ArchCare Senior Life

Provider Manual

July 2021

KEEPING OUR MEMBERS HEALTHY IN THE PLACE THEY CALL HOME
THROUGH PARTNERSHIP WITH OUR PROVIDERS

Dear Provider,

Welcome to our network. We at are pleased to present this Provider Manual. It is designed to answer your questions about ArchCare Senior Life services and to better understand our policies and procedures as it pertains to our Providers.

This manual will give you comprehensive information about our different departments, services and your roles and responsibilities as a Provider. Periodic updates will be available to you so you may stay current and you may contact Provider Relations by phone at 866-263-9083 or ProviderRelations@ArchCare.org. We welcome your feedback, questions and comments.

ArchCare Senior Life stands poised to coordinate high quality care with exceptional outcomes for our Members. Our commitment to this partnership with our Providers will assist us in delivering this care and achieving these outcomes.

Welcome to ArchCare Senior Life as a participating Provider. We look forward to working with you.

Sincerely,

ArchCare Senior Life

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LEGAL AND ADMINISTRATIVE REQUIREMENTS DISCLAIMER

The information provided in this manual is intended to be informative and to assist Providers in navigating the various aspects of participation with the ArchCare Senior Life program. Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon ArchCare Senior Life and is subject to change. ArchCare Senior Life will make reasonable efforts to notify Providers of changes to the content of this manual.

This manual may be updated at any time and is subject to change. In the event of an inconsistency between information contained in this manual and the Provider Agreement between you or your facility and ArchCare Senior Life, the Agreement shall govern.

In the event of a material change to the Provider Manual, ArchCare Senior Life will make all reasonable efforts to notify you in advance of such changes through Provider bulletins, Provider newsletters, and other mailings. In such cases, the most recently published information shall supersede all previous information and be considered the current directive. The manual is not intended to be a complete statement of all ArchCare Senior Life Plan policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communications.

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INTRODUCTION

Welcome and thank you for participating in ArchCare Senior Life.

This manual is designed to be a guide and reference for Providers who participate in the ArchCare Senior Life program. ArchCare Senior Life is designed to manage the care of Member's 55 or older who are living in the community with physical and or cognitive disabilities through a program. This program provides community based care and services that allow these people to remain in the community and lead a fulfilling life, who otherwise would need to receive their care in a nursing home.

Community based Providers participate in this program in different ways. Community Based Primary Care Physician s continue to provide medical care to their patients who become Members of the program. In addition, they play a key role as a Member of ArchCare Senior Life's IDT to help formulate an integrated care plan for their patients. The care plan is designed to insure their patients receive non-medical services that are necessary to resolve problems related to activities of daily living so they can remain in the community as long as possible; and help them to participate in their physician's medical treatment plan to the highest degree possible. Specialists play a more traditional role as consultants to the Primary Care Physician to assess patients referred to them and treat these patients when necessary. Non-physician Providers also play a more tradition role in working with the Primary Care Physician and the other IDT Members to manage patients enrolled in the ArchCare Senior Life program who require their services.

As with other insurers, the ArchCare Senior Life program has Federal and State requirements that need to be complied with and internal processes and procedures that need to be followed to insure high quality care for their Members and high quality service for its Providers. This manual attempts to explain what ArchCare Senior Life is; the different roles Providers play when they participate in ArchCare Senior Life; processes and procedures that need to be followed to comply with ArchCare and Federal and State requirements; how to contact ArchCare Senior Life; and how to utilize services available for Providers to insure they receive the highest quality of customer service possible.

OVERVIEW

PACE stands for Program of All-Inclusive Care for the Elderly. It is a national program sponsored by the Federal government through Medicare and the State governments through Medicaid. It was developed for people 55 or older who either have Medicaid, Medicare and Medicaid (dual eligibles), or Medicare only and are willing to spend down their assets to qualify for Medicaid or pay privately; who were assessed as being eligible for nursing home placement according to the standards established by the State in which they reside; but with the appropriate services and care can continue to live safely in the community. In New York, nursing home eligibility is defined as having long term care needs of 120 days or more.

The model of care is built around an IDT which includes, a Primary Care Physician , nurse, social worker, physical therapist, occupational therapist, recreational therapist, dietician, center director, transportation coordinator, personal care worker and home care coordinator. Each Member is assessed twice a year by the team. Based on the assessments, Member problems are identified and the team builds an integrated care plan to resolve them.

The ArchCare Senior Life program provides all the benefits that Medicare and Medicaid provide to its Members at no cost if they have Medicaid or are dual eligible and at the discretion of the IDT can provide additional benefits when deemed necessary for the Member.

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ELIGIBILITY

To be eligible to enroll as an ArchCare Senior Life Member, an individual must be:

1. 55 years of age or older;

2. A resident of New York (Manhattan), Bronx, Richmond or Westchester counties;

3. Eligible for nursing home level of care based on an established criteria for New York State;

4. Eligible for Medicaid; have Medicaid; have Medicare and Medicaid or have Medicare and be willing to pay privately;

5. Able to live safely in the community with the services provided by the ArchCare Senior Life program;

6. ArchCare Senior Life has expanded criteria to include patients who are hearing impaired and those who have intellectual and developmental disabilities who meet the qualifications outlined above. In addition ArchCare Senior Life has a unique program to work with patients that meet the eligibility criteria who have Parkinson's disease.

7. Expected to need the long term care services of the plan for at least 120 days.

8. When a Member is enrolled in ArchCare Senior Life, we become the sole payer for all of the Member's care and services. Services are available 24 hours a day, 7 days a week, and 365 days a year. Many services such as meals, recreational therapy, physical therapy and Adult Day Health Care can be provided in ArchCare Senior Life's centers. Services that are not provided at the centers will be provided in the home or by our network of contracted Providers, such as you, in consultation with our interdisciplinary team.

9. This Provider Manual is meant to assist you in working with our Members within the framework of ArchCare Senior Life's policies and procedures. Familiarizing yourself with and adhering to the procedures outlined in this Manual will help ensure a mutually beneficial, productive relationship in caring for our Members.

THE ROLE OF THE COMMUNITY BASED PRIMAY CARE PHYSICIAN IN ARCHCARE SENIOR LIFE

Originally Federal regulations required that ArchCare Senior Life employ Primary Care Physician s to care for ArchCare Senior Life Members. More recently Federal regulations have been changed to allow community based Primary Care Physician s to provide care for ArchCare Senior Life Members if the Member had been receiving care from the physician prior to joining ArchCare Senior Life and wants to continue receiving care from that physician. Based on this change in regulations ArchCare Senior Life has obtained a waiver from the Federal Government permitting it to contract with Community Based Primary Care Physician's (CBPCP) to provide primary care services to Members who choose to stay with their personal Primary Care Physician when enrolling in ArchCare Senior Life.

ArchCare Senior Life regulations require that each Member is managed by an interdisciplinary team (IDT), which includes the Primary Care Physician. The waiver allows the CBPCP to directly interact with the other Members of the IDT including a nurse, social worker, physical and occupational therapists, dietician and other non-physician care Providers. ArchCare Senior Life regulations provide specific guidelines with regard to CBPCP participation in the ArchCare Senior Life program, Member assessments and physician orders. In addition, ArchCare Senior Life has developed requirements that define communication and documentation issues necessary to insure high quality care for their Members.

Federal ArchCare Senior Life Regulations Guidelines

The community physician must have provided medical care to the Member prior to the Member's enrollment in the ArchCare Senior Life Program.

The community physician must contract with ArchCare Senior Life to participate in the ArchCare Senior Life program.

The community physician, as a Member of the IDT, must collaborate with the other Members of the IDT concerning the Member (their patient) to develop an integrated care plan for the Member. A new care plan must be formulated for the Member at least twice a year or more often if there is a significant change in the Member's health status, such as a hospital admission.

The physician's contribution to the Member's integrated care plan includes an assessment which provides the medical diagnoses and medical treatment plan for their patient. The integrated care plan is designed to assist the Member in overcoming problems that create poor health behaviors and prevent them from complying with the physician's medical treatment plan, and/or functioning safely in the community.

Each Member is assigned a Nurse Practitioner (NP) and a Home Care Nurse (HCN) to manage their care and work directly with the Member's community based Primary Care Physician.

Assessments

The community physician must see the Member at least four times a year. During these visits, two assessments must be done. The initial one is done when their patient first joins ArchCare Senior Life and then a reassessment is done every six months. These assessments provide information for the IDT care planning process. An ArchCare Senior Life NP will be assigned to a CBPCP for the purpose of performing initial and semiannual assessments on their patients who become ArchCare Senior Life Members

After completion of the assessment the NP will make arrangements to review the assessment with the CBPCP at their office, modify it as necessary and ensure the CBPCP signs it and places a copy in their patient's medical record.

In addition the NP will place a signed copy of the assessment in the Member's medical record at the ArchCare Senior Life Center to which the Member is assigned.

The CBPCP is required to reassess a Member who is discharged home from the hospital within 10 working days based on a significant change in their health status and the need for the IDT to have new information with which to develop a new integrated care plan. The ArchCare NP will assist the CBPCP in performing this reassessment as noted under Item 1 above.

Physician Orders

ArchCare Senior Life regulations require the physician to review the care plan and if in agreement, signs and returns it to the ArchCare Senior Life Center to which the Member is attached.

New York State requires signed physician orders for the care plan implementation that covers home care services or other required treatment, within 30 days of receiving the care plan.

Orders and Care Plans will be brought to the CBPCP for his/her review and signature by the ArchCare Senior Life HCN assigned to their patients who become ArchCare Senior Life Members.

ArchCare Senior Life Requirements

Utilization Review and the use of Specialists

ArchCare Senior Life has a brief Prior Authorization List for specific services, treatments, equipment and or evaluations (see Medical Management section). ArchCare Senior Life's Medical Management Department provides authorizations for these items upon the physician's request. Please review the list and when prior authorization is required, provide the Medical Management Department with the appropriate clinical information to justify the authorization request.

No referrals or notifications are necessary for the use of network specialists.

If there is a need to use out-of-network specialists, Medical Management must be notified so they can determine the validity of the request and if deemed valid, reach out to the specialist to join the ArchCare Senior Life network or negotiate a rate to see the Member.

The physician's office should notify ArchCare Senior Life staff about any consults or tests ordered for the Member so the staff can assist the office in: scheduling appointments, arranging for transportation and escort services, ensuring the appointment is kept and follow up on obtaining consultation reports for the physician to review.

Care Transitions

If your patient, who is a ArchCare Senior Life Member, is discharged home following a hospitalization,

his/her care should be discussed with the care coordinator or HCN managing their care within 24 hours of discharge to review discharge diagnoses, instructions and medications, and if deemed necessary seen in the office to minimize the potential for re-hospitalization within 90 days after discharge. As noted above, the Member must be seen within 24 hours but no later than 2 business days after discharge for a reassessment based on a significant change in their health status and the need for information for the IDT to develop a new integrated care plan.

Post hospitalization, if the Member is discharged to a Skilled Nursing Facility (SNF) the CBPCP should review and comment on information provided by the Member's home care nurse related to the care plan developed by the SNF care team in conjunction with the HCN.

Communication

The CBPCP must notify the IDT through the Member's HCN of any changes in the medical treatment plan (medications, wound care, infections, consults) so physician orders and the current care plan can be adjusted.

The CBPCP needs to respond to requests from and appropriately collaborate with HCN for Member care management within 2 hours for urgent issues, and within 24 hours for non-urgent issues.

The CBPCP must respond to requests and appropriately collaborate with the ArchCare Senior Life Medical Director and/or other Members of the IDT to develop or modify care plans for their patient on a timely basis; respond to calls and participate in review discussions within 48 hours of initial contact for an issue not requiring immediate attention, and within 12 hours for an issue requiring immediate attention.

