included in the FAD letter Affinity Health Plan sends to members.

Medical necessity denials from subcontracted utilization review (UR) agents (any agent conducting UR services on behalf of Affinity Health Plan members) are subject to the same appeal rights described above.
Provider External Appeal Rights

- A provider will be responsible for the full cost of an appeal for a concurrent adverse determination upheld in favor of Affinity Health Plan.

- Affinity Health Plan is responsible for the full cost of an appeal for a concurrent adverse determination that is overturned.

- Affinity Health Plan and the provider 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 such a case, the cost of the external appeal is the responsibility of Affinity Health Plan. For the provider to claim that the appeal of the final adverse determination is made on behalf of the member, the external appeal application and the designation shall be completed.

- External appeal decisions are final and shall not be subject to arbitration or review by a court of law.

Alternative Dispute Resolution

A facility licensed under Article 28 of the Public Health Law and Affinity Health Plan may agree to an alternative dispute resolution (ADR) in lieu of an external appeal under PHL Section 4906(2) after the internal utilization review process has been exhausted. Any such agreement to ADR in lieu of an external appeal shall be memorialized in a fully executed written agreement between the provider and Affinity Health Plan. Providers who have contracted to ADR in lieu of an external appeal must request review by ADR within sixty (60) calendar days of receiving the final determination of the first level internal appeal. This provision does not impact a member's external appeal rights or right of the member to appoint the provider as their designee. The cost of the ADR in lieu of an external appeal is a matter between Affinity Health Plan and the provider.

If the member files an external appeal, the external appeal determination takes precedence over the ADR.

Fair Hearings

MMC/members may avail themselves of a fair hearing process in accordance with applicable federal and state laws and regulations. To request a fair hearing, members can call 800.342.3334. Affinity Health Plan abides by and participates in New York State’s fair hearing process and complies with determinations. Members may request a fair hearing regarding:

- Adverse LDSS determinations concerning enrollment, disenrollment and eligibility

- The denial, termination, suspension, restriction, or reduction of a medical treatment or other covered services under the Affinity program benefits package. A member may also seek a fair hearing if they believe that Affinity did not act in a timely manner with regard to decisions and notifications of services and coverage decisions. A member may have any individual he or she selects or designates to represent them at a fair hearing.
We are required to continue the provision of covered services that are the subject of the fair hearing to a member if so ordered by the New York Office of Administrative Hearings (OAH) under the following circumstances:

- Affinity has or is seeking to reduce, suspend or terminate a treatment or benefit package service currently being provided and the member has filed a timely request for a fair hearing with OAH.

- With a valid order for treatment or service from a participating Affinity provider aid will continue until the matter has been resolved to the member’s satisfaction.

- The administrative process is completed and there is a determination from OAH that the member is not entitled to receive the service.

- The member, in writing, withdraws the request that the aid and/or the fair hearing continues.

- The treatment or service originally ordered by the provider has been completed, whichever occurs first.

- If the services and/or benefits in dispute have been terminated, suspended or reduced and the member timely requests a fair hearing, we will, at the direction of either the New York Department of Health or LDSS, restore the disputed services and/or benefits consistent.

- Member may seek redress of determination simultaneously through our internal appeal processes and the fair hearing process. In the event our denial is upheld at a fair hearing, the member will be liable for the underlying service(s) and the cost of any aid continuing provided pursuant to a hearing request may be recouped.

A member may request a fair hearing in the following ways:

1. By toll-free call at 800.342.3334
2. By fax at 518.473.6735
3. By internet at OTDA.ny.gov/hearings/
4. By sending a letter to:
   
   Fair Hearings  
   NYS Office of Temporary and Disability Assistance  
   Office of Administrative Hearings  
   Managed Care Unit  
   P.O. Box 22023  
   Albany, NY 12201-2023

A member may not request a fair hearing until the member receives an FAD from Affinity Health Plan. If the services the member is receiving are scheduled to end, the member may choose to ask to continue the services a provider has ordered while the fair hearing case is pending. However, if the member asks for services to be continued, and the fair hearing is decided against the member, the member may have to pay the cost for the services received while waiting for a decision. The decision from the fair hearing officer or administrative
law judge will be final. A member always has the right to file a complaint anytime with the New York State Department of Health by calling 800.206.8125.

A provider does not have standing to request a fair hearing on his/her own behalf. Providers may, however, assist members in asking for a fair hearing from New York State.

Part II. Administrative Denials and Appeals
An administrative denial is defined as a denied request for authorization of services that is not based on medical necessity. Examples include denials based on a lack of member coverage, timely submission of a claim, member eligibility, or the absence of a required authorization.

This section describes how a provider and/or member should appeal an administrative denial.

Authorization Appeals
If Affinity Health Plan denies a request for authorization of services and the basis for the denial is not lack of medical necessity, the provider, member or member’s designee may appeal the denial if they disagree with the denial. Examples include a non-covered benefit, a benefit that has been exhausted, or not requesting an authorization.

The appeal must be made within sixty (60) business days of the provider receiving the denial. The denial letters or notifications on the Explanation of Payments (EOP) are sent to the provider and member and contain instructions regarding request for appeals. A provider shall file an appeal for a retrospective denial if he/she disagrees with the denial.

An appeal is initiated by contacting Affinity Health Plan’s Appeal Department either in writing or by telephone. Verbal appeals shall be followed up by a written appeal. Written appeals shall be mailed to the address below and shall include the justification for the appeal and a copy of the original denial letter/EOP from Affinity Health Plan. If the original denial letter/EOP is not available, the appeal should indicate the dates of service(s), the member’s name, and Affinity Health Plan member ID number and a clear explanation as to why the original decision should be overturned.

Although this documentation may be forwarded following filing of the appeal, Affinity Health Plan may deny the appeal if such written documentation is not provided and Affinity Health Plan, in its own discretion, is unable to assess the basis for the appeal.

Affinity Health Plan
Attn: CGA Department
1776 Eastchester Road
Bronx, NY 10461
Phone: 888.543.9069
Fax: 718.536.3358

Affinity Health Plan will acknowledge the initiation of an appeal in writing within fifteen (15) calendar days after receiving the appeal. Affinity Health Plan must make a standard appeal determination within thirty (30) calendar days after receipt of the appeal.

If Affinity Health Plan requires additional information to conduct a standard internal appeal, then Affinity Health Plan shall notify the provider, in writing, within fifteen (15) business days of receipt of the appeal, requesting the additional information needed.
Affinity Health Plan will call three times in an attempt to contact the provider for the needed information.

Affinity Health Plan’s written determination regarding the appeal will be mailed to the member, the member’s designee, and the provider within two (2) business days of the determination of the appeal. Affinity Health Plan will indicate the reasons for its decision and, if the appeal is denied, the rationale for upholding the denial. The written notice of determination includes notice of the member’s right to request a fair hearing, if applicable.

Each notice of the appeal determination will be in writing, dated and include:

- Rationale for the determination
- Affinity Health Plan contact person and phone number
- Member coverage type
- Name and address of UR agent, contact person and phone number
- Health service that was denied, including facility/provider and developer/manufacturer of service as available

**For Medicaid, notice will also include:**

- Summary of appeal and date filed
- Date appeal process was completed
- Description of member’s fair hearing rights if not included with initial denial
- Right of member to complain to the New York State Department of Health at any time
- Statement about the notice availability in other languages and formats for special needs and how to access these formats

If Affinity Health Plan fails to make a determination within the applicable time periods, it shall be deemed to be a reversal of the original adverse determination.

There is only one level of standard appeals on any internal decision.

Following Affinity Health Plan’s notice of appeal determination, members or a designee may view their case file. The member may also present evidence to support their appeal in person or in writing.

**Claim Payment Reconsideration Requests**

**Denial of Payment**

If a provider disagrees with a claim denial, the provider must attach documentation supporting payment along with a claim review form within sixty (60) days of the EOP for the claim. If a provider does not submit a claims review form within sixty (60) days of the EOP, Affinity Health Plan’s claim determination is final, and shall not be subject to arbitration or review by a court of law.

Affinity routinely monitors claims data and reviews medical records to look for billing discrepancies. When found, an investigation is initiated and, if warranted, a corrective action is taken.
Corrective actions can include but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Reporting to one or more applicable state and federal agencies
- Legal action

**Underpayments**

If a provider disagrees with the claim payment amount, the provider shall attach documentation supporting additional payment along with a claims review form and submit the request to Affinity Health Plan within sixty (60) days of the date on the EOP for the claim. If a provider does not submit a request within sixty (60) days of the date on the EOP, Affinity Health Plan’s claim determination and payment amount is final and shall not be subject to arbitration or review by a court of law.

To be accepted for consideration, the request must (in addition to being timely):

- Be in writing
- Contain sufficient information to conduct a review
- Include a copy of the EOP

If a claims payment reconsideration request fails to include all required elements or is not received by the submission deadline, Affinity’s payment of the claim will not be revisited.

Please send claim review requests to:

Affinity Health Plan  
Attn: Claims Reconsideration  
1776 Eastchester Road  
Bronx, NY 10461

For corrected claims, please see Section 12-1 and Section 12-B.

The only written notice of our decision will be either an updated EOP or a letter upholding the initial determination/original claim decision. Such notice constitutes our final internal decision related to the claim and no further internal review is available. Should a participating provider wish to challenge our decision, further appeal rights, if any, are as dictated by the provider’s participation agreement (e.g., dispute resolution process, arbitration, etc.).

Pursuant to Section 3224-a(h)(1) of New York Insurance Law, should Affinity receive an administrative appeal from a participating provider regarding a claim that was denied exclusively because it was submitted untimely, the denial will be reversed, subject to a potential 25% reduction, if the provider is able to demonstrate that a) his/her non-compliance with the applicable claim submission timeframe was the result of an unusual occurrence; and b) he/she has a pattern/practice of timely submitting claims. The foregoing will apply only if the claim was submitted within one (1) year of the date of service.
Overpayments

If we identify an overpayment, a written overpayment recovery notice will be provided in accordance with New York State Insurance Law §3224-b(b) and/or your provider agreement prior to any recoupment, including those relating to fraud or abuse. This notice will include the member(s) name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the reason for the proposed adjustment. In response to this overpayment recovery determination, the provider may challenge the finding or remit payment as outlined within the notice.

In order to challenge an overpayment recovery determination, the provider must submit a written letter to the location specified within the overpayment recovery notice along with all relevant supporting documents within (30) thirty calendar days from the date of the overpayment recovery notice, to avoid recoupment. If a provider fails to submit a written letter challenging the overpayment recovery determination within the respective timeframe, recovery may be initiated. Affinity’s recovery process may include but is not limited to offsetting the outstanding amount against future claims payment and other collection methods deemed appropriate until the full amount is recouped. Affinity reserves the right to pursue recovery when a written response is not received from the provider thirty (30) days from the date of the notice, during the overpayment challenge process, and/or prior to any final determination made.

For additional information on claim submission, contact your provider relations representative.

Conversely, it is the provider’s responsibility to return any overpayments made by Affinity within 60 days of the overpayment.
REQUEST FOR ADMINISTRATIVE REVIEW OF PREVIOUSLY PROCESSED CLAIM

MEMBER NAME: ____________________ MEMBER ID: __________________
CLAIM NUMBER: ___________________ DATE OF SERVICE: __________________
PROVIDER NAME: __________________
NATIONAL PROVIDER IDENTIFIER or TAX IDENTIFICATION NUMBER: ____________
NAME OF REQUESTOR: ______________ DATE OF REQUEST: ______________

REASON FOR REQUEST (Please select one):
__Claim/Service denied for failure to notify (no authorization):
   Authorization is on file and valid. Authorization number is: ________________
   No authorization is required. Provide short explanation: ________________
   __________________
   Provider failed to obtain necessary authorization for the following reason: ________
   __________________

__Claim/service denied for timely filing:
   Attach the detailed acceptance status report from the vendor showing proof of timely
   filing.
   Or explain the reason for the delay in filing: __________________
   __________________

__Claim/service denied for member ineligible, attach proof of eligibility (IVR, Portal, EMES).
__Duplicate payment has been made. Please retract payment ________________.
__Payment denial or under payment. Attach supporting documentation additional payment.
__Coordination of benefits. Attach documentation from carrier within 90 calendar days of their
   explanation of benefits
__Other: __________________

REQUESTS FOR CLAIM RECONSIDERATIONS MUST BE SUBMITTED WITHIN 60 DAYS
OF THE DATE OF THE EXPLANATION OF PAYMENT (EOP) FOR THE CLAIM AT ISSUE.
FOR ALL REQUESTS, ATTACH A COPY OF THE ORIGINAL CLAIM AND REMITTANCE
ADVICE. FAILURE TO PROVIDE SUFFICIENT DOCUMENTATION MAY RESULT IN DENIAL
OF YOUR REQUEST. REQUESTS FOR CLAIMS RECONSIDERATIONS NOT SUBMITTED
WITHIN 60 DAYS OF AFFINITY HEALTH PLAN’S ADJUDICATION WILL NOT BE
RECONSIDERED AND THE DECISION SHALL BE FINAL, UNAPPEALABLE AND NOT
SUBJECT TO ARBITRATION OR REVIEW BY A COURT OF LAW.

