ArchCare Community 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 ArchCare Community Life are pleased to present this Provider Manual. It is designed to answer your questions about ArchCare Community Life and its 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 855-467-9351 or ProviderRelations@archcare.org. We welcome your feedback, questions and comments.

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

Sincerely,
ArchCare Community 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 Community Life program. Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon Archcare Community Life and is subject to change. Archcare Community Life will make reasonable efforts to notify Provider 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 Community Life, the Agreement shall govern.

In the event of a material change to the Provider Manual, Archcare Community Life will make all reasonable efforts to notify you in advance of such changes through Provider Educational Series, 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 Community Life policies and procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communication.

INTRODUCTION

Welcome and thank you for participating in ArchCare Community Life.

ArchCare is the continuing care community of the Archdiocese of New York. Nursing home alternatives that enable seniors and others with chronic health needs to continue to live safely and independently. ArchCare Community Life is composed of Skilled Nursing Home and Assisted Living Program, Home Health services for infants, children and adults; as well as Health plans that coordinate all of a Member's healthcare needs and the Medicare and Medicaid benefits for which they are eligible.

This manual serves as a guide to ArchCare Community Life's policies and procedures that govern the Archcare Community Life Plan Members, services and Providers. Please keep this manual in a convenient, accessible location and use it when applicable. This Manual is also available on the ArchCare Community Life website www.archcare.org.

Its contents are subject to periodic updates and modifications in compliance with federal and state regulations and ArchCare Community Life policy changes.

If you or your staff have any questions about the policies and procedures in this Manual, please contact the ArchCare Community Life Provider Relations Department at 855-467-9351

OVERVIEW

ArchCare Community Life is a Managed Long Term Care Program that was established to coordinate health services for the chronically ill wishing to remain in their home and communities as long as possible. Member's healthcare needs, both covered and non-covered, are coordinated by an assigned Care Manager in collaboration with Member's Primary Care Provider and Archcare Community Life Participating Providers to work with the Archcare Community Life Care Management Team to coordinate all care. This will allow the Provider to service our Members with assistance in transportation to and from the appointments, as well as, receive the best quality of care and support from Care Teams.

Mission Statement: The Mission of ArchCare Community Life is to foster and provide faith based holistic care to frail and vulnerable people unable to fully care for themselves. Through shared commitments, ArchCare seeks to improve the quality of the lives of those individuals and their families.

What is managed long-term care and how does it work?

Managed long-term care (MLTC) is a system that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long-term care plans that are approved by the New York State Department of Health. The entire array of services to which an enrolled Member is entitled can be received through the MLTC plan the Member has chosen.

Enrollment in a MLTC plan is mandatory for those who:

- Are dual eligible (eligible for both Medicaid and Medicare) and over 21 years of age and need community based long-term care services for more than 120 days.
- Reside in the counties of NYC, Nassau, Suffolk or Westchester.

Enrollment in MLTC plan is voluntary for those who:

- Are dual eligible and are 18 through 21 years of age and need community based long term care services for more than 120 days and assessed as nursing home eligible.
- Are non-dual eligible and over 18 years of age and are assessed as nursing home eligible.

Eligibility Requirements:

An individual must be:

- Determined eligible for Medicaid by the Local Departments of Social Services or entity designated by the Department.
- Determine eligible for MLTC by the MLTC Plan using the Uniform Assessment System (UAS-NY) eligibility assessment tool;
- Capable at the time of enrollment, of returning to or remaining in his/her home and community without jeopardy to his/her health and safety, based upon criteria provided by the Department, and:
- Expected to require at least one (1) of the following services covered by MLTC Plan for more than 120 days from the effective date of enrollment:
    - nursing services in the home;

- therapies in the home;
- home health aide services;
- personal care services in the home;
- adult day health care;
- private duty nursing; or
- consumer directed personal assistance service.