The CBPCP must respond to and collaborate with the Clinical Pharmacist with regard to medication issues that require changes in the medication regimen, consideration of alternative medications or justification for continued use within 14 days of initial notification of an issue.

The CBPCP, upon receipt of a NP assessment of their patient, will review the document and if necessary make corrections, then sign it and maintain the assessment in the patient's medical record.

ArchCare Senior Life believes that complying with these regulations and requirements will significantly enhance the quality of care and the care coordination and management processes for the Member. Physicians who comply with these regulations and work appropriately with ArchCare Senior Life will be entitled to a quality bonus in addition to the case rate they receive for providing office care.

THE ROLE OF THE SPECIALIST IN PACE

Specialists who are in the ArchCare Senior Life network do not require a referral form to evaluate and or treat an ArchCare Senior Life Member. A request for a consultation will be made by the ArchCare Senior Life Central Logistics Unit (CLU) regardless of which Primary Care Physician requests the appointment. This unit will obtain an appointment from the requested specialist; arrange for Member transportation to and from the specialist's office; and send information with the Member including the reason for the consultation, Member demographic information, a copy of the Member's card, contact and billing information and a "Quick Result Form" to be returned with the Member prior to the completion of a formal consultation note. The unit will also inform the referring Primary Care Physician's office about the time of the appointment, arrange for a return visit to the Primary Care Physician after the consultation and assist in making arrangements for any testing or imaging studies requested by the specialist.

Please be aware that ArchCare Senior Life has a brief Prior Authorization List for specific treatments, equipment and or evaluations (see Medical Management section). Its Medical Management Department provides authorizations for these items upon the physician's request. Please review the list and when prior authorization is required, make sure to provide the Medical Management Department with the appropriate clinical information to justify the authorization request. If after a visit you request a test, treatment or imaging study that is on this List please obtain an authorization from the Medical Management Department prior to requesting that the CLU arranges for it.

If you are an out of network specialist (do not participate with ArchCare Senior Life) and the Member has been referred to you and you do not have ArchCare Senior Life Letter of Agreement (LOA) from Provider Services, you must contact this department immediately to obtain one. This must be done prior to seeing the Member to insure appropriate post visit management of the Member's needs and appropriate reimbursement.

THE ROLE OF NON-PHYSICIAN HEALTHCARE PROVIDERS IN ARCHCARE SENIOR LIFE

All non-physician healthcare Providers providing the following services to ArchCare Senior Life Members must be in the ArchCare Senior Life network. The following is a list of non-physician network Providers and the services they provide:

- Dental Vision Audiometry
- Durable Medical Equipment Transportation
- Personal Emergency Response (PERS) Meals
- Social And Environmental

A request for a consultation, service or equipment will be made by the ArchCare Senior Life CLU regardless of which Primary Care Physician made the request. This unit will arrange for an appointment for the Member if necessary, transportation to and from the appropriate office and send information with the Member including the reason for the consultation, Member demographic information, a copy of the Member's card, contact and billing information and a "Quick Result Form" to be returned with the Member prior to the completion of a formal consultation or service note. If there is a request for durable medical equipment (DME) that is on the Prior Authorization List, the DME Provider should obtain authorization through the Medical Management Department before providing the Member with the equipment to insure appropriate reimbursement.

If a referral is made by a CBPCP for the following services outside of an ArchCare Senior Life Center, the Provider who receives the request must contact the Medical Management Department and obtain prior authorization for the requested service:

- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Pulmonary and Cardiac Rehabilitation

If prior authorization is obtained the CLU will arrange for an appointment for the Member, transportation to and from the appropriate office and send information with the Member including the reason for the consultation, Member demographic information, a copy of the Member's card, contact and billing information and a "Quick Result Form" to be returned with the Member prior to the completion of a formal service or consultation note.

SERVICE AREA:

New York
Bronx
Richmond
Westchester

IDENTIFICATION CARD

Member Identification

Every ArchCare Senior Life Member receives an identification card that will detail the Member's name and identification number. This card identifies them as an ArchCare Senior Life Member and should be presented to physicians and other Providers when seeking healthcare services. If the appointment for the requested consultation or service is made by the ArchCare Senior Life Central Logistics Unit a copy of this card will be sent with the Member as part of an information packet. The information packet also includes the reason for the consultation or requested service, Member demographic information, contact and billing information, and a "Quick Result Form" to be returned with the Member prior to the completion of a formal consultation or service note.

Members should present their cards to you at the time of services.

All providers must verify a Member's eligibility at the time of service. All Members are instructed to present their membership card each time they obtain medical services. Please note that ArchCare Senior Life may not be able to retrieve membership cards from Members when they disenroll or lose coverage, a membership card alone is not a guarantee of eligibility.

To verify Membership eligibility:

- Contact Customer Service at 866-263-9083 and speak with a representative.
- Capitated providers or providers with ongoing authorizations (i.e. Personal Care Workers, etc.) can consult their Membership roster for the present month to ensure Member appears on their list. If the Member is on the capitation list, the provider has received the monthly capitation payment for Member

COVERED SERVICES AND BENEFITS

Medical Care Services	**Long-Term Care Services**
Physician Services	Transportation
Diagnostic Services	Adult Day Health Care
Hospital Care	Nursing Care
Emergency Services	Social Work
Home Health Services	Physical and Occupational Therapy
Skilled Nursing Facility Care	Speech Therapy
Palliative Care and End of Life Care	Nutrition
Prescriptions	Home Care
Durable Medical Equipment	Audiology, Dentistry, Optometry, Podiatry

MEMBER RIGHTS AND RESPONSIBILITIES

Rights as a Member:

- Members have the Right to receive medically necessary care;
- Members have the Right to timely access to care and services;
- Members have the Right to privacy about their medical record and when Members get treatment
- Members have the Right to get information on available treatment options and alternatives presented in a manner and language Members understand;
- Members have the Right to get information in a language Members understand, Members can get oral translation services free of charge;
- Members have the Right to get information necessary to give informed consent before the start of treatment;
- Members have the Right to be treated with respect and dignity;
- Members have the Right to get a copy of their medical records and ask that the records be amended or corrected;
- Members have the Right to take part in decisions about their health care, including the right to refuse treatment and make advance directives;
- Members have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Members have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Members have the Right to be told where, when and how to get the services Members need from their Special Needs Plan, including how Members can get covered benefits from out-of-network providers if they are not available in the plan network;
- Members have the Right to complain to the New York State Department of Health or their Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate; and,
- Members have the Right to appoint someone to speak for Members about their care and treatment.

In order to obtain maximum benefits from ArchCare Senior Life, Members have the following **responsibilities**:

- To provide accurate and complete health information regarding past illnesses, hospitalizations, medications taken, allergies, and other details as needed to their care providers;
- To tell about their care needs and concerns and to ask questions to be sure they understand their care plan and can follow through on self-care;
- To access care for covered services through ArchCare Senior Life Providers (except in emergency situations), and to obtain necessary approvals from their Primary Care Provider or the Member's Care Management Team before receiving a covered service;
- To keep appointments as scheduled or request an appointment change;
- To notify ArchCare Senior Life if they plan to move or will be out of town for an extended period of time;
- To notify ArchCare Senior Life of any change which may affect the Plan's ability to provide care to the Member, i.e., doctor contact, address, phone number, in Member admission, new health related issues, primary care giver, etc.;

- To respect the rights and safety of all those involved in Member care and to assist ArchCare Senior Life in maintaining a safe home environment; and,
- To make all required payments to the plan.

NON ENGLISH SPEAKING MEMBERS

ArchCare Senior Life celebrates the diversity of its Members as we serve multicultural areas throughout counties. To ensure Members and potential Members who speak a language other than English can access the information they need, have their questions answered, and obtain all needed services, ArchCare Senior Life will provide translation/interpretation services at no cost to the Member or Member's family. ArchCare Senior Life employs bilingual enrollment and care management staff who speak the languages spoken in these communities and whose names will be available via an updated internal list of bilingual employees and/or will provide a skilled interpreter. ArchCare Senior Life will maintain a list of qualified interpreters with contact information, qualifications and availability. If other language skills are needed, ArchCare Senior Life has access to an oral interpretation service, "Language Line Services."

The Language Line is accessible at 1-888-808-9008, 24-hours a day, 365 days per year. It is staffed by medically certified interpreters who speak 170 languages.

Contracted providers are expected to meet the language needs of the Member.

IMPAIRED MEMBERS

In compliance with the Americans with Disabilities Act requirements, ArchCare Senior Life accommodates impaired Members.

For Members with visual impairments, ArchCare Senior Life provides printed materials in large print formats, and in an audio medium. Staff will also read ArchCare Senior Life materials aloud and explain them verbally for Members who are blind or have low-vision.

Staff can communicate over the telephone with Members with hearing impairments using the NYS Relay Service for TTY (dial **711**) connectivity. Sign language interpreters will also be made available as necessary for the hearing or speech impaired.
For Members with physical or developmental disabilities and who have difficulty manipulating printed materials, staff may assist in holding materials and turning pages as needed.

Contracted providers are also required to meet the needs of impaired ArchCare Senior Life Members.

REIMBURSEMENT

Payment for services rendered is subject to verification that:

The Member was enrolled in ArchCare Senior Life at the time the service was provided; and,
The Provider was compliant with ArchCare Senior Life Prior Authorization policies at the time of service.

Medicare and Medicaid will not be responsible for claims for the Member while they are enrolled as a Member of ArchCare Senior Life. All claims for services provided to ArchCare Senior Life Members must be submitted to ArchCare Senior Life. Please see Billing / Claims Information. The claims submission

address can also be found under Essential Contact Information.

Member's Rights

When enrolled in an ArchCare Senior Life program Members have certain rights and protections. The ArchCare Senior Life program must fully explain these rights to all Members or someone acting on their behalf in a way that they can understand at the time they join. As a Provider, you have the responsibility to respect every Member's rights. Please see Appendix A for an overview of the ArchCare Senior Life Members' rights.

MEDICAL MANAGEMENT

Utilization Review

The Utilization Review (UM) Program is designed to evaluate medical necessity and manage the quality and cost of specific health care services delivered to Members of the ArchCare Senior Life. All services authorized by the utilization review staff are evaluated either prospectively, concurrently, or retrospectively to determine medical necessity based on standard criteria. This program is designed to ensure that:

1. Services are medically necessary, consistent with the assigned Member's diagnoses, and are delivered at appropriate levels of care.

2. Services are provided by ArchCare Senior Life contracted Providers and that the utilization review staff is notified immediately to discuss the use of non-contracted Providers based on services that are not available through contracted Providers.

3. Hospital admissions and length of stay are justified.

4. Services are not over-utilized or under-utilized.

5. Continuity and coordination of care is monitored.

6. Guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to as appropriate. ArchCare Senior Life utilizes standard criteria, such as InterQual Criteria, National Coverage Decisions, the Medicare Benefit Policy Manual, Local Coverage Determinations and current literature to assess all requests for determination of medical necessity. All criteria are reviewed by the Quality Improvement Committee on an annual basis.

7. New technology is evaluated based on Medicare and Medicaid reviews and review of studies that determine its application and effectiveness.

8. There is coordination of thorough and timely investigations and responses to Provider Appeals (see Provider and Adverse Determinations section).

PRIOR AUTHORIZATION

The Medical Management Department through utilization review provides authorizations for specific services, procedures, tests and equipment upon a Providers' request. Prior authorization is based upon the clinical documentation that supports medical necessity for the requested item. Services, procedures and equipment that require prior authorization have been summarized on the Prior Authorization List that is distributed to the Provider network. Contact the Medical Management Department staff at 646-289-7700 for a requested item on the List.