Please submit your request for an administrative review to the following address:
Affinity Health Plan
Attn: Claims Reconsideration
1776 Eastchester Road
Bronx, NY 10461

Make copies and submit to Affinity Health Plan to request an administrative review.
SECTION 14B – PROVIDER INVOICE FAX FORM

Request for Claim Reconsideration of Claim Denial for Invoice
CGA fax number: 718.536.3358

Member Name: __________________________ Member ID: __________________________ .
Provider Name: __________________________
National Provider Identifier or Tax Identification Number: __________________________
Name of Requestor: __________________________ Date of Request: ________________

Please limit each form to one member with same provider and three claims per form.

Claim# __________________________ Date of Service: ________________
Claim# __________________________ Date of Service: ________________
Claim# __________________________ Date of Service: ________________

Comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Note: Requests for claim reconsiderations must be submitted within 60 days of the date of
the explanation of payment (EOP) for the claim at issue. For all requests, attach a copy of the
original claim and EOP. Failure to provide sufficient documentation may result in denial of
your request. Requests for claims reconsiderations not submitted within 60 days of Affinity
Health Plan’s adjudication will not be reconsidered and the decision shall be final, unable to
be appealed, and not subject to arbitration or review by a court of law.

Please make copies as necessary and fax your request for a claim reconsideration of the
manufacturer’s invoice(s) to Affinity Health Plan at 718.536.3358.
MEMBER GRIEVANCES AND COMPLAINTS

All Affinity Health Plan members have a right to file a complaint at any time if they are dissatisfied with an Affinity Health Plan provider, or with the care or services they have received. If a complaint involves a physician or provider, a provider relations representative will contact the provider to discuss the complaint. The findings will be reported to the Quality Department for consideration as to action or disposition.

Members are advised to call customer service to file a complaint. Affinity Health Plan will attempt to resolve complaints immediately by taking prompt corrective action and educating members about Affinity Health Plan policies and procedures. The substance of the complaint and the agreed-upon resolution will be documented.

Complaints are submitted in writing or recorded by Affinity Health Plan staff on behalf of members. All complaints are logged and acknowledged by Affinity Health Plan in writing. Complaints relative to the delivery of healthcare services will be referred to Affinity Health Plan’s Quality Department for investigation.

A member or designee has no less than sixty (60) business days after receipt of the notice of the complaint determination to file a written complaint appeal. Complaint appeals of clinical matters will be decided by personnel qualified to review the appeal (including licensed, certified or registered healthcare professionals who did not make the initial determination). at least one of whom must be a clinical peer reviewer.

Upon the member’s request, Affinity Health Plan will expedite the complaint process to accommodate the member's needs.

Member complaints involving providers that have been substantiated will be noted in the provider's credentials file.

NOTE: Members may always file a complaint with the New York State Department of Health and/or the city or respective county.

COMPLAINTS

If a member has a problem or dispute with care or services, the member may file a complaint with Affinity Health Plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to the following procedure. Affinity Health Plan is always available to assist a member in filing a complaint, a complaint appeal, or an action appeal. A customer service representative can assist the member or their designee with this.

A member may ask someone they trust (such as a legal representative, a family member or a friend) to file the complaint. If the member needs help from Affinity Health Plan because of a hearing or vision impairment, or if the member needs translation services or help filing the forms, please call customer service at 866.247.5678.
A member has the right to contact the New York State Department of Health about their complaint by calling 800.206.8125 or writing to:

NYSDOH Office of Managed Care
Bureau of Managed Care Certification and Surveillance
Room 1911, Corning Tower ESP
Albany, NY 12237

The member may also contact their local Department of Social Services with a complaint at any time. A member may call the New York State Department of Financial Services at 800.342.3736 if their complaint involves a billing problem.

**Filing a Complaint with the Plan**

To file by phone, the member should call Affinity’s customer service at 866.247.5678, Monday through Friday from 8:30 a.m. to 6:00 p.m. If the member contacts Affinity Health Plan after hours, they may leave a message and Affinity Health Plan will call the member back the next working day. If Affinity Health Plan needs more information to make a decision, the member will be notified. The member can write Affinity Health Plan with his or her complaint to:

Affinity Health Plan
Attn: CGA Unit
1776 Eastchester Road
Bronx, NY 10461
Phone: 888.543.9069
Fax: 718.536.3358

The member may also call customer service and request a complaint form.

If Affinity Health Plan does not solve the problem right away over the phone or if Affinity Health Plan receives a written complaint, an acknowledgement letter will be sent within fifteen (15) business days.

Affinity Health Plan will let the member know the decision in forty-five (45) calendar days of when we have all the information needed to answer the complaint; however, the member will hear from us no later than sixty (60) calendar days from the day we get the complaint. Affinity Health Plan will send the member a letter with the reasons for the decision. When a delay would risk a member’s health, Affinity Health Plan will make a decision within forty-eight (48) hours of when Affinity Health Plan has all the information needed to answer the complaint but no later than seven (7) calendar days from the day we get the complaint. Affinity Health Plan will call the member with our decision. The complaint decision will also inform the member of their appeal rights if the member is not satisfied and we will include any forms the member may need. If Affinity Health Plan is unable to make a decision about a complaint because we don’t have enough information, a letter will be sent to the member.
Complaint Appeals:

If a member disagrees with a decision, the member or their designee can file a complaint appeal with Affinity Health Plan. The member has at least sixty (60) business days after hearing from us to file an appeal. The appeal must be made in writing. If the member makes an appeal by phone it must be followed up in writing. If the member calls, Affinity Health Plan will send a form summarizing the phone appeal. If the member agrees with the summary, the member will sign and return the form to Affinity Health Plan. The member may make any needed changes before sending the form back to us.

Upon receipt of the appeal, an acknowledgment letter will be sent to the member within fifteen (15) business days. The complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about the complaint. If the complaint appeal involves clinical matters, the case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, who was/were not involved in making the first decision about the complaint.

If Affinity Health Plan has all the information needed, the member will be informed of the decision within thirty (30) business days. If a delay would risk the member’s health, a decision will be made in two (2) business days of when we have all the information we need to decide the appeal. The member will be given the reasons for our decision and our clinical rationale, if it applies. If the member is still not satisfied, the member or their designee can file a complaint at any time with the New York State Department of Health at 800.206.8125.

ACTION APPEALS

If a member disagrees with Affinity’s decision with a service authorization request, a payment denial or timeliness of an action taken by Affinity, the member or their designee can file an action appeal. The member/provider has sixty (60) days after hearing from Affinity to file an appeal. The action appeal must be in writing. If the appeal is by telephone it must also be in writing. Affinity will send the member a form summarizing the phone appeal; if the member agrees with the summary the member must sign the form and make any changes before sending it back to us. After receipt of the action appeal an acknowledgement letter will be sent within 15 calendar days.

Action appeals will be decided with member notification:

- No more than two (2) business days or 72 hours after receipt of all necessary information when a delay would significantly increase the risk to a member’s health. We will send a written notice within 24 hours of our determination.

- Within thirty (30) days after the receipt of all necessary information in all other instances. We will send a written notice within two business days of resolution and no longer than 30 days after receipt of the appeal.

- The time frame for deciding an action appeal can be extended for up to fourteen (14) days if the member or his/her designee requests an extension or if Affinity determines that the extension is in the best interest of the member and additional information is needed. The member will be notified if this extension happens.
Affinity will attempt to reach the member/provider with the action appeal decision by phone. If the member/provider is still not satisfied, the member or someone on his/her behalf can file a complaint with the New York State Department of Health at 800.206.8125. Filing an action appeal is the member’s right and Affinity will not retaliate or take any discriminatory action against the member because they filed an action appeal.

To file appeals, please contact our Complaints, Grievances and Appeals Unit at:

Affinity Health Plan
Attn: CGA Unit
1776 Eastchester Road
Bronx, NY 10461
Toll-free phone number: 888.543.9069
Fax number: 718.536.3358

EXTERNAL APPEAL
Refer to Section 13 for information on external appeals.
Enrollment of Recipients
Enrollment is based on an ePaces inquiry (for MMC and members) conducted at Emedny.org/epaces/, using code “Eligible PCP 82”. For CHP and MMC participants contact Affinity Health Plan at 866.247.5678.

Enrollment Criteria for Health and Recovery Plan (HARP) Members
Enrollment is based on a member’s history of using certain services. These members have been identified by New York State as benefitting from an additional array of services to assist in reaching their health goals. A prospective Enriched Health or HARP member is indicated by New York State’s target criteria and risk factors:

- Target criteria
  - Medicaid enrolled individuals 21 years old and over
  - Serious mental illness/substance use disorder
  - Eligible to enroll in Medicaid Managed Care
  - Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD)
  - Not Medicaid/Medicare enrolled (aka duals)

- Risk factors
  - Supplemental Security Income (SSI) individuals who received an organized mental health (MH) service in the year prior to enrollment
  - Non-SSI individuals with three or more months of assertive community treatment (ACT) or targeted case management (TCM), personalized recovery-oriented services (PROS), or prepaid mental health plan (PMHP) services in the year prior to enrollment
  - SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three (3) years prior to enrollment.
  - SSI and non-SSI individuals with three (3) or more psychiatric inpatient admissions in the three years prior to enrollment
  - SSI and non-SSI individuals discharged from an Office of Mental Health (OMH) psychiatric center after an inpatient stay greater than sixty (60) days in the year prior to enrollment
  - SSI and non-SSI individuals with a current or expired assisted outpatient
treatment (AOT) order in the five (5) years prior to enrollment.

- SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four (4) years prior to enrollment.

- Residents in OMH-funded housing for persons with serious mental illness (SMI) in any of the three (3) years prior to enrollment.

- Members with two (2) or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.

- Members with one (1) inpatient stay with a substance use disorder (SUD) primary diagnosis within the year prior to enrollment.

- Members with two (2) or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD related medical diagnosis-related group and a second diagnosis of SUD within the year prior to enrollment.

- Members with two (2) or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to secondary substance use diagnosis within the year prior to enrollment.

- Individuals transitioning with a history of involvement in children’s services.

**Enrollment Process for New Members**

Affinity Health Plan functions related to enrollment focus on:

- New member orientation
- Initial selection of primary care physician (PCP)
- PCP changes
- Member identification
- Enrollment of newborns
- Identification and documentation of third-party insurance

When Affinity Health Plan is notified of an enrollment, or an enrollment is verified by New York State, Affinity Health Plan will send the new member a welcome packet containing a member handbook, an identification card and a health risk assessment (HRA) form. The member is asked to complete the HRA and return it to Affinity Health Plan in the return addressed envelope provided. The member will receive a welcome call, during which he/she will be given the opportunity to complete the HRA verbally. The HRA form given to new members is a standardized tool. When appropriate, a member is referred for case management or disease management services. Each HRA is entered into a database and a report is sent directly to the member’s PCP.
Verification of Member Eligibility

All providers must verify a member’s eligibility at each visit.

- The provider can verify the member’s current eligibility by either using the Affinity Health Plan provider portal at Portal.AffinityPlan.org/provider/ or by using the integrated voice response (IVR) when calling 866.247.5678.
- Providers who have eMedNY access can verify eligibility on ePACES for Medicaid members.

Affinity Health Plan will reimburse providers only for services rendered to members eligible on the date of service. It is the responsibility of the provider to verify eligibility prior to providing services. The hospital, physician or office must verify eligibility/current enrollment each time a member presents or is referred for service. Possession of an Affinity Health Plan member identification (ID) card is not sufficient to verify current eligibility or identity. For a sample member ID card, see appendix C.