Population Exempted From Enrollment:

- Individuals aged 18-21 who are nursing home certifiable and require more than 120 days of community based long term care services;
- Native Americans;
- Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable; and
- Alessa Court Ordered individuals

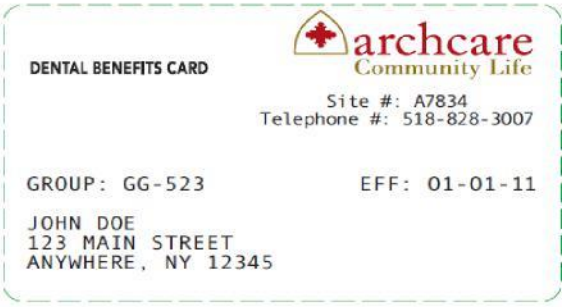
ArchCare Community Life is committed to bringing people and resources together to better plan and delivers accessible, high quality, cost effective health care services. ArchCare Community Life has developed a network of area Providers who are able to provide the services our Members may require while enrolled. The Providers in the network have been selected and credentialed by ArchCare Community Life to assure our Members the best possible care. When an individual enrolls in ArchCare Community Life they are required to use Providers in the ArchCare Community Life network and also obtain authorization from their Care Management Team.

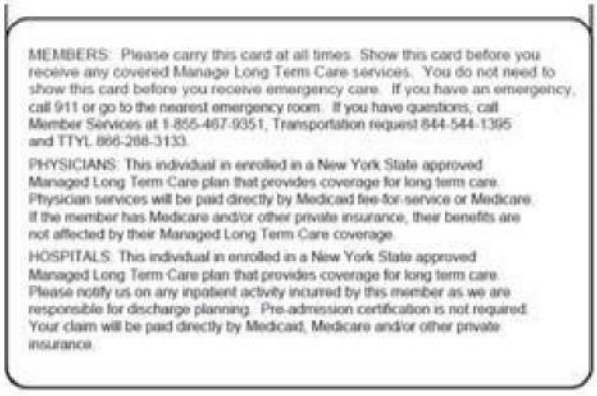
SERVICE AREA:

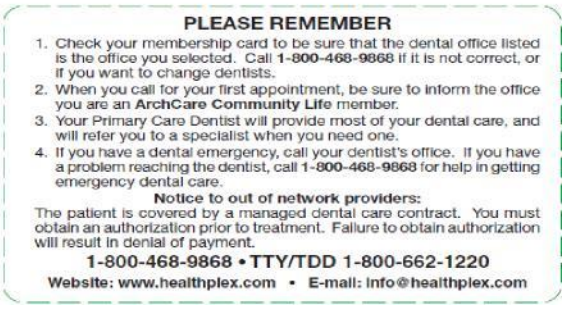
- Bronx
- Kings
- New York
- Putnam
- Queens
- Richmond
- Westchester

IDENTIFICATION CARD

Every enrolled Member of ArchCare Community Life receives an ID Card as well as a Healthplex Dental ID Card in the mail. See examples of these ID Cards below:







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 Community 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 855-467-9351 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 Members.

COVERED SERVICES AND BENEFITS

Services for Members of ArchCare Community Life and their respective coverage rules:

Service	Coverage Rules
Care Management The Care Management Team will assess the Member's health care on an ongoing basis, with your care team. The care manager will also be responsible for the coordination and delivery of planned services.	Every Member will be assigned to a Care Manager.
Non-Emergency Transportation Non-Emergency Transportation is transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the Member's condition to obtain necessary medical care and services reimbursed under the Medicaid or the Medicare programs.	Members must receive Non-emergency Transportation from the ArchCare Community Life Provider Network, and must obtain authorization from the Plan.
Home Care Includes the following services, which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.	These services may be covered by Medicare, if provided after a qualifying stay in a hospital or skilled nursing facility. When a service is covered by Medicare, Members may receive the care from a Provider who is not in the ArchCare Community Life Provider Network. When the Member's care is covered by Medicaid, then the Member will utilize his/her MLTC benefits through ArchCare. Must use an in network Provider and obtain an authorization. ***The Member's doctor will need to provide signed written orders to the Provider.***
Personal Care Personal care is some or total assistance with activities such as personal hygiene, dressing and feeding and nutritional and environmental support function tasks	The Member must receive Personal Care from the ArchCare Community Life Provider Network, and must obtain authorization from the Plan. ***The Member's doctor will need to provide signed written orders to the agency providing care.***
Physical Therapy, Occupational Therapy, Speech Pathology in a setting outside of the home Physical therapy ("PT") is rehabilitation services provided by a licensed and registered physical	Members who have Medicare benefits must use his/her Medicare benefits before using ArchCare Community Life benefits. If the Member has Medicaid he/she will use the Plan benefits. The Member must receive Physical, Occupational Therapy and/or Speech Pathology from the

Service	Coverage Rules
therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Member to his or her best functional level. Occupational therapy ("OT") is rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Member to his or her best functional level. Speech-language pathology ("SP") is rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the Member to his or her best functional level.	ArchCare Community Life Provider Network, and must obtain authorization from ***The Member's doctor will need to provide signed written orders to the respiratory care Provider.***
Nursing Home Care Care provided in a Skilled Nursing Facility	***Short term rehabilitative stays*** may be covered by Medicare. If the Member's stay in a nursing home is covered by Medicare, s/he may get care from a nursing home which is not in the ArchCare Community Life Provider Network. If the Member's Medicare benefits expire, his/her stay would become Medicaid-covered. ***The Member's doctor will need to provide signed written orders to the nursing home.***

Adult Day Health Care Adult Day Health Care provides care and services in a residential health care facility or approved extension site. Adult Day Health Care centers are under the medical direction of a physician and are set up for those who are functionally impaired but who are not homebound. To be eligible, the Member must require certain preventive, diagnostic, therapeutic and rehabilitative or palliative items or services. Adult Day Health Care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy and dental pharmaceutical, and other ancillary services, as well as leisure time activities that are a planned program of diverse and meaningful activities.	The Member must receive Adult Day Health Care from the ArchCare Community Life Provider Network, and must obtain authorization from the Plan. ***The Member's doctor will need to provide signed written orders to the Adult Day Health Care Provider.***
Social Day Care Social day care is a structured, comprehensive program that provides functionally impaired individuals with socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of the day, but for less than a 24-hour period.	The Member must receive Social Day Care from the ArchCare Community Life Provider Network, and must obtain authorization from the Plan.
Optometry/Eyeglasses Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.	The Member must receive Optometry services and Eyeglasses from the ArchCare Community Life Provider Network. Generally, an eye exam and a pair of eyeglasses are provided once every 2 years unless the Member has diabetes or unless medically needed more often. ***The Member's doctor will need to provide signed written orders.***

Audiology/Hearing Aids Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and	Audiology exams may be covered by Medicare. When a service is covered by Medicare, the Member may receive the care from a Provider who is not in the ArchCare Community Life Provider Network. When the service is covered by Medicaid, the Member will have to use an in-network Provider.
Podiatry Podiatry means services by a podiatrist, which must include routine foot care when the Member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcer, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.	Podiatric exams may be covered by Medicare. When a service is covered by Medicare, the Member may receive the care from a Provider who is not in the ArchCare Community Life Provider Network. When the service is covered by Medicaid, the Member will have to use an in-network Provider. ***The Member's doctor will need to provide signed written orders.***
Dentistry Preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.	Dental services may be covered by Medicare. When a service is covered by Medicare, the Member may receive the care from a Provider who is not in the ArchCare Community Life Provider Network. When the service is covered by Medicaid, the Member will have to use an in-network Provider.
Home-Delivered or Congregate Meals	The Member must receive Home Delivered or Congregate Meals from the ArchCare Community Life Provider Network, and must obtain authorization from the Plan.
Respiratory Therapy The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, aerosol, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.	The Member must receive Respiratory Therapy from the ArchCare Community Life Provider Network, and must obtain authorization from the Plan. ***The Member's doctor will need to provide signed written orders to the respiratory care Provider.***