Prior Authorization List
ArchCare Senior Life

Services listed below require Prior Authorization from ArchCare. Please allow 5 business days for approval of standard authorizations and 24- 48 hours for urgent requests.

Durable Medical Equipment - CustomShoes/Orthotics - C-PAPMachines - Hospital Bed - Hoyer Lift - Insulin Pumps - Prosthetics- Major Limbs Specialty mattresses - Wheelchairs(motorized, customized& scooters) - Wound Pumps - Bathroom Safety Devices	**Rehabilitation Services – Outpatient** - Physical Therapy - Occupational Therapy - Speech Therapy - Pulmonary & Cardiac Rehabilitative therapy
Inpatient Admissions - AcuteCareFacilities - SkilledNursingFacilities - Psychiatric Health Care Facilitates - Elective Admissions - Urgent/ Emergent Admissions*	**Radiology** - MRI - Functional MRI, MRA, PET scan - Bathroom Safety Devices
Out-of-Network and Out-of-Area Services - Surgery/Admissions/Testing at non-participatingfacility - Visits to non-participating Providers - Comprehensive Rehabilitation Facilities	

**Does not require prior authorization but notification of health plan within 24-48 hours of admission*

Investigational / Experimental Treatment	
All cosmetic procedures (if medically necessary) - Abdominoplasty - Blepharoplasty - Keloid & Scar Revisions - Mammoplasty, Reduction or Augmentation - Ventral Hernias - Surgical Treatment of Gynecomastia	**OutpatientServices** - Acupuncture - Ambulatory Surgeries - Chiropractic Services - Outpatient Behavioral Health - Outpatient Alcohol & Substance abuse - Podiatry

- ENT Procedures (Rhinoplasty, Septoplasty, Uvoluplasty & LAUP) - Mastopexy - Otoplasty - Varicose Veins Treatment	
Social &Environmental - PERS - Meals - Extermination - House Cleaning - Handyman services (painting, carpentry, trash removal, etc.)	**Other Services** - Radiation Therapy - Pharmokinetic Testing - Audiology Equipment Hyperbaric O2 Therapy - Skilled Home Care Services including Home Infusions

Note: Some formulary medications may require prior authorization

URGENT AND EMERGENCY CARE

ArchCare Senior Life provides coverage for the treatment of an emergency medical condition, which is defined by CMS as a condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual in serious jeopardy
2. Serious impairment to bodily functions or
3. Serious dysfunction of any bodily organ or part

Inpatient and outpatient emergency health services are covered both inside and outside of the ArchCare Senior Life service area. Prior authorization is not required for emergency care. In the event of an emergency, ArchCare Senior Life instructs its Members to seek immediate care, or call 911 for assistance. ArchCare Senior Life will not deny payment if an ArchCare Senior Life contracted health care Provider instructs a Member to seek emergency services.

Enrollment in ArchCare Senior Life includes coverage for post-stabilization care, defined as non-emergency services needed to ensure the Member remains stabilized after an emergency. In the post-stabilization period, for services on the ArchCare Senior Life Prior Authorization list, Providers should only provide services authorized by the Medical Management Department. Unauthorized services will not be paid by ArchCare Senior Life unless it is an emergency or ArchCare Senior Life fails to respond to an authorization request within one hour of being contacted for urgently needed or post-stabilization services.

Urgently needed services are defined as those conditions which require immediate medical attention due to unexpected illness or injury. Fevers, abdominal pain, nausea and vomiting and difficulty urinating are some examples of situations requiring urgently needed services.

Urgent care services are covered for Members when they are temporarily outside of the ArchCare Senior Life service area. Providers must notify ArchCare Senior Life within 24 hours or the next business day of providing emergency or urgent services to an ArchCare Senior Life Member, or if the Member is admitted to a hospital.

Members are encouraged to carry their ArchCare Senior Life identification card at all times and to notify

their care manager or Provider should they need urgent or emergency care.

LOGISTICS AND CARE COORDINATION

Office Appointments, Transportation, Documents and Orders

There are a number of workflows that are routine for ArchCare Senior Life but not for the CBPCP and their office staff. Not understanding the ArchCare Senior Life process results in duplication of effort and or miscommunication leading to frustration of all parties involved in the management of the Member. Federal regulations require ArchCare Senior Life to keep a medical record for each Member at the ArchCare Senior Life site to which they are assigned regardless of whether there is a medical record in the CBPCP office. With this in mind, a key logistical issue is sending orders for the CBPCP to sign, placing a signed copy in the CBPCP chart and one in the ArchCare Senior Life Center record. Another is moving notes and other documentation to and from the CBPCP office that need to be placed in both the CBPCP medical record and the Member's medical record in the ArchCare Senior Life Center. ArchCare Senior Life is accountable for making Member appointments for routine follow up visits (even to the CBPCP office), specialty referrals, laboratory and imaging studies, and for elective procedures. ArchCare Senior Life is also accountable for arranging Member transportation for appointments, ensuring the Member attended the scheduled appointment and obtaining results for review by the Primary Care Physician.

In an effort to seamlessly manage these issues in conjunction with the CBPCP office staff, a centralized unit has been set up to manage all of these work flows. Centralizing order and document management prevents lost and or duplication of orders and documentation; it creates a centralized point for document retrieval and office communication; maintains receipts of orders and documents and disburses them to the appropriate offices and centers for filing. Centralization ensures effective communication because there is always someone present to answer the phone and pick up messages or faxes; provide guidance to the offices and troubleshoot issues and complaints.

A general orientation will be given by the ArchCare Senior Life HCN assigned to the CBPCP office and the unit Director with regard to processes the office staff needs to follow for scheduling appointments for return visits and consultations; diagnostic tests and imaging studies; arranging for transportation and escort services; ensuring appointments are kept; documentation management; and following up on obtaining consultation reports for physician review. The unit contact number is 855- 720-9268. It is also located in the Important Numbers And Forms section of this manual.

ASSESSMENTS AND CARE PLANS

ArchCare Senior Life regulations require that a patient have an initial assessment (history and physical, medical diagnoses and medical treatment plan) when they become a Member and a semiannual assessment thereafter by their Primary Care Physician as part of the semiannual care plan development for each Member. ArchCare Senior Life provides a NP to assist the CBPCP with this process. The NP will perform this assessment for the CBPCP's ArchCare Senior Life patients. After the assessment is completed, the NP will arrange to meet with the CBPCP to review it. Once the assessment is reviewed, and if necessary edited by the CBPCP, it must be signed and a copy must be placed in the CBPCP's medical record for the Member. A copy will also be placed in the ArchCare Senior Life Member's record in the Center. Information from this assessment will be used along with information from the assessments performed by the other Members of the IDT to create the Member's semiannual care plan.

The NP will represent the CBPCP at the IDT meetings for care plan development. After the care plan is developed it will be brought to the CBPCP by the NP for review and signature along with the orders necessary to implement it, which also will require the CBPCP's signature.

Each Member is assigned to a HCN. Every attempt will be made to assign all of a CBPCP's ArchCare Senior Life Members to one HCN. Care coordination and management to resolve problems and achieve goals outlined on the care plan is an ongoing process that is primarily managed through the HCN. The HCN will visit the CBPCP office biweekly. Their role includes educating the office staff on the appropriate procedures for utilization management, referral management, transportation management and notification for medication changes. The HCN is accountable for reviewing the Member's initial care plan with the CBPCP and subsequent changes in the care plan related to semiannual assessments and/or significant changes in the Member's health status (e.g. after discharge from a hospital or SNF); obtaining Primary Care Physician signoff on the plan; a signature for the attendance at the IDT meeting, and a signature for the orders necessary to implement the care plan.

The HCN is also accountable for discussing Member issues related to interim IDT discussions or from the ArchCare Senior Life morning report with the CBPCP either in person or by phone. On a monthly basis the HCN is accountable for bringing orders to the CBPCP 's office from the central unit that require the Primary Care Physician's signature and bringing signed orders back to the central unit. On a monthly basis the HCN is accountable for reviewing all the CBPCP's ArchCare Senior Life Members with the CBPCP with regard to changes in diagnoses, medications and treatment plans; care plan intervention results; laboratory, specialty referral and imaging results; and ensuring this information is placed in the progress note section of the Member's medical record at the ArchCare Senior Life Center.

In addition to office visits every two weeks, the HCN should accompany any of the CBPCP's Members who are classified as severe or high risk to their office visit with the CBPCP to ensure the Member

understands and complies with the treatment plan offered at the time of the visit.

QUALITY PARAMETERS FOR COMMUNITY BASED PRIMAY CARE PHYSICIANS

Federal and state requirements related to service delivery in the ArchCare Senior Life program require the IDT to identify Member problems and complications, determine appropriate treatment goals, select care interventions and evaluate the effectiveness of care on an individual and program basis. This activity is the foundation for all of ArchCare Senior Life's Quality Assurance Performance Improvement Program (QAPI) parameters. Each year the ArchCare Senior Life Quality Management Committee develops a written QAPI plan for its program that deals with the elements noted above. Throughout the year plan components are tracked and reported on a quarterly, semiannual and annual basis both internally and to the Centers for Medicare and Medicaid Services (CMS) and the New York State Department of Health (NYSDOH).

Some of the plan's quality parameters require input from or management by the CBPCP. ArchCare Senior Life feels that meeting these parameter targets is essential for providing high quality service and care to its Members. Based on this concept, ArchCare Senior Life has established a Quality Bonus for CBPCP's that can be achieved by successfully assisting ArchCare Senior Life in achieving the targets set for some of the QAPI parameters. The CBPCP Quality Bonus structure with the quality parameters and targets is found in Exhibit D in the CBPCP contract.

Some of these parameters include tracking the infections acquired by their ArchCare Senior Life Members (UTI, wound, pneumonia, etc.) and their treatment outcomes and providing this information to the HCN who comes to their office and is assigned to the Member. Additional examples include:

1. Tracking falls reported by Members that resulted in the need for medical intervention and relaying this information to the HCN.

2. Ensuring that 85% of ArchCare Senior Life Members in the practice have a vaccination on an annual basis for influenza and 90% have been vaccinated for pneumonia.

3. Ensuring that 95% of their ArchCare Senior Life Members have had a discussion related to advanced directives and at a minimum have a healthcare proxy.

4. Other parameters include:
    a. Timely responsiveness to requests by the HCN related to Member care management, orders and review of care plans
    b. Responsiveness to the ArchCare Senior Life Clinical Pharmacist with regard to medication reviews related to their Member
    c. Timely review of the Member's semiannual assessment with the Nurse Practitioner assigned to assist with this process
    d. Timely submission of encounter data (superbills) related to each office visit with their Member who is participating in ArchCare Senior Life
    e. Achieving a satisfactory score on a Member satisfaction survey
    f. Achieving the quality bonus is a reflection of the quality of care ArchCare Senior Life Members are receiving in your practice.

CREDENTIALING AND RECREDENTIALING

All health care, environmental and social service providers, providing health services to ArchCare Senior Life participants must be credentialed in accordance with ArchCare Senior Life policies and procedures. Under CMS regulation, the credentialing process and approval must be completed by any network provider administering care to an ArchCare Senior Life participant. Re-credentialing will occur every three years thereafter for all contracted health care providers, facilities, and hospitals.