At times, NYSDOH will notify Affinity that a member who showed eligible was actually not eligible or had been assigned to another Medicaid managed care plan. When this occurs, Affinity may recoup payments made on behalf of that member for the time period the member was not eligible. Affinity has up to six years to recoup funds due to retro-disenrollments.

**NOTICE**

Please remember: Affinity Health Plan cannot retrieve ID cards from members who disenroll, therefore, a membership card alone **DOES NOT** guarantee eligibility.

Misuse of ID Card

If you suspect that an individual is misusing an Affinity Health Plan ID card by using a card that has been lost or stolen or by borrowing another person's card please report the incident to Affinity Health Plan's Special Investigation Unit. Call the ethics line at 866.528.1505 and follow the appropriate menu options for reporting fraud, waste or abuse; or, go to Affinity’s website and click the Ethics Line hyperlink at AffinityPlan.org/Affinity/Providers/Compliance/Fraud_and_Abuse.aspx.

**PRODUCT INFORMATION**

Medicaid recipients are required to join a Medicaid managed care plan. Individuals covered under a Medicaid managed care plan retain certain benefits via fee-for-service Medicaid. Based on the member’s county, some benefits are carved out of the Medicaid Managed Care Plan and are only covered by fee-for-service Medicaid. There are no copayments, pre-existing condition requirements, or deductibles in Medicaid Managed Care.
Affinity Health Plan Medicaid and The Essential Plan

The Essential Plan (EP) is a federally authorized basic health program (BHP) operated by New York State and offered through the New York State of Health Marketplace for qualified lower-income New York State residents and for certain legally present immigrants. EP provides essential health benefits, has a $0 or $20 premium (depending on income level), no deductible, and follows established limits on cost-sharing.

<table>
<thead>
<tr>
<th>Product Overview</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product type</strong></td>
<td>Affinity Health Plan Medicaid</td>
</tr>
<tr>
<td><strong>Provider panel</strong></td>
<td>Affinity Health Plan Medicaid Managed Care network</td>
</tr>
<tr>
<td><strong>Primary care physician (PCP) required</strong></td>
<td>Members joining Affinity Health Plan Medicaid are required to choose a PCP from the Affinity Health Plan Medicaid Managed Care network.</td>
</tr>
<tr>
<td><strong>Inpatient hospital services</strong></td>
<td>Inpatient hospital services cover a full range of medically necessary diagnostic and therapeutic care including medical, surgical, behavioral health, nursing, radiological and rehabilitative services.</td>
</tr>
<tr>
<td><strong>Alternate level of medical care</strong></td>
<td>Continued care in a hospital pending placement in an alternate lower level of care.</td>
</tr>
<tr>
<td><strong>Ambulatory services</strong></td>
<td>Outpatient hospital services are provided through ambulatory care facilities including hospital outpatient departments (OPDs), treatment centers (D&amp;Ts or free-standing clinics), and emergency rooms. These facilities may provide those medically necessary medical, surgical, behavioral health and rehabilitative services and items authorized by their operating certificates. Outpatient services (clinic) also include preventative, primary medical, specialty, behavioral health, Child/Teen Health Plan (C/THP) services, and ambulatory care facilities.</td>
</tr>
</tbody>
</table>
| **Preventive health services** | There are three levels of preventive care:  
• Primary, such as immunizations, aimed at preventing disease  
• Secondary, such as disease screening programs aimed at early detection  
• Tertiary, such as physical therapy, aimed at restoring function |
The Essential Plan (EP) Product Overview con’t

| Healthcare services covered through Affinity Health Plan | • Inpatient/outpatient services  
• Physician service  
• Nurse practitioner services  
• Midwifery services  
• Family planning  
• Preventive health services  
• Second medical surgical opinion  
• Laboratory services  
• Radiology services  
• Smoking cessation products  
• Rehabilitation services  
• EPSDT/(Child Teen Health Program)  
• Home health services  
• Private duty nursing  
• Hospice  
• Emergency services  
• Family planning  
• Foot care services  
• Eye care and low vision services  
• Durable medical equipment (DME)  
• Audiology, hearing aid services and products when medically necessary  
• Emergency transportation depending on county of residence (see Transportation below for details)  
• Non-emergency transportation depending on county of residence) (see Transportation below for details)  
• Dental services  
• Prosthetics  
• Orthotics  
• Mental health and substance abuse services for members 21 years of age and older including:  
  • Mental health and substance use disorder  
  • Outpatient clinic treatment  
  • Methadone maintenance treatment program (MMTP)  
  • Medically supervised ambulatory chemical dependence outpatient clinic programs  
  • Medically supervised chemical dependence outpatient rehabilitation program  
  • Intensive psychiatric rehabilitation treatment (IPRT) programs  
  • Personalized recovery-oriented services (PROS) programs  
  • Continuing day treatment (CDT)  
  • Partial hospitalization program (PHP)  
  • Short-term residential healthcare facility services  
• Renal dialysis |
The Essential Plan (EP) Product Overview con’t

| Healthcare services covered through Affinity Health Plan (cont’d) | • Personal care agency services-  
| | • Personal emergency response system  
| | • Directly observed TB therapy  
| | • Adult day health care  
| | • AIDS adult day health care  
| | • Prescription and non-prescription drugs, supplies and enteral Formulas  
| | • Case management  
| Transportation | Members get transportation through Affinity Health Plan in a county where transportation is provided. Call our Customer Service Department at 866.247.5678 for more information. Members can call their local Department of Social Services (LDSS) to arrange transportation if they live in one of the counties that does not provide it through Affinity Health Plan.  
| | Transportation must be scheduled in advance by 3:00 p.m. the business day before the member’s appointment.  
| | Non-emergency rides are covered by regular Medicaid (FFS) and not by Affinity Health Plan for all Medicaid members. To arrange for transportation:  
| | • Nassau and Suffolk members call Logisticare at 844.678.1103.  
| | • Westchester members call Medical Answering Services (MAS) at 866.883.7865.  
| | • New York City members call Medical Answering Services (MAS) at 844.666.6270.  
| | • Orange and Rockland members call Medical Answering Services (MAS) at 866.883.7865.  
| | For all other counties please contact your LDSS.  
| | Non-emergency medical transportation includes personal vehicle, bus, taxi, ambulette and public transportation.  
| | In New York City, emergency and non-emergency transportation services for all Medicaid Managed Care members are carved out of the managed care benefit package. Prior authorization requests and claims for non-emergency services must be directed to Medical Answering Services (MAS) at 844.666.6270.  
| | Authorizations should be requested three days before the medical appointment.  
| | If there is an emergency and a need for an ambulance, call 911. Claims for emergency transportation must be submitted to eMedNY. |
The Essential Plan (EP) Product Overview con’t

| Healthcare services covered by fee-for-service Medicaid include but are not limited to: | • Permanent residence in a residential healthcare facility  
• Substance use disorder services for members 20 years old and younger, including:  
  1. Methadone maintenance treatment program (MMTP)  
  2. Medically supervised ambulatory chemical dependence outpatient clinic programs  
  3. Medically supervised chemical dependence outpatient rehabilitation programs  
  4. Outpatient chemical dependence for youth programs  
• Mental health services for members 20 years old and younger:  
  1. Intensive psychiatric rehabilitation treatment programs  
  2. Two-day treatment  
  3. Home and community based services waiver for SED children  
  4. Case management  
  5. Partial hospitalization  
  Call your representative for further information.  
• Early intervention program  
• Preschool supportive health services  
• School supportive health services  
• Comprehensive Medicaid case management  
• HIV COBRA case management  
• School-based health centers  
• Mental retardation and developmental disability services |
|---|---|
| Non-covered services | • Cosmetic surgery, unless medically indicated  
• Personal and comfort items  
• Routine hygienic foot care in the absence of a pathological condition  
• Infertility treatment  
• Services covered by another payment source  
• Certain experimental and investigational services  
• Services which are not medically necessary |
| Referrals/authorizations | Members can self-refer to participating providers for the following benefits/services:  
• OB/GYN care  
• HIV counseling and testing  
• Mental health and substance abuse  
• Outpatient clinic services  
• Eye care  
• Dental care |
The Essential Plan (EP) Product Overview con’t

<table>
<thead>
<tr>
<th>Referrals/authorizations (cont’d)</th>
<th>For a listing of services requiring a prior authorization, please see Affinityplan.org/Providers/Resources/Pre-Authorization-Codes/Pre-Authorization-Codes/. Certain outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, outpatient radiation therapy, and PT/OT/ST services for all products require prior authorization from eviCore healthcare. For a complete list of procedures that require prior authorization from eviCore healthcare, visit eviCore.com/healthplan/Affinitycare.</th>
</tr>
</thead>
</table>
| Enhanced Affinity Health Plan Medicaid services | Affinity Health Plan Medicaid provides members with the following enhanced services:  
• Baby care program  
• Asthma care program  
• Case management  
• Diabetic management  
• Depression management  
• Women’s health program  
• Smoking cessation  
• Stress management  
• Weight control  
• Cholesterol control |
Affinity Health Plan Child Health Plus (CHP)

The New York State health insurance plan for children is called Child Health Plus. Depending on a family’s income, a child may be eligible to join either Medicaid or Child Health Plus. Both Children’s Medicaid and Child Health Plus are available through Affinity Health Plan. Based on the family size and income, Child Health Plus is free or low cost. There are no copayments, pre-existing condition requirements or deductibles.

To be eligible for either Medicaid or Child Health Plus, children must be under the age of nineteen (19) and be residents of New York City, or of Nassau, Orange, Rockland, Suffolk or Westchester counties. Whether a child qualifies for Medicaid or Child Health Plus depends on gross family income. Children who are not eligible for Medicaid can enroll in Child Health Plus if they don’t already have health insurance and are not eligible for coverage under the public employees’ state health benefits plan. Some children who were covered by employer-based health insurance within the past six months may be subject to a waiting period before they can be enrolled in Child Health Plus.

**Product Overview**

<table>
<thead>
<tr>
<th>Product type</th>
<th>Affinity Health Plan Child Health Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider panel</td>
<td>Affinity Health Plan Child Health Plus network</td>
</tr>
<tr>
<td>Primary care physician required</td>
<td>Members joining Affinity Health Plan Child Health Plus are required to choose a PCP from the Affinity Health Plan Child Health Plus network.</td>
</tr>
</tbody>
</table>

**Benefit package**

- Health promotion visits
- Inpatient hospital or medical or surgical care
- Inpatient mental health and alcohol and substance abuse services
- Inpatient rehabilitation
- Professional services for diagnosis and treatment of illness and injury
- Hospice services and expenses
- Outpatient surgery
- Diagnostic and laboratory tests
- Durable medical equipment prosthetic appliances and orthotic devices
- Therapeutic services
- Speech and hearing services including hearing aids
- Pre-surgical testing
- Second surgical and medical opinion
- Outpatient mental health visits for diagnosis and treatment of alcoholism and substance abuse
- Home health care
- Prescription and non-prescription drugs
- Emergency medical services
- Ambulance services
- Maternity care
- Diabetic supplies and equipment, education and home visits
- Emergency, preventive and routine vision care
- Autism spectrum disorder services
<table>
<thead>
<tr>
<th>Non-covered services</th>
<th>These benefits are not covered by Affinity Health Plan Child Health Plus and are defined as non-covered services by the Child Health Plus contract:</th>
</tr>
</thead>
</table>
|                      | • Experimental medical or surgical procedures  
|                      | • Administration or injection of any drugs  
|                      | • Replacement of lost or stolen prescriptions  
|                      | • Experimental drugs  
|                      | • Nutritional supplements taken electively  
|                      | • Non-FDA approved drugs. Affinity Health Plan will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type of which FDA approval was obtained. However, the drug must be recognized for treatment of the type of cancer by one of these publications:  
|                      | • AMA Drug Evaluations  
|                      | • American Hospital Formulary Service  
|                      | • U.S. Pharmacopoeia Drug Information  
|                      | • Drugs which can be bought without a prescription, except as defined  
|                      | • Prescription drugs used for purposes of erectile dysfunction  
|                      | • Prescription drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person  
|                      | • Private duty nursing  
|                      | • Home health care, except as defined  
|                      | • Chiropractic care  
|                      | • Services in a skilled nursing facility or rehabilitation facility  
|                      | • Cosmetic, plastic or reconstructive surgery except as defined  
|                      | • In vitro fertilization, artificial insemination or other means of conception and infertility services  
|                      | • Services covered by another payment source  
|                      | • Transportation except as defined  
|                      | • Personal or comfort items  
|                      | • Residential psychiatric treatment  
|                      | • Orthodontia services  
|                      | • Services which are not medically necessary |