Nutrition Services/Counseling The assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs.	The Member must receive Nutritional Services/Counseling from the ArchCare Community Life Provider Network, and must obtain authorization from the Plan.
Medical Surgical Supplies/Enteral Feeding and Supplies/Parenteral Nutrition and Supplies Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and device and durable medical equipment or orthopedic footwear that treat a specific medical condition, which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.	These items may be covered by Medicare. If an item is covered by Medicare, the Member may receive the item from a Provider who is not in the ArchCare Community Life Provider Network. When the item is covered by Medicaid, the Member must use an in-network Provider and must obtain authorization from the Plan. ***The Member's doctor will need to provide signed written orders to the Provider.***
Durable Medical Equipment Durable medical equipment is made up of devices and equipment, including prosthetic, orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition and which have the following characteristics: • can withstand repeated use for a protracted period of time • are primarily and customarily used for medical purposes • are generally not useful in the absence of an illness or injury • are not usually fitted, designed or fashioned for a particular individual's use Where equipment is intended for use by only one patient, it may be either custom-made or customized.	These items may be covered by Medicare. If an item is covered by Medicare, the Member may receive the item from a Provider who is not in the ArchCare Community Life Provider Network. When the item is covered by Medicaid, the Member must use an in-network Provider and must obtain authorization from the Plan. ***The Member's doctor or podiatrist will need to provide signed written orders to the Provider.***
Social and Environmental Supports Social and environmental supports are services and items that maintain the medical needs of the Member and include, the following: • home maintenance tasks • homemaker/chore services • housing improvement respite care	The Member must receive Social and Environmental supports from the ArchCare Community Life Provider Network, and must obtain authorization from the Plan.

Personal Emergency Response Systems (PERS) PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.	The member must receive PERS from the Provider Network and must obtain authorization from the plan.

NON-COVERED SERVICES

The following are non-covered services for Managed Long Term Care Plans;

- Primary Care Provider Services
- Specialist physician services such as orthopedic, endocrinologist, dermatologist, etc.
- Inpatient/Outpatient hospital
- Pharmacy- prescription and non-prescription drugs
- Dialysis
- Mental Health/Chemical dependency programs
- Emergency transportation
- Laboratory, Pathology, Diagnostic Testing and Radiology
- Infusion Therapy
- Part A stays at Nursing Homes
- Emergency Department
- Hospice
- Alcohol and Substance Abuse

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 managed long term care 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 Community 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 Community 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 Community Life if they plan to move or will be out of town for an extended period of time;
- To notify ArchCare Community 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 Community Life in maintaining a safe home environment; and,
- To make all required payments to the plan.

NON ENGLISH SPEAKING MEMBERS

ArchCare Community Life celebrates the diversity of its Members as we serve multicultural areas of Manhattan, the Bronx, Staten Island and Westchester County. 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 Community Life will provide translation/interpretation services at no cost to the Member or Member's family. ArchCare Community 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 Community Life will maintain a list of qualified interpreters with contact information, qualifications and availability. If other language skills are needed, ArchCare Community 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.

Language interpreter services must be provided during a medical visit scheduled appointments and scheduled encounters by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible.

IMPAIRED MEMBERS

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

For Members with visual impairments, ArchCare Community Life provides printed materials in large print formats, and in an audio medium. Staff will also read ArchCare Community 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 Community Life Members.

CARE MANAGEMENT

Care Management is the "core" of ArchCare Community Life. This process ensures consistent oversight, coordination and support to Members and their families in accessing covered and coordinated services. The Care Plan, completed after assessment and enrollment of the Member, is mutually agreed upon with the Member and the Primary Care Provider, and is reviewed and revised over time in response to the changing needs of the Member. ArchCare Community Life is dedicated to the provision of services which will enable Members to remain safe and secure in their place of residence.