The following items are required along with the provider/ancillary credentialing applications in order to complete the credentialing process:

Physician and Health Care Providers

- Current Curriculum Vitae
- Work history past five years
- Current valid State license to practice
- Valid DEA & CDS (controlled dangerous substances) certificates
- Education and Training
- Copy of Insurance Certificate
- Board Certification status
- Hospital admitting privileges
- Disclosure Statement and Signed Attestation
- Verification of "Opt Out" or Private Contract from Medicare participation
- History of professional liability claims that resulted in settlements or judgments paid by the or on behalf of practitioner

Facility Credentialing

- Medicare and/or Medicaid license
- Copy of New York State Operating License
- Copy of Insurance Certificate
- Copy of any accreditations and/or surveys
- A copy of any notice of disciplinary actions taken within the past five years by the New York State Department of Health or other government agency that regulates the services by the provider;
- A copy of any notice of sanctions imposed upon the provider within the past five years by the Medicare or Medicaid program;

Skilled Nursing Facility Credentialing

- Medicare, Medicaid or JCAHO accreditation
- NYSDOH Cash Assessment Letter/Benchmark Rate Letter
- Copy of License
- Copy of Insurance Certificate
- State Survey and any Plan of Correction
- Copy of last 3 years of federal and state surveys including any corrective action plans.

Appeals Process for Providers Terminated or Rejected from the ArchCare Senior Life Provider Network.

A provider has the right to appeal a Peer Review and Credentialing Sub-Committee decision that has negatively impacted the provider. ArchCare Senior Life complies with all state and federal mandates with respect to appeals for providers terminated or rejected from the ArchCare Senior Life Provider Network. ArchCare Senior Life notifies the provider in writing of the reason for the denial, suspension and termination. Terminated or rejected providers may submit a request for an appeal as outlined in the letter of rejection/termination sent by ArchCare Senior Life. In addition, the request for appeal must be received by ArchCare Senior Life within ten (10) days of the date of the rejection/termination letter. Upon receipt of the letter by ArchCare Senior Life, the appeal is forwarded to the ArchCare Senior Life Peer Review Committee for review and further processing ArchCare Senior Life will ensure that the majority of the hearing panel members are peers of the affected physician.

Provider Monitoring & Evaluation

ArchCare Senior Life, DOH, CMS and their designees shall each have the right, during provider's normal operating hours, and at any other time a contractor function or activity is being conducted, to monitor and evaluate, through inspection or other means, provider's performance, including, but not limited to, the quality, appropriateness, access to service and timeliness of services provided under the provider contract.

All providers are required to cooperate with and provide reasonable assistance to ArchCare Senior Life, DOH, CMS and their designee in the monitoring and evaluation of the services provided a copy of any notice of disciplinary actions taken within the past five years by the New York State Department of Health or other government agency that regulates the services by the provider; under the provider contract.

A copy of any notice of sanctions imposed upon the provider within the past five years by the Medicare or Medicaid program; the credentialing process is considered complete when the credentialing committee approves the credentialing application. Once the credentialing process has been completed, and an executed contract is received and countersigned, the physician or health care provider will be considered participating. The physician or health care provider will use their NPI (National Provider Identification) number as their “provider number”.

Delegated Credentialing

ArchCare Senior Life offers delegated credentialing for large groups of health care providers. ArchCare Senior Life delegates the credentialing function to groups that meet ArchCare Senior Life and National Committee for Quality Assurance (NCQA) standards and state and federal law. The decision by ArchCare Senior Life to delegate the credentialing function results from a review of the group’s credentialing policies and procedures and an on-site audit of the group’s credentialing files. The ArchCare Senior Life Credentialing Committee reviews the resulting delegation report and makes a determination to approve, defer or grant provisional delegated status for the group. If provisional status is granted, this is followed by a reassessment within a specified period of time and a final decision to approve or defer. Groups granted “delegated status” are required to sign a delegated credentialing agreement with ArchCare Senior Life.

Medical Record

As part of the re-credentialing process ArchCare Senior Life will review on a quarterly basis medical quality and utilization management data on an aggregate basis. This tracking and reporting of data supports analysis of trends and outliers across sites and within specific service areas. Pharmaceutical management and utilization practices is tracked and discussed quarterly by the Medical Director. ArchCare Senior Life newly hired

Provider's and mid-level practitioners receive competency and orientation checklist which is reviewed and signed off by the Medical Director. The ArchCare Senior Life Medical Director administers and completes the competency evaluation initially and is on-going.

Prior to the physician date for recredentialing, a provider relations representative will contact the Medical Director of ArchCare Senior Life to determine current performance evaluations and job competencies meet standards for re-credentialing.

Provider Information

Providers are responsible for contacting ArchCare Senior Life to report any changes in their practice. It is essential that ArchCare Senior Life maintain an accurate provider database in order to ensure proper payment of claims and capitation, to comply with provider information reporting requirements mandated by governmental and regulatory authorities, and to provide the most up-to-date information on provider choices to our participants. Any changes to the following list of items must be reported to ArchCare Senior Life within 30 (thirty) days of the change, using our Provider Change Request Form attached in the appendix of this manual:

- Provider's name and Tax ID number(s)
- Provider's address, zip code, telephone or fax
- Provider's billing address
- Languages spoken in the provider's office
- Wheelchair accessibility
- Provider's NY license (e.g., revocation, suspension)
- National Provider Identification Number (if applicable)
- Provider's board eligibility/board certification status
- Hospital affiliation status

Please use the "Provider Information Update Form" Found in Important Phone Numbers and Forms Section in this manual.

Adverse Credentialing Determination Appeals As a network provider, you have the right to:

- Review information submitted to your credentialing application.
- Correct erroneous information collected during the credentialing process.
- Be informed of the status of your credentialing or re-credentialing application.
- Be notified of these rights.

Requests for Additional Information

If ArchCare Senior Life receives information from an outside source that differs substantially from information you have provided us, we will contact you directly as soon as the discrepancy is noted and request your clarification in writing within 10 business days. Requests should be made in writing to:

ArchCare Senior Life
Attention: Credentialing Department
205 Lexington Ave, 8th Flr
New York, NY 11016

PROVIDER NETWORK AND PROVIDER RELATIONS

The Provider Relations Department of ArchCare Senior Life establishes, maintains, and supports the provider network. The Provider Relations Department is responsible for provider recruitment, contracting, credentialing and re-credentialing. Once providers join the network, Provider Relations staff orients them to ArchCare Senior Life's program, policies and procedures and keeps them up-to-date on information regarding the HMO SNP. In addition, Provider Relations staff reviews and updates all contracts as needed and investigates and resolves all contract provider-related complaints.

PROVIDER NOTICES

ArchCare Senior Life contacts individual providers as needed to maximize care and service to Members, and oversees contractual requirements. Staff contacts providers by telephone, email and fax. Provider Relations staff will send providers information regarding any important changes in our policies and procedures to keep all providers up-to-date.

RE-CREDENTIALING

All contracted providers are re-credentialed every 3 years. The re-credentialing process requires the provider to send updated information. ArchCare Senior Life will also perform a review of provider PI Indicators which may include the following:

- Member/family complaints
- Information from QAPI activities
- Member satisfaction surveys

The provider is notified in writing of the re-credentialing decision if it is denied. The provider is informed at that time in writing of their right to appeal the decision.

PROVIDER RIGHTS AND RESPONSIBLITIES

Provider Rights:

ArchCare Senior Life's providers can act within the scope of their license to advise or advocate for Members on the following issues:

- Health status of Care Plan options that would include providing sufficient information to the Member to decide among various service options.
- Filing a complaint or making a report of comment to an appropriate governmental body regarding ArchCare Senior Life policies, if the provider believes that the policies negatively impact the quality of, or access to care.

Provider Responsibilities:

ArchCare Senior Life's provider's responsibilities include:

- Provision of quality care within the scope of practice as defined by ArchCare Senior Life and in accordance with ArchCare Senior Life 's access, quality and participation standards;

- Adherence to ArchCare Senior Life ’s clinical guidelines;
- Provide care to Members without regard to age, race, sex, religious background, national origin, disability and sexual orientation, source of payment, veteran status, claims experience, social status, health status, or marital status;
- Comply with Americans with Disabilities Act (ADA) guidelines set forth by the Department of Health;
- Maintenance of proper billing practices with submission of claims that are verifiable electronically by telephonic systems such as Santrax, CellTrack, HHAeXchange, SanData, etc., for service hour provision as available and can be accessed at any time by ArchCare Senior Life.
- Maintain Member confidentiality and maintain PHI in compliance with HIPAA regulations;
- Report the abuse of Members immediately to Provider Relations at 855-467-9351.

The following are types of elder abuse/maltreatment/neglect to which all health care providers must be alert for:

- **Physical Abuse** – The infliction of injury, confinement, or punishment that results in physical harm to the person. Examples include:
    - Hitting pushing, pinching, shaking or shoving the person;
    - Restraining the person;
    - Using too hot or too cold bath water during care;
    - Improper use of medications.

- **Sexual abuse** – Any sexual contact that results from threat, force, or the inability of the person to give consent, including but not limited to, assault, rape, or sexual harassment. Examples include:
    - Intimately and inappropriately touching a member during bathing, dressing or any care necessary for the patient that is NOT indicated for treatment or care to that patient;
    - Male/female patient, family or staff fondling a confused patient;
    - Any sexual activity where both parties cannot or do not give full consent;
    - Exposing the member/taking away the member’s privacy.

- **Psychological/Emotional Abuse** – The threat of injury, confinement, punishment, verbal intimidation or humiliation which may result in mental harm such as anxiety or depression. Examples include:

    - Ignoring the member;
    - Using baby talk/demeaning language;
    - Prohibiting free choice;
    - Threatening the member;
    - Exposing the member/taking away the member’s privacy.

- **Neglect** – There are two types of neglect:

    - **Active Neglect** – The willful deprivation of goods or services which are necessary to maintain physical or mental health. Examples:
        - Purposely withholding food or other items;
        - Not assisting a participant who needs or requests help;
        - Knowingly postponing care because of some personal activity;
        - Not delivering mail or messages promptly and confidentially;

    - **Passive Neglect** – The deprivation of goods and services without conscious intent to inflict physical or emotional distress. Examples:

- Failure to fulfill a caretaking obligation including abandonment or isolation, denial of food, shelter, clothing, medical assistance or personal needs, or the withholding of necessary medications or assistive devices (e.g. hearing aids, glasses).

- **Financial Abuse (Misappropriation of Funds)** – Improper conduct with or without informed consent of the resident that results in monetary, person or other benefit, gain, or profit for the perpetrator, or monetary or personal loss for the member. Examples:
    - Stealing or helping oneself to the resident's property;
    - Not treating reports of theft seriously;
    - Not returning change after making purchases for the patient;
    - Borrowing from one resident for another without permission.

Abuse Prevention – ISTRIPP

I – Identify suspected incidents
S – Screen new employees
T – Train on abuse and prevention
R – Report to DOH
I – Investigate Events
P – Prevent by supervising and care planning
P – Protect member during investigation

Reporting

If a Provider suspects Member abuse, the Provider must immediately notify Provider Relations at 855-467-9351and the Member's CMT. In addition, Providers must initiate the proper notifications to an agency or authority that are required by the law in effect at the time. For example, in New York City, providers must report Member abuse to Adult Protective Services at (212) 630-1853.

LHCSA and CHHA Incident Logs

LHCSA and CHHA Providers are required by DOH to maintain incident logs that include incidents relating to Member abuse. Providers must present these logs to the ArchCare Compliance Department, upon request.