<table>
<thead>
<tr>
<th>Referral/authorizations</th>
<th>Members can self-refer to participating providers for the following benefits/services:</th>
</tr>
</thead>
</table>
|                         | • OB/GYN care  
|                         | • Mental health and substance abuse assessments (first assessment in a calendar year)  
|                         | • Eye care  
|                         | • Dental care |
## CHP Product Overview con’t

| **Referral/authorizations (cont’d)** | The following benefits/services require prior authorization:  
| | - Durable medical equipment (DME) and hospital inpatient and outpatient services  
| | - Certain outpatient high-tech radiology services, outpatient non-obstetrical ultrasounds, outpatient diagnostic cardiology services, outpatient radiation therapy services and PT/OT/ST for all products require prior authorization from eviCore healthcare. For a complete list of procedures that require prior authorization from eviCore healthcare visit eviCore.com/healthplan/affinityplan.org.  
| | - Members may self-refer to a participating behavioral health provider, be referred by a participating PCP or specialist physician, or be referred by a clinical case manager at Affinity Health Plan or Beacon. Members are informed of this benefit at the time of enrollment.  
| | - Behavioral health providers should contact Beacon to register the patient's care and obtain a prior authorization in all but emergency cases. For emergency situations, the provider should treat the patient and notify the Unit as soon as practical but not later than 24 hours.  
| | - For a complete list of services that require prior authorization from Affinity Health Plan, visit AffinityPlan.org/Providers/Resources/Pre-Authorization-Codes/Pre-Authorization-Codes/. |

| **Enhanced Affinity Health Plan services** | Affinity Health Plan Child Health Plus provides members with the following enhanced services:  
| | - Baby care program  
| | - Asthma care program  
| | - Case management  
| | - Diabetic management  
| | - Depression management |
Affinity Health Plan Enriched Health Plan (also known as HARP)

The Enriched Health Plan is a managed care product that manages physical health, mental health, and substance use services in an integrated manner for adults with significant behavioral health needs. Enriched Health is an enhanced Medicaid; it includes all of the benefits available under mainstream Managed Care, plus additional support services known as Home and Community Based Services (HCBS). Enriched Health’s goal is to create an environment where Affinity Health Plan, network providers, members, families, and New York State partner together to help members recover from serious mental illness and substance use disorders, and to prevent chronic medical conditions.

Product Overview

<table>
<thead>
<tr>
<th>Product type</th>
<th>Affinity Health Plan Enriched Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider panel</td>
<td>Affinity Health Plan Enriched Health network</td>
</tr>
<tr>
<td>Primary care physician required</td>
<td>Members joining Affinity Health Plan Enriched Health are required to choose a PCP from the Affinity Health Plan Enriched Health network.</td>
</tr>
</tbody>
</table>

<table>
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<th>Benefit package</th>
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</thead>
<tbody>
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<td>• Health promotion visits</td>
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<td>• Inpatient hospital or medical or surgical care</td>
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<td>• Inpatient mental health and alcohol and substance abuse services</td>
</tr>
<tr>
<td>• Inpatient rehabilitation</td>
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<tr>
<td>• Professional services for diagnosis and treatment of illness and injury</td>
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<tr>
<td>• Hospice services and expenses</td>
</tr>
<tr>
<td>• Outpatient surgery</td>
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<tr>
<td>• Second surgical and medical opinion</td>
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<td>• Outpatient mental health visits for diagnosis and treatment of alcoholism and substance abuse</td>
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<td>• Autism spectrum disorder services</td>
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</table>

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<tr>
<th>Non-covered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>These benefits are not covered by Affinity Health Plan and are defined as non-covered services by the Enriched Health contract:</td>
</tr>
<tr>
<td>• Experimental medical or surgical procedures</td>
</tr>
<tr>
<td>• Administration or injection of any drugs</td>
</tr>
<tr>
<td>• Replacement of lost or stolen prescriptions</td>
</tr>
<tr>
<td>• Experimental drugs</td>
</tr>
<tr>
<td>• Nutritional supplements taken electively</td>
</tr>
</tbody>
</table>
### HARP Product Overview con’t

| Non-covered services (con’t) | • Non-FDA approved drugs. Affinity Health Plan will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type of which FDA approval was obtained. However, the drug must be recognized for treatment of the type of cancer by one of these publications:
|                          | 1. AMA Drug Evaluations
|                          | 2. American Hospital Formulary Service
|                          | 3. U.S. Pharmacopoeia Drug Information
|                          | • Drugs which can be bought without a prescription, except as defined
|                          | • Prescription drugs used for purposes of erectile dysfunction
|                          | • Prescription drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person
|                          | • Private duty nursing
|                          | • Home health care, except as defined
|                          | • Chiropractic care
|                          | • Services in a skilled nursing facility or rehabilitation facility
|                          | • Cosmetic, plastic or reconstructive surgery except as defined
|                          | • In vitro fertilization, artificial insemination or other means of conception and infertility services
|                          | • Services covered by another payment source
|                          | • Transportation except as defined
|                          | • Personal or comfort items
|                          | • Residential psychiatric treatment
|                          | • Orthodontia services
|                          | • Services which are not medically necessary

| Referral/authorizations | Members can self-refer to participating providers for the following benefits/services:
|                        | • OB/GYN care
|                        | • Mental health and substance abuse assessments (first assessment in a calendar year)
|                        | • Eye care
|                        | • Dental care |
Referral/authorizations (cont’d) | The following benefits/services require prior authorization:
- Durable medical equipment (DME) and hospital inpatient and outpatient service
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- Members may self-refer to a participating behavioral health provider, be referred by a participating PCP or specialist physician, or be referred by a clinical case manager at Affinity Health Plan or Beacon. Members are informed of this benefit at the time of enrollment.
- Behavioral health providers should contact Beacon to register the patient's care and obtain a prior authorization in all but emergency cases. For emergency situations, the provider should treat the patient and notify the Unit as soon as practical but not later than 24 hours.
- For a complete list of services that require prior authorization from Affinity Health Plan visit AffinityPlan.org/en-us/providers/authorizationgrids.aspx.

Enhanced Affinity Health Plan services | Affinity Health Plan Child Health Plus provides members with the following enhanced services:
- Baby care program
- Asthma care program
- Case management
- Diabetic management
- Depression management
SECTION 17.A – BEHAVIORAL HEALTH BENEFITS FOR ALL MEDICAID POPULATIONS 21 AND OVER

OFFICE OF MENTAL HEALTH

Mental health outpatient clinic is a program for adults, adolescents, and/or children which provides an array of treatment services for assessment and/or symptom reduction or management. The services can include group therapy, and individual therapy.

Inpatient treatment programs are a 24-hour a day hospital-based program which includes psychiatric, medical, nursing and social services which are required for the assessment and/or treatment of a person with a primary diagnosis of mental illness which cannot adequately be served in the community.

Continuing day treatment is a program that provides seriously mentally ill adults with the skills and supports necessary to remain in the community and work toward a level of greater independence.

Intensive psychiatric rehabilitation treatment (IPRT) is a time-limited rehabilitative program for adults and/or adolescents, which focuses on building skills and developing community supports to assist individuals in attaining a specific goal.

Partial hospitalization is a program for adults or adolescents which provides active treatment designed to stabilize or improve acute symptoms in a person who would otherwise need hospitalization.

Assertive community treatment (ACT) is an evidence-based practice model designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with severe mental illness and whose needs have not been well met by more traditional mental health services. ACT teams are multi-disciplinary and include members from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational habilitation. The ACT team members collaborate to deliver integrated services of the individuals’ choice, assist in making progress towards goals, and adjust services over time to meet individuals’ changing needs and goals. The ACT team services the individual in their living situations rather than in hospitals or clinic. It is a mobile team that provides services 24-hours a day, seven days a week.

Personalized recovery-oriented services (PROS) is a comprehensive recovery-oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. The program helps to improve functioning, reduce inpatient utilization, reduce emergency services, reduce falling into the criminal justice system, increase employment, attain higher levels of education, and secure preferred housing.
Comprehensive psychiatric emergency program (CPEP) is a hospital-based program which provides access to crisis outreach, intervention and residential services, and/or offers beds for extended observation (up to 72 hours) to adults who need emergency mental health services.

Crisis intervention is emergency and temporary care given to an individual who is unable to function as they normally would due to unusual life stresses. The purpose of crisis intervention is to increase stabilization of the individual during a difficult situation he or she cannot cope with on their own.

OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES

Opioid treatment program is a treatment program that is certified to provide supervised assessment and medication-assisted treatment to individuals who are addicted to opioids. Treatment can be provided in many environments, including intensive outpatient, residential and hospital settings.

Inpatient rehabilitation provides intensive management of chemical dependence symptoms. Medical management and monitoring of physical or mental complications from chemical dependence is given to individuals who cannot be effectively served as outpatients and who are not in need of acute care or medical detoxification.

Detoxification is for individuals who are dependent on drugs or alcohol. Medical treatments, usually including counseling, are needed to help individuals overcome physical and psychological dependence on alcohol or drugs.

Medically managed detoxification is offered in an acute inpatient hospital setting to individuals requiring the most intensive level of services usually due to medical or psychiatric complications.

Medically supervised withdrawal (inpatient) is a service offered in an inpatient or residential setting to those requiring 24-hour support.

Medically supervised withdrawal (outpatient) is a general detoxification offered in an outpatient setting to those individuals with stable social support.

Outpatient services are offered to individuals who need treatment to remain abstinent but who are stable enough to remain or return to a supportive and or supervised living situation. There are two types of chemical dependence outpatient services: general outpatient services and outpatient rehabilitation services. Rehabilitation services treat clients more frequently and have more staff to serve the greater needs of the individuals attending rehabilitation service programs. The frequency in outpatient services varies during the course of treatment and the progress of the individual. Both outpatient services provide group and individual counseling, education on substance abuse disease and relapse prevention.
Residential addiction services assist the individuals who are unable to maintain sobriety or participate in treatment without the structure of a 24-hour a day, seven day a week rehabilitation setting, but who are not in need of inpatient services.