Upon enrollment the coordination of the Member's care will begin with a Care Management Team (CMT) which includes nursing, social work, Member Services Representatives, the Medical Director and the Member's Primary Care Provider. Together, they will collaborate on the established Care Plan with the Member, and their formal and informal supports to ensure that the Member receives the appropriate level of services. The team provides education for the Member and caregiver including but not limited to: health prevention/maintenance, life planning, various disease processes, and accessing benefits and community resources. If, at any time the CMT notices a change in the Member, or the Member tells the CMT about changes in his/her health status, CMT will address the problem and confer with the primary care physician.

Providers partner with the CMT by supplying the services ordered in the Care Plan which maximize Member care and satisfaction.

Objectives of the Care Management Team:

- Ensure primary accountability for care management, from enrollment and continuing through transition to the CMT;
- Establish effective systems to ensure consistent oversight of care and service expectation that is met across all service provision;
- Establish protocols for routine and event monitoring; i.e.; hospitalization, short/long term nursing home placement, new diagnosis, major social environmental changes, increasing frequency of falls, pain management, or change in cognitive status;
- Establish standards for documentation and practice; and,

- Apply cost management protocols to be a prudent buyer of service and a prudent Provider of service.

Contact with Members/Families/Caregivers:

- Members/families/caregivers are instructed to contact the CMT if they have any questions, concerns, compliments, or complaints related to Provider. They should not contact the Provider directly.
- Members/families/caregivers who contact Provider for service issues; i.e.; aide change, item promised not delivered etc., should be told to contact the CMT, and the Provider should inform the CMT that they have been contacted.

COORDINATION OF SERVICES

ArchCare Community Life provides and coordinates services which are designed to keep Members living in their homes, for as long as possible. This coordination of services starts after the Member has enrolled, even prior to start of services which happens on the first day of the month, after the State's enrollment broker places the Member on its MLTC Roster.

After the Member is enrolled and prior to being placed on service, the CMT staff Member will be assigned to call and maintain contact with the Member/family/caregiver. The CMT will arrange for the vendors to provide the covered services that are assessed at the initial visit to provide service the first day of enrollment. The CMT will monitor the health status of the Member at this time as the Member transitions from Enrollee to Member of ArchCare Community Life.

ASSESSMENTS OF MEMBERS

There are various assessments of Members conducted as all times and as necessary.

Conflict Free Evaluation and Enrollment Center- Patients new to Managed Long Term Care must first be referred to the Conflict Free Evaluation and Enrollment Center (otherwise known as the CFEEC) before scheduling an assessment with ArchCare Community Life. The CFEEC is a subdivision of New York Medicaid Choice/Maximus. They can be contacted at 1-855-222-8350.

Initial Assessment

On-Going Assessments – Done no less than monthly via telephone. This call ascertains if the Member's needs are being met, notes any changes in Member status, identifies opportunities for improvements in care, and maximizes Member satisfaction. These calls may initiate additional assessments to be conducted by professionals to determine whether the Care Plan needs to be revised or service changes need to be accomplished. This will assist in the Member maximize care and address with social or clinical issues.

Semi-Annual Assessments – Done every 180 days by a Registered Nurse who conducts a formal assessment in the Member's home. Based upon the assessment and a most recent Care Plan, revisions may be made. The new Care Plan is communicated to and agreed upon by the Member/family/caregiver and CMT. If there is any change in the service Providers or the service(s) provided, the same will be communicated to the Providers to meet the needs of the Member.

AUTHORIZATION PROCESS

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 855-467-9351 for further information.