All Providers are required to:

- Comply with all regulatory and professional standards of practice and are responsible to acquire physician orders whenever required by regulation or local, state or federal law as well as for determination of medical necessity and/or 3rd party reimbursement. The Case Manager/Team may assist in obtaining orders if the Provider has been unsuccessful.
- Notify ArchCare Senior Life immediately whenever there is identification of a clinical issue of serious concern, change in Member status, refusal of service, inability to access Member's home, or inability to provide service for any reason.
- Communicate verbally and in writing on a timely basis regarding the nature and extent of services provided to the Member and the Member's progress and status.
- Cooperate with ArchCare Senior Life on any grievance, appeal, or incident investigations as required. Incident reports must be submitted to ArchCare Senior Life within 10 working days of

request.
- Communicate to ArchCare Senior Life complaint made by or on behalf of the Member.
- Cooperate with ArchCare Senior Life's quality assurance and improvement programs (QAPI) as needed.
- Assure that all Provider's employees and agents involved in direct contact with Members carry proper Agency identification.
- Notify ArchCare Senior Life of the provision of any unauthorized urgent services within 48 hours.
- Prior to the addition of any new Provider owner, director, employee, agent, contractor or referral source, and on a monthly basis thereafter, Provider shall confirm that such individuals and entities are not Excluded by checking the excluded parties lists maintained by the New York State Office of the Medicaid Inspector General, the United States Department of Health and Human Services Office of Inspector General, and the United States General Services Administration;

In addition:

DME and Medical Supply Providers are responsible for:

- Verifying primary payor coverage and eligibility prior to delivery;
- Acquiring physician orders whenever required by regulation or local, state or federal law as well as for determination of medical necessity and/or 3rd party reimbursement;
- Exhausting all other payment sources prior to billing ArchCare Senior Life ; and,
- Timely delivery of requested products.

Note: It is the responsibility of the provider to determine whether Medicare covers the item or service being billed. If the service or item is covered or if the provider does not know if the service or item is covered, the provider must first submit a claim to Medicare, as ArchCare Senior Life is always the payer of last resort.

If the item is normally covered by Medicare but the Provider has prior information that Medicare will not reimburse due to duplicate or excessive deliveries, the information should be communicated to the ArchCare Senior Life Case Manager prior to delivery.

ARCHCARE SENIOR LIFE 'S RESPONSIBILTIES TO PROVIDERS

ArchCare Senior Life recognizes its obligation to assure providers the following:

- Comprehensive plan training and orientation programs;
- Timely and on-going communication from knowledgeable staff;
- Assistance with Primary Care Physician issues; i.e., order signing etc.;
- Timely payment for covered services rendered to Members;
- Timely responses to questions or concerns;
- Assistance with complex Member issues;
- Timely resolution of grievances and appeals; and,
- Constructive feedback on performance and utilization.

PROVIDER CONFIDENTIALITY

ArchCare Senior Life respects its relationship with providers. Implicit in this agreement are the values of maintaining confidentiality, non-disclosure and return of trade secrets and intellectual property of ArchCare Senior Life and the providers. Breaches of those values by either ArchCare Senior Life or its providers must be reported immediately to the other party, whether or not the breach was intentional. Providers will sign a confidentiality agreement form as part of the credentialing process.

Medical records are documents that contain information about the Members' medical treatments. To safeguard their privacy, this information can only be released with the Members written consent or if required by law. In compliance with federal and state requirements, providers should:

- Maintain confidentiality policies based on good practices and legal requirements;
- Require all employees to sign a confidentiality statement as well as to adhere to Standards of Conduct that prohibit the release of a Members' personal identifiable health information;
- Release identifiable Member information only when consent is provided; and,
- Obtain Member consent to use his/her identifiable information for general treatment, coordination of care, quality assessment, utilization review, fraud detection, or accreditation purposes. Member-identifiable information used for any other purpose requires clear and specific consent from the Member.

NON DISCLOSURE

Providers and employees, agents or independent contractors of the Provider (deemed to be the provider) may not disclose to third parties ArchCare Senior Life trade secret and/or intellectual properties, whether such information is marked confidential without the prior written consent of ArchCare Senior Life . The provider must take reasonable steps to safeguard ArchCare Senior Life's trade secret and intellectual property to prevent unauthorized or improper use or copying. Provider promises to return (or destroy at the option of ArchCare Senior Life) any and all ArchCare Senior Life 's trade secret and intellectual property that can reasonably be returned or destroyed to ArchCare Senior Life or designee.

TERMINATION OF PROVIDER AGREEMENT

Termination by ArchCare Senior Life

ArchCare Senior Life may at its option, terminate the Agreement immediately and without notice to the Provider in the event of: a) conduct by the Provider or employee(s) which in the judgment of ArchCare Senior Life poses and imminent harm to the Member; b) the provider cannot deliver the services authorized for the Member; c) a determination by ArchCare Senior Life that the provider or the provider employees or agents have committed fraud; d) a final determination that the state licensing board or other governmental agency has found that the provider has been suspended, terminated or denied approval to participate in the New York State Medicaid Program.

Termination by the Provider

If ArchCare Senior Life defaults in the performance of any material duty or obligation hereunder, the provider, at their option may give ArchCare Senior Life written notice identifying the alleged default or breach and if ArchCare Senior Life does not cure such default or breach within 30 calendar days, provider at their option, may terminate the Agreement per the terms of the provider agreement and upon written notice to

ArchCare Senior Life.

When a Providerprovider leaves the plan for reasons other than fraud, loss of license, or other final disciplinary action impairing the ability to practice, ArchCare Senior Life will authorize our Member to continue an ongoing course of treatment for a period of up to ninety (90) days. The request for continuation of care will be authorized provided that the request is agreed to or made by the Member, and the provider agrees to accept ArchCare Senior Life's reimbursement rates as payment in full. The provider must also agree to adhere to ArchCare Senior Life's quality assurance requirements, abide by policies and procedures, and supply ArchCare Senior Life with the necessary medical information and encounter data related to the Member's care. The Medical Director along with the CMT and the family/caregiver of the Member will assist with and coordinate the transition of care plan.

PROVIDER PARTICIPATION IN ARCHCARE SENIOR LIFE

ArchCare Senior Life values its relationship with our providers and the perspective that both parties bring to maximizing care and efficient operations. Informal access is always available to providers through the Provider Relations Department. ArchCare Senior Life welcomes input and participation by providers through internal committee involvement and completion of provider satisfaction surveys.

COMMITTEE PARTICIPATION

Providers are selected to participate in committee activities. ArchCare Senior Life's committees, such as the Quality and Utilization Management Committee, explores care and operational quality indicators. No provider may review any case in which their agency or self is professionally involved as it is noted to be a conflict of interest. When reviewing cases, the provider makes decisions only on the appropriateness of care and service. ArchCare Senior Life requires staff and committee participants to sign a Conflict of Interest statement on an annual basis. ArchCare Senior Life will exclude providers who refuse to sign the conflict of interest statement.

PROVIDER SATISFACTION SURVEY PARTICIPATION

Provider input is welcomed at all times. ArchCare Senior Life also conducts periodic surveys of provider satisfaction. Results will be used to determine system and operational improvements to maximize clinical outcomes and operational effectiveness.

GENERAL BILLING AND CLAIM SUBMISSION REQUIREMENTS

Payment for services rendered is subject to verification that the member was enrolled in ArchCare Senior Life at the time the services was provided and to the provider's compliance with the ArchCare Senior Life Clinical Services and prior authorization policies at the time of service.

Providers must verify member eligibility at the time of service to ensure the member is enrolled in ArchCare Senior Life. Failure to do so may affect claims payment. Note, however, that members may retroactively lose their eligibility with ArchCare Senior Life after the date of service. Therefore, verification of eligibility is not a guarantee of payment by ArchCare Senior Life.

SUBMITTING CLAIMS ELECTRONICALLY

Through the partnership with Peak TPA, claims may be submitted electronically through 4 clearinghouses: Smart Data Solutions, Change Healthcare, Ability, and Trizetto. Claims submitted electronically receive status reports indicating the claims are accepted, rejected and/or pending.

Claims submitted electronically must include:

1. The ArchCare Payer ID Number 27034 on each claim.
2. A complete ArchCare Senior Life Member ID Number.
3. A National Provider Identifier (NPI).

To sign up for electronic billing please contact the clearinghouse directly.

Smart Data Solutions 855.297.4436 https://sdata.us/contact/

Change Healthcare 800.494.3188 info@mdsmed.com

Ability 888.558.0569 https://www.abilitynetwork.com/about/contact/

TriZetto 800.969.3666 providersales@cognizant.com

Additional software vendors and clearinghouses may transmit claims. Providers should verify transmission with vendor prior to claim submission to ensure timely receipt and accurate processing of claims.

SUBMMITTING PAPER CLAIMS

(Effective 11/1/2021) All paper claims must be submitted to:
ArchCare Senior Life
PeakTPA
P.O. Box 21631
Eagan, MN 55121

Note for group practices and facilities: When submitting claims, please ensure separate billing NPI and provider NPI numbers are entered in the appropriate fields. Office visit claims submitted for the group practice, with the group practice NPI number instead of the individual NPI number for the servicing provider, cannot be processed.

CLAIMS SUBMISSION AND ENCOUNTER DATA

ArchCare is required to report encounter data to New York State, CMS and other regulatory agencies, which lists the types and number of healthcare services members receive. Encounter data is essential for claims processing and utilization reporting as well as for complying with the reporting requirements of CMS, New York State and other governmental and regulatory agencies. It is essential that this information be submitted in a timely and accurate manner.

For participating providers who are paid on a fee-for-service basis, the claim usually provides the encounter data ArchCare requires. In addition, participating ArchCare providers reimbursed on a capitated basis are still required to submit claims so that encounter data is reported to ArchCare.

REQUIRED DATA ELEMENTS AND CLAIM FORMS

Prior to being adjudicated, all claims are reviewed for completeness and correctness of the data elements required for processing payments, reporting and data entry into the ArchCare Senior Life claims processing system. If the following information is missing from the claim, the claim is not 'clean' and will be rejected:

Data Element	**CMS 1500**	**UB-04**
Patient Name	X	X
Patient Date of Birth	X	X
Patient Address	X	X
Patient Gender	X	X
ArchCare Senior Life Member ID Number	X	X
Coordination of Benefits (COB / other insured's medical insurance coverage information.)	X	X
Date(s) of Service	X	X
ICD – 9 Diagnosis Code(s) including 4th and 5th digit, when required	X	X
CPT- 4 Procedure Code(s)	X	X
HCPCS Code(s)	X	X
Service Code Modifier(s), when required	X	X
Place of Service	X	
Service Units	X	X
Charges per Service and total charges	X	X
Provider Name	X	X
Provider Address / Phone Number	X	X
National Provider Identifier - NPI	X	X
Tax ID Number	X	X
ArchCare Senior Life Payer ID Number 27034 – for EDI	X	X

Hospital / Facility Name and Address		X
Type of Bill		X
Admission Date and Type		X
Patient Discharge Status Code		X
Condition Code(s)		X
Occurrence Codes and Dates		X
Value Code(s)		X
Revenue Code(s) and corresponding CPT / HCPCS Code(s)		X
Health Insurance Prospective Payment System (HIPPS) Rate		X
Principal, Admitting, and Other ICD – 9 Diagnosis Codes		X
Present on Admission (POA) indicator, as applicable		X

REQUIREMENTS FOR BILLING BY FACILITIES (SKILLED NURSING FACILITY (SNF) AND HOME HEALTH (HH) AGENCIES)

Facility claims must be submitted on the UB-04 or on electronic media (837I):

- Report the name and NPI of the attending provider in Field 76.

Professional services that are not part of the facility claim should be billed on a CMS 1500 form or on electronic media (837P).

TIME FRAMES FOR CLAIM SUBMISSION, ADJUDICATION AND PAYMENT

TIMELY CLAIM SUBMISSION

Both in-network and out of network providers are encouraged to submit all claims within thirty (30) days from the date of service for prompt adjudication and payment. Claims must be submitted within one hundred twenty (120) days from the date of service or within the time period set forth in the provider's agreement with ArchCare Senior Life. Claims submitted outside of aforementioned timeframes will not be paid except under the reasons outlined in the Late Claim Submission below. In no event will ArchCare Senior Life pay claims submitted more than one year from the date of service.