### HOME AND COMMUNITY BASED SERVICES (HCBS)

<table>
<thead>
<tr>
<th>Service Components</th>
<th>For Whom</th>
<th>Delivered By</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Habilitation</strong></td>
<td>People in need of functional and social skills building because they might never have had them or have major challenges with attaining them. Some examples are long-term hospitalization or incarceration.</td>
<td>Unlicensed behavioral health staff with minimum HS equivalent education and 1-3 years relevant experience, certification/credentialing not required (e.g., certified peers, credentialed CASAC) supervised by licensed mental health practitioners or qualified health professionals.</td>
<td>Help person to attain skills including communication, self-help, domestic self-care such as housecleaning, personal hygiene, socialization, activities of daily living such as cooking and budgeting, relationship building, use of community resources such as public transportation navigation.</td>
</tr>
<tr>
<td><strong>Psychosocial rehabilitation (PSR)</strong></td>
<td>People who need to regain functional/social skills they once had (e.g., someone who has been through an episode of depression after having a period of stability).</td>
<td>Unlicensed behavioral health staff (who should periodically report to supervising licensed practitioner).</td>
<td>Same as above, but perhaps less intensive support needs because the person once possessed the skill(s) but needs support to regain them.</td>
</tr>
<tr>
<td><strong>Community psychiatric support and treatment (CPST)</strong></td>
<td>People who are disengaged from site-based services due to behavioral or physical setbacks and need time-limited mobile treatment and/or PSR-type support services.</td>
<td>Providers who have experience providing similar services and are either licensed or utilizing evidence-based or best practices of an off-site treatment model and using licensed professionals.</td>
<td>Clinical treatment including prescribing medication and psychotherapy as well as psychosocial rehabilitation/ habilitation type services as described above. This service is not meant to be ongoing or long-term, but until such time as a person can go to a service provider in the community, like a clinic, on their own again.</td>
</tr>
<tr>
<td><strong>Family support and training</strong></td>
<td>People with a need and preference for engagement with and education/training support for their chosen family including relations and significant others.</td>
<td>Unlicensed behavioral health staff supervised by licensed mental health practitioners or qualified health professionals.</td>
<td>Peer support and counseling on how the chosen family can help in the individual's recovery; training &amp; support to engage the family in the education about treatment regimens, recovery support options, recovery concepts, and medication education.</td>
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<tr>
<td><strong>Peer support services</strong></td>
<td>People with a need and preference for peer support. Peer supporters are those who also have behavioral health histories themselves and can help people by using shared experiences such as hospitalization and incarceration. People who may not trust mental health professionals.</td>
<td>NYS OMH-certified peer specialists and OASAS certified recovery peer advocates supervised by licensed behavioral health practitioners.</td>
<td>Advocacy such as helping the individual navigate the public benefits system for food stamps; outreach and engagement; promotion and education on self-help tools; recovery support; transitional/bridging support from jail/prison/hospitalization; pre-crisis and crisis support.</td>
</tr>
<tr>
<td><strong>Education support services</strong></td>
<td>People who want to obtain formal education to become competitively employed. (Competitive employment refers to jobs that any person in the general community can apply for and which pay at least minimum wage.)</td>
<td>Education specialists should possess a BA and two years of experience supporting individuals pursue education goals, who are supervised by a manager with at least a BA (preferably a master’s in rehabilitation or relevant field) and a minimum three years of relevant work experience in the behavioral health field preferably as an education specialist.</td>
<td>Provides person with supports to obtain formal education/training such as TASC, vocational program or post-secondary degree in order to achieve employment goal. Services include finding financial aid, applying to schools, registration, navigating school system, negotiating reasonable accommodations and identifying tutoring resources.</td>
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<tr>
<td><strong>Pre-vocational</strong></td>
<td>People who want to prepare for real, competitive employment in</td>
<td>Employment specialists may be unlicensed staff and should possess</td>
<td>Provides person with time-limited work experience such as paid/unpaid</td>
</tr>
<tr>
<td>employment</td>
<td>the general community who have little to no work experience or</td>
<td>education and experience equivalent to an undergraduate degree in</td>
<td>internships and volunteer opportunities. This helps individuals</td>
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<td></td>
<td>who haven’t worked in a long time.</td>
<td>vocational services, business, personnel management, behavioral</td>
<td>develop or strengthen work-related soft skills including</td>
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<td>health, disability or social services counseling, who are</td>
<td>attendance, teamwork, task completion, problem solving,</td>
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<td></td>
<td>supervised by a manager with at least a BA (preferably a master’s</td>
<td>communication and social skills. Work opportunities must be in</td>
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<td>in rehabilitation or in the behavioral health field) and a</td>
<td>an integrated workplace setting where people in the general</td>
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<td></td>
<td>minimum three years of relevant work experience and a</td>
<td>community are employed.</td>
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<td>minimum 1.5 years of management experience.</td>
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<tr>
<td><strong>Transitional</strong></td>
<td>People who want to prepare for real competitive employment in</td>
<td>Employment specialists may be unlicensed staff and should possess</td>
<td>Provides person with time-limited paid internships offered only</td>
</tr>
<tr>
<td>employment</td>
<td>the general community who have little to no work experience or</td>
<td>education and experience equivalent to an undergraduate degree in</td>
<td>by HCBS providers who have Clubhouse and Psychosocial Club</td>
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<td></td>
<td>who haven’t worked in a long time.</td>
<td>vocational services, business, personnel management, behavioral</td>
<td>programs. Transitional employment slots belong to and are</td>
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<td>health, disability or social services counseling, who are</td>
<td>arranged by the providers in a formal agreement with</td>
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<td></td>
<td>supervised by a manager with at least a BA (preferably a master’s</td>
<td>businesses who hire people in the general community.</td>
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<td>in rehabilitation or in the behavioral health field) and a</td>
<td>Opportunities help people develop or strengthen work-related</td>
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<td></td>
<td>minimum of three years of relevant work experience and a</td>
<td>soft skills such as attendance, task completion and teamwork.</td>
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<td>minimum 1.5 years of management experience.</td>
<td>Since businesses know who they are working with, transitional employment</td>
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<td>is a true opportunity for people to experience “the dignity of</td>
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<td>right to fail.”</td>
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<tr>
<td><strong>Intensive supported employment</strong></td>
<td>People who want to obtain competitive employment.</td>
<td>Employment specialists may be unlicensed staff and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, behavioral health, disability or social services counseling, who are supervised by a manager with at least a BA (preferably a master’s in rehabilitation or in the behavioral health field) and a minimum three years of relevant work experience and a minimum of 1.5 years of management experience.</td>
<td>Provides person with employment supports to obtain competitive employment. Services include resume writing, interviewing prep, job search and placement, benefits counseling and advocacy around negotiating reasonable workplace accommodations.</td>
</tr>
<tr>
<td><strong>Ongoing supported employment</strong></td>
<td>People who want to retain competitive employment.</td>
<td>Employment specialists may be unlicensed staff and should possess education and experience equivalent to an undergraduate degree in vocational services, business, personnel management, behavioral health, disability or social services counseling, who are supervised by a manager with at least a BA (preferably a master’s in rehabilitation or in the behavioral health field) and a minimum of three years of relevant work experience and a minimum of 1.5 years of management experience.</td>
<td>Provides person with employment supports to keep a job. Services include understanding HR policies and job responsibilities, supervision, employer/employee expectations, advocacy around workplace accommodations, benefits counseling and disclosure issues.</td>
</tr>
</tbody>
</table>
### Short-term crisis respite (available for all HARP members; HCBS eligibility assessment is not required)

| People who are experiencing challenges in daily life, are at risk for an escalation of symptoms, and feel they cannot be managed at home or in a community environment without on-site supports. |
| Unlicensed staff, primarily certified peers, supervised by a manager with 3-5 years of experience in social service or related setting. |
| Peer support, coordination with other providers, health and wellness coaching, crisis prevention planning, education on self-help tools, conflict resolution, wellness activities, engagement of family and other natural supports, referrals/linkages, and engagement of natural supports. Services are provided in a safe and comfortable home-like environment which is primarily staffed by peers. Stays should be no longer than one week per episode, not to exceed a maximum of 21 days per year. Individual stays greater than 72 hours require prior authorization. It is recommended that the managed care plan be contacted immediately when a person is admitted into the respite. Individuals requiring longer stays may be evaluated on an individual basis and approved for longer stays based on medical necessity. |
**Affinity Health Plan Medicaid Personal Care Services (PCS)**

Personal care service means some or total assistance with personal hygiene, dressing and feeding, and nutritional and environmental support functions. Such services must be essential to the maintenance of the member's health and safety in his or her own home, as determined by Affinity Health Plan in accordance with the regulations of the New York State Department of Health.

Services are ordered by the attending physician, based on an assessment of the member's needs and of the appropriateness and cost-effectiveness of services, provided by a qualified person in accordance with a plan of care, and supervised by a registered professional nurse.

**Prior Authorizations**

Affinity Health Plan is responsible for coordinating, arranging, and authorizing payment to providers for the member’s medically necessary covered services. Covered services are provided through a network of participating healthcare providers as listed in Affinity Health Plan's provider directory.
Initial authorization for personal care services must be based on:

1) A physician’s order that meets the requirements of the DOH guidelines:
   - Downstate (NYC) DOH M11Q
   - Upstate DOH 4359

To obtain copies of the physician's order forms go to AffinityPlan.org (see the provider section under provider resources). Physicians need to fax the completed order form to Affinity Health Plan at 718.794.7822 before an in-home assessment can be scheduled. The order needs to include the date the member was last seen by the physician, which must be within the last 30 days. After a request is received, a home visit assessment will be done to determine the level of care appropriate for the member’s need. Once services are approved, ongoing authorizations will require an updated physician's order every six months. Members will continue to require a physician visit within 30 days of the order.

2) A nursing and social assessment that meets the requirements of DOH guidelines, including:
   - UAS assessment
   - Time task tool

If Affinity does not agree with the hours requested, Premier Nurses will meet with the member/member’s representative to discuss the changes. If the reduction stands, Affinity will issue an initial adverse determination. We will provide a minimum of 10 days' notice for any changes. Affinity performs re-assessments every six months.

Some or total assistance shall be defined as follows:

- **Some assistance** shall mean that a specific function or task is performed and completed by the member with help from another individual.

- **Total assistance** shall mean that a specific function or task is performed and completed for the member.

- **Continuous 24-hour personal care services** shall mean the provision of uninterrupted care, by more than one person, for a member who, because of his/her medical condition and disabilities, requires total assistance with toileting and/or walking and/or transferring and/or feeding at unscheduled times during the day and night.

**Affinity Health Plan Medicaid Consumer Directed Personal Assistance Services (CDPAS)**

CDPAS means some or total assistance with personal hygiene, dressing and feeding, nutritional and environmental support functions, as well as nursing and health-related tasks. Such services must be essential to the maintenance of the consumer’s health and safety in his or her own home, as determined by Affinity Health Plan in accordance with the regulations of the New York State Department of Health.

CDPAS include tasks that may be performed by a personal care aide, home health aide or a nurse. The consumer assumes full responsibility for hiring, training, supervising, and, if necessary, terminating the employment of persons providing the services.
Affinity Health Plan Personal Emergency Response System (PERS)
Telephonic communication means emergency responders are signaled by a member’s device in an emergency. This is covered when medically necessary and is authorized in conjunction with authorized PCS services.

Standard of Care
Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

<table>
<thead>
<tr>
<th>Level I</th>
<th>Level II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shall be limited to the performance of nutritional and environmental support functions. Nutritional and environmental support functions shall include some or total assistance with the following:</td>
<td>Shall include the performance of nutritional and environmental support functions and personal care functions. Personal care functions shall include some or total assistance with the following:</td>
</tr>
<tr>
<td>• Making and changing beds</td>
<td>• Bathing of the member</td>
</tr>
<tr>
<td>• Dusting and vacuuming the rooms</td>
<td>• Dressing</td>
</tr>
<tr>
<td>• Light cleaning of the kitchen, bedroom and bathroom</td>
<td>• Grooming</td>
</tr>
<tr>
<td>• Dishwashing</td>
<td>• Toileting</td>
</tr>
<tr>
<td>• Listing needed supplies</td>
<td>• Walking</td>
</tr>
<tr>
<td>• Shopping for the member if no other arrangements are possible</td>
<td>• Transferring from bed to chair or wheelchair</td>
</tr>
<tr>
<td>• Member's laundering, including necessary ironing and mending</td>
<td>• Preparing of meals in accordance with modified diets</td>
</tr>
<tr>
<td>• Payment of bills and other essential errands</td>
<td>• Feeding</td>
</tr>
<tr>
<td>• Preparing meals, including simple modified diets</td>
<td>• Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication and administration, disposing of used supplies and materials, and storing the medication properly</td>
</tr>
<tr>
<td></td>
<td>• Providing routine skin care</td>
</tr>
<tr>
<td></td>
<td>• Using medical supplies and equipment such as walkers and wheelchairs</td>
</tr>
<tr>
<td></td>
<td>• Changing of simple dressings</td>
</tr>
</tbody>
</table>
Services include the following:

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Previous HCPCS Code</th>
<th>Previous Service Billing Units</th>
<th>Codes and Rates Effective up to 03/31/2018</th>
<th>New HCPCS Code</th>
<th>New Service Billing Units</th>
<th>Codes and Rates Effective 04/01/2018 forward</th>
<th>Contract Note Regarding Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Assistance (PCA)</td>
<td>T1019</td>
<td>Per 15 mins</td>
<td>S5130U1</td>
<td>T1019U1</td>
<td>Per 15 mins</td>
<td>Code change only</td>
<td></td>
</tr>
<tr>
<td>Level I (housekeeping)</td>
<td>T1019TG</td>
<td>Per 15 mins</td>
<td>T1019U1</td>
<td>S5130U1</td>
<td>Per 15 mins</td>
<td>Code change only</td>
<td></td>
</tr>
<tr>
<td>Level II</td>
<td>T1020</td>
<td>Hourly Code</td>
<td>T1019U1</td>
<td>T1019U2</td>
<td>Per 15 mins</td>
<td>Code and unit change</td>
<td></td>
</tr>
<tr>
<td>Level II Mutual Case (multiple)</td>
<td>T1020TT</td>
<td>Hourly Code</td>
<td>T1019U3</td>
<td>T1019U3</td>
<td>Per 15 mins</td>
<td>Code and unit change</td>
<td></td>
</tr>
<tr>
<td>Level II Shared Aide (up to two)</td>
<td>T1020TF</td>
<td>Hourly Code</td>
<td>T1019U2</td>
<td>T1019U2</td>
<td>Per 15 mins</td>
<td>Code and unit change</td>
<td></td>
</tr>
<tr>
<td>Level II-Hard to Serve</td>
<td>T1020TG</td>
<td>Hourly Code</td>
<td>T1019U4</td>
<td>T1019U4</td>
<td>Per 15 mins</td>
<td>Code and unit change</td>
<td></td>
</tr>
<tr>
<td>Live In Level II</td>
<td>T1022</td>
<td>Per Diem*</td>
<td>T1020</td>
<td>T1020</td>
<td>Per Diem</td>
<td>Code change only</td>
<td></td>
</tr>
<tr>
<td>Live In Level II Mutual Case (multiple)</td>
<td>T1022TT</td>
<td>Per Diem*</td>
<td>T1020U2</td>
<td>T1020U2</td>
<td>Per Diem</td>
<td>Code change only</td>
<td></td>
</tr>
<tr>
<td>Live In Level II - Two Client Hard to Serve</td>
<td>T1022TG</td>
<td>Per Diem*</td>
<td>T1020U5</td>
<td>T1020U5</td>
<td>Per Diem</td>
<td>Code change only</td>
<td></td>
</tr>
<tr>
<td>Home Health Aid (HHA)</td>
<td>S9122</td>
<td>Hourly Code</td>
<td>S9122</td>
<td>S9122</td>
<td>Hourly Code</td>
<td>No code or rate change</td>
<td></td>
</tr>
<tr>
<td>Home Health Aid Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer Directed Personal Aid Services</td>
<td>T1019U1</td>
<td>Per 15 mins</td>
<td>T1019U8</td>
<td>T1019U8</td>
<td>Per 15 mins</td>
<td>Code change</td>
<td></td>
</tr>
<tr>
<td>(CDPAS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For members requiring additional accommodations, and for enhanced service rates, contact us at 866.247.5678.