CREDENTIALING AND RECREDENTIALING

All health care, environmental and social service Providers, providing health services to ArchCare Community Life participants must be credentialed in accordance with ArchCare Community Life policies and procedures. Under CMS regulation, the credentialing process and approval must be completed by any network Provider administering care to an ArchCare Community 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

- Completed application
- 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 Malpractice Insurance Certificate or COI
- Board Certificate
- 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

- Completed ancillary application
- 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 or Federal Survey and any Plan of Correction

Licensed Home Care Service Agencies/Certified Home Health Agency

- Copy of Insurance Certificate
- State Survey and any Plan of Correction
- NYSDOH Wage Parity Attestation
- Copy of License
- Medicare and/or Medicaid number
- Attestation that yearly criminal background check, physicals and trainings are completed for all employees.

Social Adult Day Center

- Copy of Insurance Certificate
- Certificate or Occupancy
- OMIG Certification
- Fire Inspection
- Site Visit – completed before application is processed

Livery Taxi

- Copy of Insurance Certificate
- NYCTLC
- Attestation of Criminal Background Check and Motor Vehicle Clearance
- Vehicle registration
- Vehicle Safety Inspection

Copy of last 3 years of federal and state surveys including any Appeals Process for Providers terminated or rejected from the ArchCare Community 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 Community Life complies with all state and federal mandates with respect to appeals for Providers terminated or rejected from the ArchCare Community Life Provider Network. ArchCare Community 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 Community Life.

In addition, the request for appeal must be received by ArchCare Community Life within ten (10) days of the date of the rejection/termination letter. Upon receipt of the letter by ArchCare Community Life, the appeal is forwarded to the ArchCare Community Life Peer Review Committee for review and further processing ArchCare Community Life will ensure that the majority of the hearing panel Members are peers of the affected physician.

Provider Monitoring & Evaluation

ArchCare Community 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 Community Life, DOH, CMS and their designee in the monitoring and evaluation of the services provided under 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;

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, Provider will be considered participating. The Provider will use their NPI (National Provider Identification) number as their "Provider number".

Delegated Credentialing

ArchCare Community Life offers delegated credentialing for large groups of health care Providers. ArchCare Community Life delegates the credentialing function to groups that meet ArchCare Community Life and National Committee for Quality Assurance (NCQA) standards and state and federal law. The decision by ArchCare Community 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 Community 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 Community Life.

Medical Record

As part of the re-credentialing process ArchCare Community 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 Community Life newly hired Primary Care Provider's and mid-level practitioners receive competency and orientation checklist which is reviewed and signed off by the Medical Director. The ArchCare Community 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 Community Life to determine current performance evaluations and job competencies meet standards for re-credentialing.

Provider Information

Providers are responsible for contacting ArchCare Community Life to report any changes in their practice. It is essential that ArchCare Community 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 Community 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 Community 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 Community Life
Attention: Credentialing Department
205 Lexington Ave, 8th Flr
New York, NY 10016

PROVIDER NETWORK AND PROVIDER RELATIONS

The Provider Relations Department of ArchCare Community 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 Community Life's program, policies and procedures and keeps them up-to-date on information regarding the MLTC. In addition, Provider Relations staff reviews and updates all contracts as needed and investigates and resolves all contract Provider-related complaints.

PROVIDER NOTICES

ArchCare Community 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.

PROVIDER CREDENTIALING AND RE-CREDENTIALING

There are a number of steps that ArchCare Community Life must complete before considering a Provider as a permanent part of the network.

First Step:

A completed application must be returned with the required supporting documents, e.g.; current Certificates of Liability Insurance, licensure/certification etc. This completed application package is then submitted to the Credentialing and Peer Review Sub-committee which recommends approval to ArchCare Community Life's Board of Directors.

Second Step:

ArchCare Community Life staff executes a Provider network agreement, which includes all of the network services which will be supplied by the contracted Provider organization.

Re-Credentialing:

All contracted Providers are re-credentialed every 3 years. The re-credentialing process requires the Provider to send updated information. ArchCare Community 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.

ArchCare Community Life may, at its option, terminate the Provider Agreement upon ninety (90) days written notice to the Provider.