LATE CLAIM SUBMISSION

In certain circumstances, ArchCare Senior Life will process claims submitted outside of timely filing defined above. Please note that 'unclean' claims that are returned to the provider for necessary information are adjudicated according to the original date of service. They do not fall into the category of exceptions to required timely filing limits.

The following situations allow for special handling of claims. Claims must be submitted with a written explanation and appropriate documentation showing the date the claim came within the provider's control:

Reason for Delay	
Litigation involving payment of the claim	Within ninety (90) calendar days from the time the submission came within the provider's control
Medicare or other third party processing delays affecting the claim	Within thirty (30) calendar days from the time the submission came within the provider's control
Delay in member eligibility determination	Within thirty (30) calendar days from the time of notification of eligibility (submit with documentation substantiating the delay)
Member's Enrollment with ArchCare Senior Life was not known on the date of service	Within ninety (90) days from the time the member's enrollment is verified. Providers must make diligent attempts to determine the member's coverage with the Plan.

COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) ensures that the proper payers are held responsible for the cost of healthcare services and is one (1) of the factors that can help hold down copayments. ArchCare Senior Life follows all standard guidelines for COB. Members are asked to provide information about other medical health insurance plans under which they are covered.

ARCHCARE SENIOR LIFE IS ALWAYS THE SECONDARY PAYER IN THE FOLLOWING CIRCUMSTANCES

 Workers compensation

Automobile medical

 No-fault or liability auto insurance

ARCHCARE SENIOR LIFE DOES NOT PAY FOR SERVICES PROVIDED UNDER THE FOLLOWING CIRCUMSTANCES WHEN THERE IS COB

- The Department of Veterans Affairs (VA) or other VA facilities (except for certain emergency hospital services)
- When VA-authorized services are provided at a non-VA hospital or by a non-VA provider

ArchCare Senior Life will use the same guidelines as Medicare for the determination of primary and secondary payer. As a result, ArchCare Senior Life is the secondary payer for all of the cases listed above as well as for the following:

- Most Employer Group Health Plans (EGHP)
- Most EGHPs for disabled members
- All benefits payable under an EGHP in the case of individuals who are entitled to benefits solely or partly on the basis of end stage renal disease (ESRD) during a period of thirty (30) months. (This applies to all services, not just ESRD. If the individual entitlement changes from ESRD to over sixty-five (65) or disability, the coordination period will continue.)

EXPLANATION OF PAYMENT (EOP)

The EOP describes how claims for services rendered to ArchCare Senior Life members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim.

The EOP includes the following elements (see Appendix A for a sample of the EOP):

- Payer's Name
- Vendor Name and Identification (ID) Number
- Provider Name and Identification (ID) Number
- Patient's Name
- Member's Identification (ID) Number
- Claim Date of Service
- Service
- Total Billed Charges
- Allowed Amount
- Explanation for Denied Charges
- Amount Applied to Deductible
- Co-payment/Co-insurance Amount
- Total Payment Made and to Whom

The EOP is arranged by vendor by provider. Each claim represented on an EOP may be comprised of multiple rows of text. The line number indicated to the left of the date of service identifies the beginning and end of a particular claim. Key fields that indicate payment amounts and denials are as follows:

- **Paid Claim Lines**: If the "Paid Amount" field reads greater than zero (0), the claim line was paid in the amount indicated.
- **Denied Claim Lines**: If the "Not Covered" field is greater than zero (0) and equal to the charged amount, the service was denied.
- **Claim Processed as a Capitated Service**: If the "Paid Amount" field is zero (0), but the EOP Explanation Codes is '171' – Capitated Covered Services, the service was processed as a Capitated Service.
- **End of Claim**: Each claim is summarized by a claim total. If there are multiple claims for a single member, the EOP also summarizes the total amount paid for that member.

ELECTRONIC REMITTANCE & ELECTRONIC FUND TRANSFER

Electronic Remittance Advice are accessible online through Payspan Health. To establish an account, follow the information here: https://www.payspanhealth.com/NPS/Support/Index Or call 877-331-7154, Option 1.

CLAIM STATUS INQUIRIES, CLAIM RECONSIDERATION AND APPEAL PROCESS

Claim Status Inquiries

Providers may call Provider Services at 800-373-3177 to request a claim status. Providers can view claim status online using the Peak provider portal. If you are a network provider and require assistance with the Peak provider portal, email: providerportal@peak.cpstn.com.

Requests for Reconsideration of a Claim or Appeal

Please note that the process described here does not apply to utilization management determinations concerning medical necessity. See appropriate section for information on medical management appeals.

A provider may be dissatisfied with a decision made by ArchCare Senior Life regarding a claim determination. Some of the common reasons include, but are not limited to:

- Claim was incorrectly processed
- Denial of a service / claim
- Denial for the untimely submission of claim(s)
- Failure to obtain prior authorization

Providers who are dissatisfied with a claim determination made by ArchCare Senior Life must submit a written request for review and reconsideration with all supporting documentation **within sixty (60) business da**ys from ArchCare Senior Life's initial date of action that led to the dispute, to the following address:

ArchCare Senior Life
205 Lexington Avenue, 8th Floor
New York, NY 10016
Attention: Provider Disputes

Provide a clear explanation of the basis upon which you believe the initial determination/action is incorrect along with all supporting documentation and a copy of the Explanation of Payment (EOP) or include:

- The provider's full name
- The provider's identification number
- The provider's contact information
- The Member's name and ArchCare Senior Life 's Member identification number
- Date(s) of service
- The ArchCare Senior Life claim(s) number
- A copy of the original claim or corrected claim, if applicable

ArchCare Senior Life will investigate all written requests for review and reconsideration and issue a written explanation stating that the claim has been either reprocessed or the initial denial has been upheld within **60 calendar days** from the date of receipt of the provider's request for review and reconsideration.

ArchCare Senior Life will not review or reconsider claim determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and

reconsideration after the **60 business day** time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services irrespective of the merits of the underlying dispute if the request for review and reconsideration is not timely filed. In such cases providers may not bill members for services rendered.

Corrected Claim Submission

Corrected Claims must be submitted within 60 days from the original adjudication date. When submitting a correction to a previously submitted claim, re-submit the entire claim with the corrected/updated information. (i.e., diagnosis codes, procedure codes, dates of service, etc.). Remember to identify that the claim is a resubmission by checking the appropriate code on either an electronic claim or paper claim form.

What is a Corrected Claim?

If a claim is submitted and later found to contain errors or incorrect information, certain data elements can be corrected and/or added and it can resubmitted to ArchCare within the appropriate timeframe for consideration. This resubmission is a corrected claim. The data elements that can be corrected or added are:

- Diagnosis code
- Number of Units
- Revenue code
- Total Charges
- Dates of service
- Procedure codes
- Modifiers
- Place of service
- Late charges
- Member information
- Provider information

Overpayments

Provider Identification

Notice and Correction of Payment Errors. Providers shall notify ArchCare of any overpayments or payments made in error within ten (10) business days of becoming aware of such overpayments or erroneous payments, and return or arrange for the return of any such overpayment or payment made in error.

Providers with overpayments must voluntarily submit a refund check made payable to ArchCare within 30 calendar days from the date of becoming aware.

Refund check should be mailed to:

ArchCare Senior Life
205 Lexington Avenue, 8th Floor
New York, NY 10016
Attention: Provider Disputes

Plan Identification

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

ArchCare Senior Life will not pursue overpayment recovery efforts for claims older than twenty-four (24) months after the date of the original payment to a provider unless the overpayment is:

- Based upon a reasonable belief of fraud, intentional misconduct or abusive billing;
- Required or initiated by the request of a self-insured plan or,
- Required by a state or federal government program.

In addition, if a provider asserts that ArchCare Senior Life has underpaid any claim(s) to a provider, ArchCare Senior Life may offset any underpayments that may be owed against past overpayments made by ArchCare Senior Life dating as far back as the claim underpayment.

Notice of Overpayments before Seeking Recovery

If ArchCare Senior Life has determined that an overpayment has occurred, ArchCare Senior Life will provide thirty (30) days written notice to the provider of the overpayment and request repayment. This notice will include the member's name, service date(s), payment amount(s), proposed adjustment and a reasonably specific explanation of the reason for the overpayment and the adjustment. In response to this notice, the provider may dispute the finding or remit payment as outlined below.

If You Agree That We Have Overpaid You

Upon receipt of a request for repayment, providers may voluntarily submit a refund check made payable to ArchCare Senior Life within 30 calendar days from the date the overpayment notice was mailed by ArchCare Senior Life . Providers should further include a statement in writing regarding the purpose of the refund check to ensure the proper recording and timely processing of the refund.

Refund check should be mailed to:

ArchCare Senior Life
205 Lexington Avenue, 8th Floor
New York, NY 10016
Attention: Provider Disputes

If You Disagree that We Overpaid You

If a provider disagrees with ArchCare Senior Life's determination concerning the overpayment, the provider must submit a written request for an appeal within 30 calendar days from the date the overpayment notice was mailed by ArchCare Senior Life and include all supporting documentation in accordance with the provider appeal procedure.

If upon reviewing all supporting documentation submitted by a provider, ArchCare Senior Life determines that the overpayment determination should be upheld, providers may initiate arbitration pursuant to their provider agreement. ArchCare Senior Life will proceed to offset the amount of the

overpayment prior to any final determination made pursuant to binding arbitration.

If You Fail to Respond to Our Notice of Overpayment

If a provider fails to dispute a request for repayment concerning an overpayment determination made by ArchCare Senior Life within 30 calendar days from the date the overpayment notice was mailed by ArchCare Senior Life, the provider will have acknowledged and accepted the amount requested by ArchCare Senior Life.

ArchCare Senior Life will offset the amount outstanding against current and future claim remittance(s) until the full amount is recovered by ArchCare Senior Life.

NOTIFYING ARCHCARE WHEN CHANGING OR UPDATING INFORMATION

A notification must be sent to Provider Relations 15 days in advance of the following:

- Change of Staff
- Change of Office Location, phone, fax or email
- Change in tax status or billing information (new W – 9 must be filed)

ArchCare Provider Relations Contact Information:

Email: ProviderRelations@ArchCare.org
Phone: 800-373-3177
Fax: 646-417-7167

COMPLAINTS, GRIEVANCES, APPEALS AND COMPLIMENTS

ArchCare Senior Life strives to achieve Member satisfaction at all times. Systems have been implemented to accept, investigate and make a determination and handle appeals for all grievances and to report compliments in compliance with all regulatory requirements. ArchCare Senior Life offers assistance to Members and their representatives in all phases of the grievance, appeal and compliance process.

ArchCare Senior Life will try to resolve any complaint that a Member may have. ArchCare Senior Life will try to solve complaints over the telephone, especially if these complaints are because of misinformation, a misunderstanding or a lack of information. However, if the complaint cannot be resolved in this manner, a more formal Member grievance review process is available.

COMPLAINTS AND GRIEVANCES

The regulatory definition of grievance is "any expression of dissatisfaction" regarding care and treatment that does not involve change in scope of duration of services and includes all issues previously thought of as complaints.

- A grievance can be verbal or written.
- A grievance can be filed by a Member, family/caregiver, friend or provider on behalf of the Member.
- A grievance can be made to one of the CMT, or any other ArchCare Senior Life Member.
- Grievances are tracked by a formal mechanism.
- Attempts are made to rectify grievances immediately or within required time frames, based on the nature of the issue.
- The initial determination notice includes an explanation of the reasons for the decision.
- A Member who is dissatisfied with the outcome of the grievance determination may request a 2nd review by filing a grievance appeal.
- All grievances are submitted in a report to the NYS Department of Health on a quarterly basis.