**Billing/Claims**

- Claims remittances are available through the online Affinity Health Plan provider portal. If you do not have a logon and password to access the portal, please contact your provider relations representative. Remittances are also available through a HIPAA-mandated 835 electronic remittance advice (ERA).
• All claims must be submitted electronically within 90 days from the date of service. The unique payer ID for Affinity Health Plan (ID 13334) is needed for all submissions. For a complete list of vendors please visit AffinityPlan.org.

• Obtain the status of a claim by visiting the provider portal at AffinityPlan.org.
SECTION 18 — AUTHORIZATIONS NON-PAR PROVIDERS

Authorizations for Non-Participating (Non-Par) Providers

It is Affinity Health Plan policy that member care should be provided by participating providers. The primary care physician (PCP), specialists or facility, and the Utilization Management (UM) staff have the responsibility to make every effort to minimize the use of non-participating providers.

Referral to a non-participating provider may occur when:

a. The Affinity network does not include an available provider with the appropriate training and experience to meet the needs of members; or

b. Medically necessary services are not available through the network of Affinity providers. The referral must be approved by Affinity and will be made pursuant to a treatment plan approved by Affinity, the PCP and the non-participating provider.

In general, members may not use a non-participating specialist unless there is no specialist in the network that can provide the requested treatment.

Non-emergency services by non-participating providers are considered out-of-network (OON) referrals and must meet all of the following:

1. The services to be provided are covered benefits.
2. Affinity Health Plan does not have a participating provider within an appropriate geographic area or with the appropriate training and experience to meet the particular healthcare needs of the member.
3. An authorization request is submitted to Affinity Health Plan prior to the start of the service, and the service is authorized by Affinity Health Plan.
4. A single-case agreement has been signed, if applicable.

If a new member has an existing relationship with a healthcare provider who is not a member of the Affinity Health Plan provider network, Affinity Health Plan shall permit the new member to continue an ongoing course of treatment by the non-participating provider during a transitional period of up to sixty (60) days from the effective date of enrollment, if authorizations requirements are met.

A new member whose current provider does not participate in the Affinity network may request approval to continue an ongoing course of treatment with that provider for a transitional period. If the member has a life-threatening disease or condition or a degenerative and disabling disease or condition, the transitional period is up to sixty (60) days.
If the new member is within the second or third trimester of pregnancy on the date the member enrollment is effective, the transitional period shall include the provision of prenatal care until delivery and the provision of postpartum care directly related to the delivery up until 60 days post-partum. If the new member elects to continue to receive care from such non-participating provider, such care shall be authorized by Affinity Health Plan for the transitional period only if the conditions outlined in sections I(1), I(3), II and III of this document are met.

All out-of-network (OON) referrals are subject to prior authorization review in accordance with the procedures outlined in this manual’s Section 8 Emergency and Inpatient Services and Section 11 Referral and Authorizations.

Responsibilities of Utilization Management (UM)

When UM receives a request for out-of-network provider:

- UM advises of any participating providers who can meet the member’s needs.
- Affinity Health Plan’s medical director will review the request for medical necessity and may discuss care with the member’s PCP/referring provider as indicated.
- If Affinity Health Plan denies the request for an out-of-network provider, UM will notify the member that services are available within the Affinity Health Plan network. UM will provide the member with the names of at least three (3) participating providers who can provide the requested services along with their office locations and contact information, provided that three (3) participating providers are available. If three (3) participating providers are not available, UM will provide the names, office locations, and contact information of the available provider(s). If indicated, Affinity Health Plan will ensure that the member receives assistance in making an appointment.
- UM will contact the PCP and/or referring provider with the decision to either approve or deny the request for an out-of-network provider. See Section 8 Emergency and Inpatient Services or Section 11 Referral and Authorizations of this manual for additional information.
SECTION 19 — GENERAL COMPLIANCE, FRAUD, WASTE AND ABUSE

FRAUD, WASTE, AND ABUSE

Healthcare fraud, waste, and abuse affects everyone (e.g., members, providers, taxpayers, Affinity, etc.). As a result, and pursuant to applicable requirements, we operate a comprehensive fraud and abuse program within our Special Investigations Unit. You have a duty to support this program by reporting questionable activities and potentially fraudulent/abusive actions.

DEFINITIONS

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste: Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program or Affinity. Waste is generally the misuse of resources.

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program.

EXAMPLES OF MEMBER FRAUD, WASTE, AND ABUSE

- Consistently switching providers in an effort to obtain prescriptions for controlled substances
- Prescription forging or prescription modification to obtain controlled substances, other medications or more medication than prescribed
- Members sharing their Affinity ID cards with non-members
- Non-disclosure of other health insurance coverage
- Obtaining unnecessary equipment and supplies

EXAMPLES OF PROVIDER FRAUD, WASTE, AND ABUSE

- Lack of medical necessity for medical services, home health care, durable medical equipment and prescription drugs billed
- Services not provided, but billed
- Up-coding of CPT and DRG codes to obtain a higher rate of reimbursement
- Inappropriate use of CPT codes and/or modifiers to seek higher reimbursement
- Unbundling CPT codes to obtain higher reimbursement
- Not checking member IDs resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed to increase reimbursement
- Billing for services outside of your medical qualifications
• Using member lists for the purpose of submitting fraudulent claims
• Duplicate billings for services rendered
• Drugs billed for participating members as if they were non-participant members
• Payments stemming from kickbacks or Stark violations
• Retaining overpayments made in error by Affinity
• Balance billing of members after Affinity has paid the approved state fee-for-service and/or contracted fee for services rendered.

Affinity routinely monitors claims data and reviews medical records to look for billing discrepancies. When found, an investigation is initiated and, if warranted, a corrective action is taken.

Corrective actions can include, but are not limited to:

• Member and/or provider education
• Written corrective action plan
• Provider termination with or without cause
• Provider summary suspension
• Recovery of overpaid funds
• Member disenrollment
• Reporting to one or more applicable state and federal agencies
• Legal action

THE FEDERAL AND STATE FALSE CLAIMS ACT AND OTHER RELEVANT LAWS

Federal False Claims Act

Using the False Claims Act (FCA), you can help reduce fraud against the federal government. The Act allows everyone to bring whistleblower lawsuits on behalf of the government known as *qui tam* suits, which are suits against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

As amended in 2009, the False Claims Act addresses those who:

A) Knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval

B) Knowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim

C) Conspire to commit a violation of any other section of the False Claims Act

D) Have possession, custody or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all of that money or property

E) Are authorized to make or deliver a document certifying receipt of property used, or to
be used by the government, and intending to defraud the government, make or deliver the receipt without completely knowing that the information on the receipt is true

F) Knowingly buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the armed forces, who lawfully may not sell or pledge property

G) Knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government

Knowingly is defined as acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information. An example would be if a healthcare provider, such as a hospital or a physician, knowingly up-codes or overbills, resulting in overpayment of the claim using Medicaid dollars.

The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicaid that are designed to reduce program spending. As an entity that offers Medicaid coverage, Affinity is required to comply with certain provisions of the DRA. One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Act, and other laws regarding Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste, and abuse when handling Affinity business.

The time for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the government knows or should have known about the illegal conduct, but in no event later than 10 years after the illegal activity.

New York State False Claims Act

The New York State False Claims Act (FCA) is modeled after the federal FCA and is effective for all claims filed or presented on or after April 1, 2007. Similar to the information above, the New York State FCA includes the remedies, whistleblower protections, and non-retaliation provisions.

Other fraud related New York laws:

- **Article 175 of the Penal Law** makes it a misdemeanor to make or cause to make a false entry in a business record, improperly alter a business record, omit making a true entry in a business record when obligated to do so, prevent another person from making a true entry in a business record or cause another person to omit making a true entry in a business record. If the activity involves the commission of another crime, it is punishable as a felony.
• **Article 175 of the Penal Law** also makes it a misdemeanor to knowingly file a false instrument with a government agency. If the instrument is filed with the intent to defraud the government, the activity is punishable as a felony.

• **Article 176 of the Penal Law** makes it a misdemeanor to commit a fraudulent insurance act which is defined, among other things, as knowingly and with the intent to defraud, presenting, or causing to be presented a false or misleading claim for payment to a public or private health plan. If the amount improperly received exceeds $1,000, the crime is punishable as a felony.

• **Article 177 of the Penal Law** makes it a misdemeanor to engage in health care fraud which is defined as knowingly and willfully providing false information to a public or private health plan for the purpose of requesting payment to which the person is not entitled. If the amount improperly received from a single health plan in any one year period exceeds $3,000 the crime is punishable as a felony.

• **Section 403 of the Insurance Law** authorizes the insurance department to impose civil penalties for any action that constitutes a fraudulent insurance act under Article 176 of the Penal Law. Civil penalties may be up to $5,000 plus the amount of the claim for each violation.

• **Section 740 of the Labor Law** prohibits an employer from taking any retaliatory action against an employee because the employee (i) discloses or threatens to disclose to a supervisor or government agency any illegal policy or practice of the employer that threatens public health or safety, or constitutes health care fraud; (ii) provides information to or testifies before any government agency conducting an investigation into such a policy or practice; or (iii) objects to or refuses to participate in any such policy or practice. However, retaliatory action is prohibited only if the employee, prior to providing information to a government agency, notifies his or her supervisor of the illegal policy or practice and affords the employer a reasonable opportunity to correct the problem. An employee subject to illegal retaliation may file a civil action against the employer and is entitled to reinstatement, lost wages and attorney fees.

**Federal Anti-Kickback Statute**
Under the federal Anti-Kickback Statute (42 §1320a-7b), and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal healthcare program.

**Federal Stark Law**
Under the federal Stark law (42 U.S.C. §1395[a] and §1903[s]), and subject to certain exceptions, providers are prohibited from referring federal health care program members for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs.
Health Insurance Portability and Accountability Act (HIPAA)
As part of the Health Insurance Portability and Accountability Act (HIPAA) (18 U.S.C. §1347), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute or attempt to execute a scheme or artifice to defraud any federal healthcare program or obtain by means of false or fraudulent pretenses, representations or promises any money or property owned by or under the custody or control of any federal healthcare program.

Health Information Technology for Economic and Clinical Health (HITECH)
The Health Information Technology for Economic and Clinical Health (HITECH) Act enacted as part of the American Recovery and Reinvestment Act of 2009 imposes notification requirements on covered entities, business associates, vendors of personal health records (PHR) and related entities in the event of certain security breaches relating to protected health information (PHI).

PROTECTION FOR REPORTERS OF FRAUD, WASTE, AND ABUSE
In addition, federal and state law and Affinity’s policy prohibit any retaliation, retribution or intimidation against persons who report suspected violations of these laws to law enforcement officials or who file whistleblower lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution, retaliation or intimidation should also report this to our special investigation unit.