APPEALS

- An appeal can be verbal or written.
- An appeal can be filed by a Member, family/caregiver, friend or provider on behalf of the Member.
- The request for an appeal must be received within 60 days after the receipt of the notice of grievance decision.
- During the appeal process, the Member may present their case in person and may also review the medical record that is part of the appeal.
- Appeals are tracked by a formal mechanism.
- Appeal decisions are made within required time frames, based on the nature of the issue.
- Appeal determinations are made by someone other than the person making the initial determination
- The appeal determination notice includes an explanation of the reasons for the decision including any clinical rationale, as appropriate.
- A report of all appeals is submitted to the NYS Department of Health on a quarterly basis.

QUALITY ASSURANCE PERFORMANCE IMPROVEMENT

With the advice and participation of the ArchCare Senior Life Quality Committees, the Quality Management Department assesses the delivery of services and determines if and when improvements are needed. When indicated, corrective action plans are directed toward individual providers, medical groups, or facilities. In addition, ArchCare Senior Life's Quality Management Program focuses on several key projects yearly, aimed at improving the delivery system as a whole. Project interventions may be administrative or clinical in nature.

CREDENTIALING

ArchCare Senior Life fully credentials all physicians and allied health providers. The process is comprehensive and includes verification of the provider's credentials. In addition, ArchCare Community Health verifies that the provider has agreed to participate in the Medicaid program, as appropriate.

Provider performance measures include, but are not limited to: Member related grievances, appointment availability, adherence to clinical guidelines, and compliance to the medical record documentation improvement projects. These measures are constantly reviewed. Time sensitive credentialing documents such as copies of license registration, and malpractice insurance must be updated, as necessary. Overall cooperation with mandated requirements that assists ArchCare Senior Life to keep individual provider files current at all times is appreciated. A site visit may also be performed based in the provider's specialty.

When concerns about the quality of care given Members occur, a medical record review or incident report may be required as part of the investigation. After investigating the concern the incident may be directed to the Quality Management Committee and the committee may direct the Director of Quality Management to continue to monitor the situation, or it may require that a corrective action plan be implemented. Incident Reports that are requested must be submitted to the Director of Quality Management. The committee may instruct the Director of Quality Management to continue to monitor the situation, or it may require that a corrective action plan be implemented. Incident Reports that are requested must be submitted within two business days of the request.

ArchCare Senior Life's guidelines for access to care for its Members are in compliance with the Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) access requirements.

QUALITY INDICATORS

Providers are measured on a number of performance measures that are continuously tracked. Some of these measures are outlined below.

Providers must accommodate the following types of appointments within the indicated time frames:

- Preventative care appointments — within 15 days of request
- Routine care appointments — within 4 weeks of request
- Urgent care appointments — within 24 hours of request
- Non-urgent sick visit appointments — within 48-72 hours of request
- Appointments for specialty care — within 7 calendar days
- Placement for personal care — within 24 hours of request

Additionally, providers must maintain a mechanism for 24 hour/7 day Member telephone access and office coverage to respond to emergencies for their Members as they arise, and be able to render decisions based on the nature of the emergency. Emergent conditions are those conditions whose onset are acute and may occur with or without a prior medical history of the condition. Pre-recorded referral to a hospital Emergency Department does not constitute appropriate 24 hour/7 day coverage.

On the day of an appointment, a Member should not wait more than thirty (30) minutes past their scheduled appointment time. If an emergency arises for the provider and the wait time is more than thirty (30) minutes, the Member must be notified of the delay and given the opportunity to reschedule cancelled appointments.

Telephone Response

Telephone response to a Member calls to the office should be handled by a physician or designated office staff as appropriate to the situation.

- Emergency conditions should receive immediate response;
- Urgent conditions should be responded to within 4 hours;
- Semi-urgent conditions should be responded to during the current day;
- Routine conditions should be responded to within 2 working days; and,
- After hour calls whose nature is not completely clear, should receive a response within 30 minutes.

QAPI WORKPLAN

A comprehensive QAPI plan has been designed to meet the goals of ArchCare Senior Life in providing high quality services consistent with professional practice and within regulatory standards and achieving positive Member outcomes. All of this is done within a fiscally responsible environment.

Copies of ArchCare Senior Life's QAPI Plan are available from the Director of Quality Management.

The QAPI Plan includes the following:

- The plan involves all ArchCare Senior Life employees, providers, Members and their support systems in our CQI efforts.
- The plan is to systematically improve, monitor, and evaluate the care provided and to maximize Member satisfaction.
- The plan defines ArchCare Senior Life's objects and includes the operational components designed to support desired outcomes.
- Provider performance plays a key role in the QAPI Plan that includes quality of services, identification and correction of issues, and outcomes.
- A multi-disciplinary team performs, reviews, and analyzes evaluations and makes recommendations for additional targeted studies, CQI, and Member/provider satisfaction.
- Ultimate oversight of ArchCare Senior Life's QAPI Plan is the responsibility of the Board of Directors of ArchCare Senior Life.

COMPLIANCE & FRAUD WASTE AND ABUSE

Overview

ArchCare Senior Life is committed to preventing and detecting fraud, waste and abuse. As an ArchCare Senior Life contracted provider, you have specific responsibilities in the areas of compliance, fraud, waste and abuse.

Here is a short list reviewing some key responsibilities relating to the ArchCare Senior Life Compliance Program.

Training

Compliance and Fraud, Waste and Abuse training is a CMS and New York State Department of Health ("DOH") requirement for provider staff who are involved with the administration or delivery of Medicaid benefits. Provider staff must complete this training within 90 days of hire, and on an annual basis.

Proof of your completion of this training must be made available to the ArchCare Senior Life Compliance Department, upon request.

Audit Cooperation

It is the responsibility of provider staff to cooperate with ArchCare Senior Life , and any of its subsidiaries or affiliates as necessary, to support ArchCare Senior Life in carrying out its monitoring responsibilities, including but not limited to, allowing ArchCare Senior Life to inspect, evaluate and audit your provider's books and records.

Record Retention

The provider must maintain its books and records relating to its services, for a period of at least ten (10) years, or longer as otherwise required by law [C.F.R. § 423.505(d)].

OIG/GSA, OMIG and EPLS Exclusion List Process

Providers must verify that they have researched and will continue to monitor and ensure none of its employees, vendors or contractors are excluded from the:

- OIG exclusion list database;
- OMIG excluded provider list; and

These checks must be conducted at least monthly.

Code of Conduct

CMS and DOH requires providers have in place, or adopt a plan, which includes the adoption of a code of conduct, to detect, prevent, and correct fraud, waste and abuse in the delivery of its services.

Provider staff, including physicians, licensed professionals, billing and other staff, are required to read the ArchCare Senior Life Code of Conduct and agree to abide by the standards specified in the Code, and/or adopt

and follow a code of conduct, compliance program, and compliance policies particular to its own organization that reflects a commitment to detecting, preventing, and correcting non-compliance with Medicare and Medicaid requirements in the delivery of their Medicare and Medicaid services, including detecting, preventing, and correcting fraud, waste, and abuse.

Reporting of Suspected Non-Compliance, Fraud, Waste and Abuse

You are required to report any suspected non-compliance and/or potential fraud, waste or abuse of any of CMS's or DOH's rules and regulations as soon as you become aware of it, to ArchCare Senior Life 's Compliance Hotline at 800-443-0463**, or the ArchCare Senior Life compliance email at ComplianceReport@ArchCare.org.**

Remember, you have an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible. You can also contact any one of the **Compliance Resources** listed here.

New York State Medicaid Fraud Hotline 1-877-87-FRAUD

Director of Compliance ArchCare Community Life
Email:compliancereport@ArchCare.org

Examples of practices that are considered fraud, waste and abuse which are prohibited by ArchCare Senior Life, and require immediate reporting, include, but are not limited to:

- Submission of false information for the purpose of obtaining greater compensation than what the provider is entitled to;
- Billing for services not rendered;
- Billing for services prior to the rendering of the service;
- Knowingly demanding or collecting any compensation in addition to claims submitted for covered services;
- Submission of false information to obtain authorization for services;
- Ordering or furnishing inappropriate, medically unnecessary or excessive care or services;
- Practicing beyond the scope of licensure for that entity, or practicing after one's license has been suspended or revoked;
- Failing to furnish or maintain sufficient documentation on the extent of care and service to Members for audit and/or investigative purposes; and,
- Submitting bills or accepting payment for care, services, or supplies rendered by a provider who has been disqualified from participation in the Medicaid Program.

When calling the ArchCare Senior Life Compliance Hotline or emailing the ArchCare Senior Life Compliance Reporting email address:

- You have an assurance of anonymity and non-retaliation in the reporting process, and confidentiality to the extent reasonably possible.
- You have an obligation to disclose any action or situation that is, or may appear to be, a conflict of interest that would make it difficult for you to perform your work objectively or effectively.
- If you suspect issues of non-compliance or potential fraud, waste and abuse, you must report the issue to your supervisor or any other resources available to you, including the resources below.

Reminder: It is illegal for a provider to retaliate against an employee who makes a good-faith report of suspected fraud, waste, or abuse, or cooperates in an investigation.

False Claims Act

Scope of the False Claims Act

The False Claims Act (the "FCA") is a federal law (31 U.S.C. § 3279) that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The FCA makes it illegal to knowingly present, or cause to be presented, a false or fraudulent claim for payment to the federal government. Under the FCA, the term "knowingly" means acting not only with actual knowledge but also with deliberate ignorance or reckless disregard of the truth.

FCA Penalties

The federal government may impose harsh penalties under the FCA. These penalties include "treble damages" (damages equal to three times the amount of the false claims) and civil penalties of up to $11,000 per claim. Individuals or organizations violating the FCA may also be excluded from participating in federal programs.

Potential FCA Violations

Knowingly submitting claims to ArchCare Senior Life for services not actually provided. Examples of the type of conduct that may violate the FCA include the following:

- Submitting a claim for DME or Supplies when delivery was refused by the member;
- Submitting a claim for 2-man transportation, as authorized, but providing 1 man; and
- Submitting a claim for a service not provided.

The FCA's Qui Tam Provisions

The FCA contains a *qui tam*, or whistleblower, provision that permits individuals with knowledge of false claims activity to file a lawsuit on behalf of the federal government.

The FCA's Prohibition on Retaliation

The FCA prohibits retaliation against employees for filing a qui tam lawsuit or otherwise assisting in the prosecution of an FCA claim. Under the FCA, employees who are the subject of such retaliation may be awarded reinstatement, back pay and other compensation. ArchCare Senior Life's False Claims Act Policy strictly prohibits any form of retaliation against employees for filing or assisting in the prosecution of an FCA case.

State Laws Punishing False Claims and Statements

There are a number of New York State laws punishing the submission of false claims and the making of false statements:

- 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.

FRAUD, WASTE AND ABUSE

- Ordering or furnishing inappropriate, improper, unnecessary or excessive care services or supplies.
- Failing to maintain or furnish, for audit and investigative purposes, sufficient documentation on the extent of care and services rendered to members.
- Offering or accepting inducements to influence members to join the plan or to use or avoid using a particular service.
- Submitting bills or accepting payment for care, services or supplies rendered by a Provider who has been disqualified from participation in the Medicare or Medicaid programs

Providers must comply with federal laws and regulations designed to prevent fraud, waste and abuse, but not limited to, applicable provisions of federal criminal law, the False Claims Act, the anti-kickback statute, and the Health Insurance Portability and Accountability Act administrative simplification rules, applicable state and federal law, including, but not limited to, Title VI of The Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act and all other laws applicable to recipients of federal funds from which payments to Providers under this Agreement are made in whole or in part, and all applicable Medicare laws, regulations, reporting requirements, and CMS instructions.

Confirmed cases of fraud and abuse are reported to the appropriate state agency. Providers who suspect fraud, waste and abuse on the part of another Provider or a member should contact the ArchCare Compliance Hotline at 800-443-0463. Remember, you may report anonymously as ArchCare Senior Life abides by a zero-tolerance against non-compliance.

HEALTH INSURANCE AND PORTABILITY ACT (HIPAA)

ArchCare Senior Life is concerned with protecting member privacy and is committed to complying with the HIPAA privacy regulations. Generally, covered health plans and covered Providers are not required to obtain individual member consent or authorization for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations. Activities such as: care coordination, reviewing the competence of health care professionals, billing/claims management, and quality improvement fall into this category. If you have further concerns, please contact ArchCare Compliance Hotline at 800-443-0463.

HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH

(HITECH Act)

The HITECH Act was passed as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

Enacted in part to assist Providers who are, or will be, utilizing electronic health records (EHR) systems, the HITECH Act addresses consumer access to their EHR, increases application of HIPAA privacy standards to business associates of covered entities, and implements a tiered system of civil monetary penalties for HIPAA violations.

Under the HITECH Act, business associates are now responsible for complying with the provisions and regulations of HIPAA and are directly answerable to the government for HIPAA breaches.

Business associates are now also directly liable for civil and criminal penalties. This increased statutory liability for business associates under HIPAA will likely result in the necessity of updating business associate and vendor lists as well as renegotiating business associate agreements. In addition, business associates will most likely incur costs associated with bringing themselves into direct HIPAA compliance.

The HITECH Act also expands the notification requirements due to breaches of an individual's PHI. Both covered entities and business associates are now obligated to notify individuals of breaches of their PHI. In

cases where more than 500 “residents of a State or jurisdiction” have had their PHI breached, “prominent media outlets” serving that area must also be notified.

Individuals should be notified in writing or e-mail if that is their preferred method of contact, and be provided with basic information about the breach, such as:

1. When the breach happened, when the event was discovered, and a brief statement about what happened
2. What type of PHI was breached?
3. Things that the individual can do in order “to protect themselves from potential harm resulting from the breach”
4. What corrective actions and investigation the covered entity is doing to prevent future breaches and mitigate losses; and contact information for the individual to use in case of any questions.
5. In addition to disclosure accounting, the individual is also entitled to receive a copy of his or her electronic health record, if they request; this information may be sent to the individual, or another person designated by individual.

For more information about the HITECH Act, please visit the CMS website at www.cms.gov.

THE PROVIDER AND ADVERSE DETERMINATIONS

An Adverse Determination is defined as a decision not to provide or pay for a requested service, treatment or equipment in whole or in part or a decision to discontinue or reduce a service that has been requested by a Provider on behalf of a member. This is a utilization review decision that can only be made by a physician who is licensed to practice medicine in the state of New York. The information the reviewing physician receives from the requesting Provider is used to determine the medical necessity for the requested service, treatment or equipment. The reviewing physician must base his or her decision on nationally excepted guidelines such as the Medicare coverage guidelines, Medicare manual references, InterQual guidelines, the approved Evidence of Coverage.

If the Provider’s request is denied, an adverse determination, the Provider has the following recourse. Prior to denying a request the reviewing physician, a Medical Director, will attempt to contact the requesting Provider and discuss the case. If the Medical Director has not attempted to discuss the case with the requesting Provider or was unable to contact the Provider after three attempts, the Provider has an opportunity to provide additional information to the Medical Director and request a reconsideration review of the adverse decision. The reconsideration review will occur within one business day of the physician request and will be conducted by the Medical Director involved in the original decision. If the Medical Director upholds his or her decision to deny, written notification will be sent to the Provider and the member with the decision and the reason for it.

If the Provider has discussed the case with the Medical Director and disagrees with his/her determination to deny, they may request a Standard Appeal. Your request and the information you provided will be reviewed by a different Medical Director than the one who reviewed your initial request and denied it. We’ll give you a written decision on a standard appeal within 30 days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re

taking extra time and will explain why more time is needed. You have 60 days from the time you receive

the written notification of an adverse determination to initiate an appeal.

If you believe the health of your patient could be seriously harmed by waiting up to 30 days for a decision you can request an Expedited Appeal – We'll give you a decision on an expedited appeal within 72 hours after we get your request for an appeal.

MEDICAL RECORDS

Maintenance and Retention of Medical Records

- Providers must maintain adequate medical records for all ArchCare Senior Life members treated by the Provider. Subject to all applicable statutory and legal privacy and confidentiality requirements, these medical records must remain available to each physician and other health professionals treating the member. In addition, upon request, the medical records must be available to ArchCare Senior Life for review to determine whether the medical record and quality of services provided to the member was appropriate.
- Records should be maintained during the term of this agreement and for ten (10) years thereafter. The Provider must comply with all applicable state and federal law regarding access to these records. Disposal of any medical records by the Provider during this time period is permitted only upon prior written approval by ArchCare Senior Life and the NYSDOH. Records involving matters in litigation shall be kept for a permitted period of time only upon prior written approval by ArchCare Senior Life and NYSDOH. Microfilm or electronic copies of records may be substituted for the originals with the prior written approval of ArchCare Senior Life and the NYSDOH, provided that the microfilming procedures are reliable and are supported by an adequate retrieval system.

Access to and Audit of Records

- At all times during the period that the ArchCare Senior Life contract is active and for a period of ten (10) years thereafter, Providers must provide ArchCare Senior Life, all authorized representatives of the state and federal governments and to appropriate individuals with knowledge of financial records (including independent public auditors) full access to its records which pertain to services performed and determination of amounts payable under this agreement. The Provider must permit ArchCare Senior Life representatives to examine, audit and copy such records at the site at which they are located. Such access shall include both announced and unannounced inspections and on-site audit.
- The Provider must promptly notify ArchCare Senior Life of any request for access to any records maintained pursuant to their contract with ArchCare Senior Life. All provisions of your Agreement with ArchCare Senior Life relating to access and audit of records shall survive the termination of the Agreement and be binding until the expiration of the record retention period.

EMERGENCY AND DISASTER PREPAREDNESS

ArchCare Community Life has a formal plan for emergency and disaster preparedness (EPP). The EPP is designed to respond to weather and other natural disaster, industrial disasters, damage to office structures, communications and other technical disasters, personnel actions, medical events and terrorist threats and activities.

As part of our EPP, a priority status will be assigned to every Member at enrollment with an update as needed but no less than 180 days.

Level 1 at high risk and need uninterrupted services;

Level 2 at moderate risk and may need some assist during an emergency situation;

Level 3 at low risk who are Members who need services and have family support who can provide care in an emergency situation

Senior management will confirm an emergency and direct appropriate action to be taken. In the event of an emergency, Providers will be contacted by ArchCare Community Life staff with specific instructions.

Providers are expected to notify ArchCare Community Life if they experience emergencies of disasters along with procedures, until normal operations have been restored.

IMPORTANT NUMBERS AND FORMS

ARCHCARE SENIOR LIFE QUICK REFERENCE GUIDE	
Member Eligibility	Telephone: 866.263.9083 Option 4
Utilization Management	Telephone: 866-263-9083
ED Visits & Hospitalization Reporting afterhours & Weekends	Telephone: 855-467-9351
Transportation	Telephone: 646-289-7701
Compliance	Hotline 1-800-443-0463, or the ArchCare Community Life Compliance E-mail at: ComplianceReport@ArchCare.org
Provider Relations	ProviderRelations@ArchCare.org
Claims Submission	**Submitting Claims Electronically:** Through the partnership with Peak TPA, claims may be submitted electronically through 4 clearinghouses: Smart Data Solutions, Change Healthcare, Ability, and Trizetto. Claims submitted electronically receive a status report indicating the claims are accepted, rejected and/or pending. Claims submitted electronically must include: 1. The ArchCare PayerID: 27034 2. ArchCare Advantage Member ID Number 3. National Provider Identifier (NPI) **Submitting Paper Claims:** ArchCare Advantage PeakTPA P.O. Box 21631 Eagan, MN 55121 Note for Group Practices and Facilities: When submitting claims, please ensure separate billing NPI and Provider NPI numbers are entered in the appropriate fields.

Pharmacy Prior Authorizations:

https://www.ArchCare.org/health-plans/senior-life/pharmacy-benefits/coverage-determinations-and-exceptions-pace

DEFINITIONS

1. Enrollment Agreement is the document issued to a Member by ArchCare Senior Life that describes the covered services the Member is entitled to receive as a Member of ArchCare Senior Life; and its obligations to arrange for the delivery of those services to ArchCare Senior Life Members who are eligible for such services pursuant to the terms of Plan's contract with the New York State Department of Health and Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services.

2. Covered Service is defined as those services which are medically indicated and which Members are entitled to receive under the terms of the Enrollment Agreement.

3. DOH is defined as the New York State Department of Health.

4. An Emergency medical condition is defined as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in:
    a. Serious jeopardy to the health of the individual;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any organ or part.

5. CMS is defined as the Centers for Medicare and Medicaid Services.

6. Medically Necessary Services are those health care services that are covered in the Members' enrollment agreement and:
    a. Provide for the diagnosis, prevention, or direct care of a medical condition;
    b. Are appropriate and necessary, for the diagnosis, prevention, or treatment of a medical condition and could not be omitted without adversely affecting the Member's condition
    c. Are within standards of good medical practice recognized within the organized medical community
    d. Are appropriate to and consistent with the Member's diagnosis and (except for Emergency Services or Urgent Services) their care plan
    e. Would be likely to materially improve or to help in maintaining the Member's physical condition
    f. Would be likely to materially improve or to help in maintaining the Member's ability to engage in essential activities of daily living
    g. Are not primarily for the convenience of the Member or his/ her family, his/ her physician, or another care Provider
    h. Are the most appropriate and economical level and source of care or supply that can be provided safely.
    i. And whose provision is based on guidelines, standards, and criteria such as InterQual Criteria, National Coverage Decisions, Medicare Benefit Policy Manual and Local Coverage Determinations and review of appropriate literature related to the requested service.

7. Member is defined as any person who is eligible to receive Covered Services under the

eligibility criteria set by DOH and is enrolled in ArchCare Senior Life.

8. Interdisciplinary Team is defined as a group of health professionals or caregivers composed of the Primary Care Physician , registered nurse, social worker, physical therapist, occupational therapist, recreational therapist, activity coordinator, dietitian, ArchCare Senior Life Center manager, home health care coordinator, home health aides/personal care attendants, and drivers.

9. ArchCare Senior Life is defined as the Program of All-inclusive Care for the Elderly. It offers a benefit plan to frail seniors who are nursing home eligible who live at home with the support of ArchCare Senior Life services. ArchCare Senior Life is an integrated comprehensive program that combines the services of an adult day center, home health care, medical outpatient clinic or office care, and a network of specialty care Providers including inpatient hospital and nursing home care when needed.

10. Participating Agency is defined as an agency or health care Provider that has signed an ArchCare Senior Life Service Agreement.

11. Primary Care Physician is defined as any physician, professional service corporation or partnership who or which has agreed to provide specific primary health services to Members and to coordinate the overall health care of Members as their Primary Care Physician .

12. A Provider is defined as Providers of individual services who are contracted vendors. The Provider must meet applicable New York state licensure, certification, or registration requirements in which they practice, and meet ArchCare Senior Life's credentialing criteria.

13. Quality Assurance Performance Improvement (QAPI): ArchCare Senior Life has a quality assurance performance improvement committee consisting of its program director, director of Member services, Medical Director and other clinical and non- clinical professional staff as deemed appropriate. All Contracted Service Providers are encouraged to participate in Quality Assessment.

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