Additional information on the False Claims Act and our fraud, waste, and abuse policies can be found on AffinityPlan.org/Contact-Us/Reach-Out-to-Us/Fraud,-Waste-and- Abuse/Fraud,-Waste-and-Abuse/.

PROHIBITED AFFILIATION
Affinity is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended, or otherwise excluded from participating in federal procurement and non-procurement activities. Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state healthcare programs. If you become aware that your corporate entity, those with more than 5% ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify Affinity immediately as outlined in this manual.

OWNERSHIP, DEBARMENT, AND CRIMINAL CONVICTIONS
Before Affinity enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment or suspension status and any criminal convictions related to federal healthcare programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.
In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child or sibling. Please contact us by using the contact information in the reporting section below. If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request. If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations (CFR) 42 CFR 455.100-106 for more information and definitions of relevant terms.

All requests for disclosure of ownership, controlling interest, business transactions or related information made by Affinity or a governmental agency must be fulfilled within 35 days of the date of a request.

SANCTION SCREENING

It should be noted that at minimum, Affinity providers, vendors and business partners must review the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), the General Service Administration (GSA) Excluded Parties Lists System (EPLS), and the New York State Office of Medicaid Inspector General (OMIG) Medicaid Terminations and Exclusions list prior to hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or First Tier, Downstream, and Related Entity (FDR) to ensure that none of these persons or entities are excluded or become excluded from participation in federal or state programs. The LEIE and EPLS screenings must also occur at least monthly thereafter; the OMIG Medicaid Terminations and Exclusions list must be checked periodically after being hired or contracted.

Note that Affinity providers, vendors and business partners are required to collect the date of birth and social security number of employees (regardless of position) and board members prior to hire or appointment in order to execute this sanction screen requirement as well as other oversight requirements. Additional, Affinity, organizations acting on behalf of Affinity, or a governmental agency must be furnished this information upon request.

For a definition of FDR, refer to the General Compliance, Fraud, Waste, and Abuse section of this Section 18.

A ROADMAP TO AVOID MEDICARE AND MEDICAID FRAUD, WASTE, AND ABUSE

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid program and program beneficiaries from fraud, waste and abuse. This brochure can be found on the Office of the Inspector General’s website at OIG.hhs.gov/compliance.
SECTION 20 — ABUSE AND NEGLECT

New York law defines abuse and neglect of vulnerable persons in broad terms, including both actual harm and the risk of harm. The following are a list of terms and some examples of abuse and neglect.

- **Physical Abuse**: Intentional contact (hitting, kicking, shoving, etc.), corporal punishment, injury which cannot be explained and is suspicious due to extendor location, the number of injuries at one time, or the frequency over time.

- **Psychological Abuse**: Taunting, name-calling, using threatening words or gestures.

- **Sexual Abuse**: Inappropriate touching, indecent exposure, sexual assault, taking or distributing sexually explicit pictures, voyeurism or other sexual exploitation.

- **Neglect**: Failure to provide supervision or adequate food, clothing, shelter or health care, or access to an educational entitlement.

- **Deliberate misuse of restraint or seclusion**: Use of these interventions with excessive force, as a punishment or for the convenience of staff.

- **Controlled Substances**: Using, administering or providing any controlled substance contrary to law.

- **Aversive conditioning**: Unpleasant physical stimulus used to modify behavior without person-specific legal authorization.

- **Obstruction**: Interfering with the discovery, reporting or investigation of abuse or neglect, falsifying records or intentionally making false statements.

VULNERABLE PERSONS

Vulnerable persons are individuals with special needs who are receiving supports or services at state operated, licensed and certified facilities and programs.

MANDATED REPORTERS

New York State and the New York State Child Protective System recognize certain professionals as holding the important role of mandated reporter. These professionals can be held liable by both the civil and criminal legal systems for intentionally failing to make a report. Mandated reporters are required to report instances of suspected abuse or maltreatment only when they are presented with reasonable cause to suspect abuse or maltreatment in their professional roles.

You are a mandated reporter if you are part of the following two groups:

1. **Custodians** are individuals who are employed by or volunteer at state operated, licensed, or certified facilities or agencies under the Justice Center's jurisdiction. Consultants, volunteers or contractors of organizations or companies that contract with facilities and agencies under the Justice Center’s jurisdiction are also considered
to be custodians if they have regular and substantial contact with a service recipient.

2. **Human Service Professionals** (medical/clinical professionals, education professionals, law enforcement professionals) include child care or foster care worker; chiropractor; Christian Science practitioner; coroner; dental hygienist; dentist; district attorney or assistant district attorney; emergency medical technician; hospital personnel engaged in the admission, examination, care, or treatment of persons; intern; investigator employed in the office of the district attorney; any other law enforcement official; licensed creative arts therapist; licensed marriage and family therapist; licensed mental health counselor; licensed occupational therapist; licensed physical therapist; licensed practical nurse; licensed psychoanalyst; licensed speech/language pathologist/audiologist; medical examiner; mental health professional; nurse practitioner; NYS Office of Alcoholism and Substance Abuse - all persons credentialed by OASAS; optometrist; osteopath; peace officer; physician; podiatrist; police officer; psychologist; registered nurse; registered physician’s assistant; resident (medical); social services worker; social worker; surgeon, and school official, including but not limited to: school teacher, school guidance counselor; school psychologist; school social worker; school nurse; school administrator; or other school personnel required to hold teaching or administrative license or certificate.

Please be aware that there may be changes to this list. The current list is in Section 413 of the New York State Social Services Law.

**REPORTING ABUSE AND NEGLECT TO VULNERABLE PERSONS CENTRAL REGISTER**

The trained call center representatives who answer your call will ask you for as much information as you can provide about the suspected abuse, neglect or maltreatment, and the location where it occurred. Below are examples of some of the questions you might be asked when you call.

- What is the victim’s name?
- What happened to the victim?
- Who caused the harm?
- Where did the incident occur?

When a caller makes a report, the call center representative carefully enters all details of the incident into an automated case management system. The trained call center representative will first determine if an emergency response is necessary and/or if the person receiving services faces imminent danger. If it is an emergency situation, the representative will instruct the caller to phone 9-1-1 immediately, if this has not yet occurred. Serious abuse and neglect cases will be investigated by the Justice Center, with lesser offenses generally delegated to
the appropriate state agency for investigation. If criminal conduct may be involved, the Justice Center’s special prosecutor/inspector general will investigate and prosecute offenders when the evidence warrants such action.

All calls made to the Vulnerable Persons Central Register hotline are recorded for quality assurance; however, all reports are confidential. The law provides protections against the disclosure of a reporter’s identity, subject to limited exceptions such as consent from the reporter or in the event of a court order. The law grants immunity to voluntary reporters and mandated reporters from any legal claims which may arise from a good faith act of providing information to the Vulnerable Persons Central Register hotline. An employer or agency is prohibited from taking any retaliatory action against a person who has made a good faith act of providing information to the hotline.

Reports of suspected abuse and neglect of a person in state care should be made immediately at any time of the day or night and on any day of the week by telephone to the Vulnerable Persons Central Register hotline (VPCR). If an individual is in immediate danger you will be asked to hang up and call 9-1-1. The telephone numbers to contact the VPCR hotline are:

**Vulnerable Persons Central Register (VPCR) hotline:**
toll free 855.373.2122
TTY: 855.373.2123

**Incident reporting form:** VPRC.justicecenter.ny.gov/WIRW/#/
**Justice Center for the Protection of People with Special Needs:**
JusticeCenter.ny.gov/incident-reporting/report-abuse

**LAWS PERTAINING TO THE JUSTICE CENTER**

The Protection of People with Special Needs Act created new safeguards for people with special needs who are served by state operated, licensed or certified facilities and programs. These standards and practices have been implemented to protect individuals in state care against abuse, neglect or other conduct that would jeopardize their health, safety and welfare.

The agencies include the Office for People with Developmental Disabilities (OPWDD), the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS), certain adult homes overseen by the Department of Health (DOH), and residential schools and programs overseen by the State Education Department (SED).

Chapter 501 of the Laws of 2012 defines abuse and neglect, vulnerable persons and the process and procedures regarding Justice Center investigations, outcomes and records.

**REPORTING CHILD ABUSE AND NEGLECT**

Reports of suspected child abuse or maltreatment should be made immediately at any time of the day and on any day of the week by telephone to the New York Statewide Central Register
of Child Abuse and Maltreatment (sometimes referred to as the State Central Register or SCR).

The child protective specialist who answers your call will ask you for as much information as you can provide about both the suspected abuse or maltreatment, and the family about which you are calling. Below are examples of questions the child protective specialist might ask you when you call. Even if you have very little information available to you, please call the SCR. The specialists will analyze the information you do have and determine if it is sufficient to register a report. Below are examples of some of the questions you might be asked when you call.

- What is the nature and extent of the child's injuries, or the risk of harm to the child?
- Have there been any prior suspicious injuries to this child or his/her siblings?
- What is the child's name, home address and age?
- What is the name and address of the parent or other person legally responsible who caused the injury, or created the risk of harm to the child?
- What are the names and addresses of the child's siblings and parents if different from the information provided above?
- Do you have any information regarding treatment of the child, or the child's current whereabouts?

The child protective service (CPS) unit of the local department of social services is required to begin an investigation of each report within 24 hours. The investigation should include an evaluation of the safety of the child named in the report and any other children in the home, and a determination of the risk to the children if they continue to remain in the home.

CPS may take a child into protective custody if it is necessary for the protection from further abuse or maltreatment. Based upon an assessment of the circumstances, CPS may offer the family appropriate services. The CPS caseworker has the obligation and authority to petition the family court to mandate services when they are necessary for the care and protection of a child.

CPS has 60 days after receiving the report to determine whether the report is indicated or unfounded. The law requires CPS to provide written notice to the parents or other subjects of the report concerning the rights accorded to them by the New York State Social Services Law. The CPS investigator will also inform the SCR of the determination of the investigation.

According to Section 240.50 of the New York State Penal Law, falsely reporting an incident to the State Central Register is a Class A misdemeanor. If you are the victim of a false report, you should contact your local district attorney's office to discuss what options are available.
Child abuse hotline: toll free 800.342.3720

If you are reporting abuse or maltreatment of a child by a parent or other person legally responsible for that child, or by a day care program, please call the NY Statewide Central Register of Child Abuse and Maltreatment at 800.342.3720. Additional information can be found at OCFS.ny.gov/main/cps/faqs.asp.

Within 48 hours of an oral report, a written report must be written using form LDSS 2221A found at OCFS.state.ny.us/main/forms/cps/.
SECTION 21 — GENERAL COMPLIANCE, FRAUD, WASTE AND ABUSE

HOW TO REPORT COMPLIANCE CONERNS, INCLUDING FRAUD, WASTE, AND ABUSE

It is Affinity’s policy to detect and prevent any activity that may constitute fraud, waste, or abuse, including violations of the federal False Claims Act or any federal or state Medicaid fraud laws. If you have knowledge or information that any such activity may be or has taken place, please contact our Special Investigations Unit.

Compliance concerns, including fraud, waste, or abuse, can be reported anonymously or directly to Affinity.

To report anonymously, call our ethics line at 866.528.1505 and follow the appropriate menu option for reporting fraud, waste, or abuse. You may also report online at AffinityPlan.org/Affinity/Providers/Compliance/Fraud_and_Abuse.aspx.

You may send a written report to:

Affinity Health Plan
Attn: Special Investigations Unit (or Compliance Unit)
1776 Eastchester Road
Bronx, NY 10461

To report compliance concerns including fraud, waste and abuse directly:

- call the a compliance officer at 718.794.5731
- email a report to compliance@affinityplan.org
- fax a report to 718.536.3391

When you report fraud, waste, or abuse please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law.
APPENDIX A — QUICK REFERENCE GUIDE

Key Affinity Health Plan contact information:

**Quick Reference Guide**

Medicaid (ME), Child Health Plus (CHP), Essential Plans (EP) and Health And Recovery Plan (HARP - Enriched Health Plan)

<table>
<thead>
<tr>
<th>Important Contact Information</th>
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<tbody>
<tr>
<td><strong>Provider Services</strong></td>
</tr>
<tr>
<td>Tel.: 866.247.5678</td>
</tr>
<tr>
<td>Fax 718.794.7308</td>
</tr>
<tr>
<td>Monday - Friday, 8:30 a.m. - 6:00 p.m.</td>
</tr>
<tr>
<td>Email: <a href="mailto:ProviderRelations@affinityplan.org">ProviderRelations@affinityplan.org</a></td>
</tr>
<tr>
<td><strong>Member Services</strong></td>
</tr>
<tr>
<td>Tel.: 866.247.5678</td>
</tr>
<tr>
<td>Fax 718.794.7308</td>
</tr>
<tr>
<td>Monday - Friday, 8:30 a.m. - 6:00 p.m.</td>
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<tr>
<td><strong>Utilization / Medical Management</strong></td>
</tr>
<tr>
<td>Tel.: 866.247.5678</td>
</tr>
<tr>
<td>Fax 718.794.7308</td>
</tr>
<tr>
<td>Monday - Friday, 8:30 a.m. - 6:00 p.m.</td>
</tr>
<tr>
<td><strong>Quality Management, Quality Risk Inquiries</strong></td>
</tr>
<tr>
<td><a href="mailto:QM@affinityplan.org">QM@affinityplan.org</a></td>
</tr>
<tr>
<td><strong>Discharge Plans</strong></td>
</tr>
<tr>
<td><a href="mailto:transitionalcareteam@affinityplan.org">transitionalcareteam@affinityplan.org</a></td>
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<tr>
<td><strong>Credentiaing</strong></td>
</tr>
<tr>
<td>medicalcredentialing@hp @affinityplan.org</td>
</tr>
</tbody>
</table>

**Provider Portal:**

http://identity.affinityplan.org/account

Access the secure provider portal to verify member eligibility, review claim status, and search for providers; to check authorization status and review details; to update demographic information; and to download member roster; Quality Incentive Program, and Gate-in-Care and non-users reports.

If you have a problem logging onto the portal call 866.247.5676.

**Access and Availability**

Refer to the Provider Manual Section 4 for complete information at http://affinityplan.org/uploadedFiles/affinityplan/Publications_and_Training/Files/Provider_Manual.pdf

**Notification Requirements**

Notification of the member’s hospital admission within two business days of admission through the emergency room 988.543.9074. Follow the voice prompt for “authorizations” to contact the Utilization Management Department. Behavioral Health Admissions - Notify no later than two business days by calling 850.374.0651.

**Member Enrollment and Renewal**

Enrollment assistance 866.731.8001
Member renewals: 866.243.3774 Monday to Friday, 8:30 a.m. - 6:00 p.m.
Recertification@affinityplan.org
Online https://www.affinityplan.org/Contact-Us/Reach-Out-to-Us/Contact-Us/Pharmacy/Pharmacy-Management-Enquiries/pharmacy@affinityplan.org

**CVS Caremark (Pharmacy)**

Tel 866.247.5678
Fax 866.355.7569
Website https://www.affinityplan.org/Providers/Support/Pharmacy/Pharmacy/Pharmacy-Management-Enquiries/pharmacy@affinityplan.org

**LogiCare (Transportation)**

Reservations: 844.878.1033
(Monday through Friday, 8:00 a.m. - 5:00 p.m.)
Urgent transportation: 844.878.1033
Provider fac. 866.642.2351

**DentaQuest (Dental)**

Providers service line: 888.308.2508
Member service line: 888.243.0562
Find a dentist: https://providerlookup.affinityplan.org/#/

**Superior Vision (Optical)**

Optical providers go through Superior Vision.
Provider service line: 866.819.4295 or 800.283.4033, option 3.
Call to join the network at 844.243.2900 or complete the provider nomination request form on our website https://supervisorvision.com/providers/.
Member service lines: 800.878.6901 or 800.283.8789 or 866.810.3312

**Beacon Health Strategies (Behavioral Health)**

Provider service line: 800.074.831 (pre-authorization)
Provider Relations department: 718.394.7566
Member service line: 866.432.3114
Letter of interest form: www.beaconhealthstrategies.com/
becoming_a_provider@beaconhealthstrategies.com/www.Beaconhealthstrategies.com
APPENDIX A – QUICK REFERENCE GUIDE

EFT payment - Change Healthcare and ECHO Health

To sign up for electronic payments (EFT) visit https://view.echohealthinc.com/EFTERA/Direct/Affinity/index.html
To access EOP visit www.providerspayments.com
ECHO contact
Website: https://view.echohealthinc.com/UI/inquiry.aspx#
Customer service: 888.634.3511
cs_requests@echohealthinc.com

Compliance
General inquiry: compliance@affinityplan.org
Legal, Compliance, and Special Investigations: 718.794.5731
Affinity's confidential hotline for reporting compliance concerns including fraud, waste, and abuse is 866.652.81505.
CMA inquiries: compliancegrievance&appealunit@affinityplan.org

Pre-authorizations
A complete list of the treatments and procedures that require providers to obtain pre-authorizations: https://www.affinityplan.org/Providers/Resources/Pre-Authorization-Codes/Pre-Authorization-Codes/
For radiation therapy, ultrasound, sleep management, physical therapy (PT), occupational therapy (OT), speech therapy (ST), cardiac imaging and radiology services contact eviCore: 866.242.5615
Fax: 800.34.522.046
For chiropractic contact Landmark: 800.638.4657
For DME contact ReliaCare: 877.331.5170
For all other authorization requests fax the prior authorization request form to 718.794.7822.
If you wish to speak to a representative call 888.543.9074.
For detail visit http://affinityplan.org/Providers/Resources/Authorizations/Authorizations/

Claims Guidelines - Customer Service / Claims: 866.247.5678
Claims submissions: Claims must be submitted within the timeframe of the date of service that is specified on your contract (or 90 days) and should be done so either electronically or mailed as a hardcopy to the addresses shown for the Claims department.
PCPs must submit encounter for capitated service and well service codes when rendered at the time of a sick visit.
Electronic claim submissions: Review our EDI frequently asked questions (FAQs). For inquiries on submitting EDI claims through Edeon, our clearinghouse, you may access the Edeon website at www.edeon.com.

Affinity Health Plan
Claim Payer IDs
Medical Claims: Medicaid, OHP, Essential Plan and HARP 1334
Medical Claims: Medicare (for date of service to 12/31/2018) 13333
Behavioral Health Claims 43324
Plan ID (SIBR03) is 00009

Mailing Address for Paper Claims
All original submissions and corrected claims must be mailed to:
PO Box 981726
El Paso, TX 79998

Claims Administrative Reconsiderations
Mail denials not related to authorization or medical necessity denial:
Attention: Claims Department
PO Box 812
NY, NY 10028-0081

Note: Appeals related to Medical Necessity Denials should not be sent to this post office box.
Claims Resolution: Providerrelations@affinityplan.org

Appeals / Claims Questions / Inquiries
For Appeals:
When appealing an Affinity adverse determination in writing you must submit your written request to
Affinity Health Plan
1776 Eastchester Rd
Bronx, NY 10461
or Fax to 718.536.3358
APPENDIX B — VENDOR CONTACT INFORMATION

Behavioral Health and Substance Abuse Services
Beacon Health Options provides behavioral health and substance abuse services. Beacon’s network specialists develop and deliver services for our members. Visit BeaconHealthoptions.com for a listing of providers, to research community resources or to access the Beacon Healthwise Knowledge Base.

Member contact information
- 24-hour clinical access: 800.974.6831
- Main number: 781.994.7500
- Fax number: 781.994.7600
- TTY number (for the hearing impaired): 781.994.7660

Visit BeaconHealthoptions.com or call 888.438.1914. To view your claims, visit My Beacon portal. Additionally, there are resources available to access information regarding Transition Age Youth (TAY) and members with First Episode Psychosis (FEP), community forums, volunteer activities, and community organizations.

Chiropractic
Landmark Healthcare provides managed chiropractic services to members through its local provider network. Visit LandmarkHealthcare.com or call 800.638.4557. More detailed and specific information about the benefits available to members in Affinity's health programs is available by directly contacting the benefits administrators.

Dental
DentaQuest provides dental services to members in the Essential Plan through their network of contracted providers. Visit Dentaquest.com or call 866.731.8004.

eviCore
EviCore manages the authorization process for radiation therapy, ultrasound, sleep management, physical therapy (PT), occupational therapy (OT), speech therapy (ST), cardiac imaging, and radiology services. For more information and codes related to these services, visit eviCore.com/healthplan/Affinity or call 866.242.5615 and choose option number 6.

The following is clarification on the authorization services provided via Affinity Health Plan’s partnership with eviCore healthcare:
- Ultrasound
  For a routine pregnancy, the first two ultrasounds – nuchal translucency (76813) and fetal anatomy survey (76805) – do not require prior authorization. Any additional ultrasounds will require prior authorization.
• **Non-obstetric ultrasounds**
  The first ultrasound for any one specific condition (e.g., pelvic ultrasound for pelvic pain, thyroid ultrasound for a thyroid mass, renal ultrasound for hematuria) does not require a prior authorization. Any additional ultrasound for the same condition will require prior authorization.

• **PT/OT/ST**
  Prior authorization is not required for the first six visits within the benefit period. Visit seven and beyond will require prior authorization. Please refer to the specific program benefits for limitations.

• **Sleep study supplies**
  Prior authorization is required every three months. Out-of-network services or services rendered by a non-participating physician or provider continue to require prior authorization. Participating Affinity providers must refer to in-network providers and/or render services in in-network facilities.

**Laboratory Services**

**Bio-Reference Laboratories**
Phone: 800.229.5227
- GeneDX: 888.729.1206
- GenPath Women’s Health: 800.633.4522
- GenPath Oncology: 800.627.1479

**Empire City Laboratories, Inc.**
Phone: 718.788.3840

**LabCorp**
Phone: 888.522.2677
- Integrated Oncology: 800.710.1800
- Dianon Systems, Inc.: 800.328.2666
- Integrated Genetics: 800.848.4436
- Litholink Corporation: 800.338.4333
- MedTox Laboratories, Inc.: 800.832.3244
- Monogram Biosciences, Inc.: 800.777.0177

**Lenco Diagnostic Lab**
Phone: 855.870.0097

**Spectra (including Shield Medical Lab)**
Phone: 800.553.0873

**Sunrise Medical Laboratories**
Phone: 800.782.0282
Xeron Clinical Laboratories
Phone: 718.762.3310

Quest Diagnostics, Inc.
Phone: 866.697.8378

Pharmacy
CVS Caremark is Affinity’s pharmacy benefits manager for Medicaid. Members in these programs can get prescription drugs not only at CVS pharmacies, but at all the other chain and independent pharmacies that participate in their network. Visit Caremark.com, or call:

877.775.5623 (for customer care)
877.432.6793 (for authorizations)
888.543.9069 (for appeals)

Transportation Services
A non-emergency transportation service which includes personal vehicle, bus, taxi, ambulate, and public transportation to medical appointments are now administered through New York State. You or your provider must call the vendor listed below to arrange transportation:

- NYC (Bronx, Brooklyn, Manhattan, Queens, Staten Island): Logisticare 877.564.5922
- Long Island (Nassau and Suffolk): Logisticare 844.678.1103
- All other counties: Medical Answering Services 800.850.5340

You also can access this information online. If possible, you or your provider should call the vendor at least three days before your medical appointment and provide your appointment date, time and address, and the doctor you are seeing.

Vision
Superior Vision is a national vision benefits manager. Superior Vision’s network of optometrists provides routine vision care for all Affinity members. Visit SuperiorVision.com or call 866.810.3312.
APPENDIX C — SAMPLE MEMBER ID CARDS

The program codes on the ID cards are as follows: ME (Medicaid), HARP, CH (Child Health Plus), and EP (Essential Plan).

**Please note:** The ID card does not guarantee eligibility. It is for identification purposes only. Eligibility must be verified at each visit. Failure to verify eligibility may result in non-payment of claims.

**MEDICAID SAMPLE ID CARD**

![MEDICAID SAMPLE ID CARD](image)

**HEALTH AND RECOVERY PLAN SAMPLE ID CARD (HARP)**

![HEALTH AND RECOVERY PLAN SAMPLE ID CARD](image)
APPENDIX C – SAMPLE MEMBER ID CARDS

CHILD HEALTH PLUS SAMPLE ID CARD

ESSENTIAL PLAN SAMPLE ID CARD
For more information call us toll-free at

866.247.5678

Monday to Friday, 8:30 a.m. to 6:00 p.m.

TTY users should call

800.662.1220

AffinityPlan.org