PROVIDER RIGHTS AND RESPONSIBLITIES

Provider Rights:

ArchCare Community Life's Providers must 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 Community Life policies, if the Provider believes that the policies negatively impact the quality of, or access to care.

Provider Responsibilities:

ArchCare Community Life's Provider's responsibilities include:

- Provision of quality care within the scope of practice as defined by ArchCare Community Life and in accordance with ArchCare Community Life's access, quality and participation standards;
- Adherence to ArchCare Community 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 Community 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- 9351 and 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 Community Life 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 Community 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 Community Life on any grievance, appeal, or incident investigations as required. Incident reports must be submitted to ArchCare Community Life within 10 working days of request.
- Communicate to ArchCare Community Life complaint made by or on behalf of the Member.
- Cooperate with ArchCare Community Life's quality assurance and improvement programs (QAPI) to report ArchCare Community Life incidents involving Members.
- Assure that all Provider's employees and agents involved in direct contact with Members carry proper Agency identification.
- Notify ArchCare Community 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:

Home Care Providers are responsible for:

- Obtaining physician orders;
- Developing the aide care plan for requested services and forwarding the care plan to the Care Management Team;
- Ensuring that Family Members of ArchCare Community Life enrollees who are HHA/ PCA are NOT assigned to handle the care of their family Member;
- Notifying Member in advance of name of assigned staff;
- **Notifying ArchCare Community Life and Members in advance of need for replacements and name of replacement staff;**
- Submitting evaluation and progress notes following first assessment visit by any/all disciplines and every two weeks thereafter unless specified otherwise;
- Cooperating fully with ArchCare Community Life case management; communicate verbally or in writing regarding the Member's progress even if the episode of care does not result in any payment by ArchCare Community Life to the participating Provider;
- **Confirming aide daily attendance:** all Licensed Home Care Providers (LHCSAs) must implement an electronic Visit Verification(EVV) attendance program in addition to other manual random verification. Agency protocols on Aide Attendance Verification must be available to ArchCare Community Life Provider Relations upon request. If a Member does not allow the aide to call in or call out from their telephone, the Case Manager must be informed and the information documented;
- Submitting EVV reports as requested. Reports should be indicate:
  (a) date and time of electronic call in/out;
  (b) date and time of manual modifications/entries; and
  (c) name of user modifying/entering time in/out.
- Maintain full compliance with the New York State Home Care Worker Wage Parity Law (New York State Public Health Law Section 3614-c, as amended, and all New York State Health Department regulations and guidance with respect thereto) (the **"Wage Parity Law"**); and shall provide ArchCare Community Life with all information to verify such compliance.
  - Complete Annual Wage Parity Attestations via EMEDNY and submit attestation copy to Provider Relations via email.

Residential Health Care Providers (RHCP) are responsible for: For Short Term Stay (up to 6 months):

- Determining the type of health insurance coverage the prospective resident has and whether or not the RHCP is authorized to serve the Member;
- Submitting progress notes to ArchCare Community Life Case Manager Bi-Weekly;
- Obtaining authorization for any covered service outside of daily rate; and,
- Assisting in the Medicaid recertification process.

For Long Term Care:

- Determining eligibility for Institutional Medicaid and other Third Party Health Insurance and whether or not the RHCP is authorized to serve the Member;

- Submitting Conversion Applications for Members placed for long term care;
- Identifying the admission as a Managed Long Term Care admission;
- Collecting the National Alliance on Mental Illness (NAMI will be deducted from payments) and submitting proof of NAMI income annually;
- Submitting Resident Monthly Summaries to the ArchCare Community Life Care Manager;
- Including ArchCare Community Life Care Manager in case conferences;
- Obtaining authorization for any covered service outside of daily rate; and,
- Assisting in the Medicaid recertification process.

Note: ArchCare Community Life Members must be eligible for Institutional Medicaid to remain in a RHFC for long term care.

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 Community 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 Community 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 Community Life Case Manager prior to delivery.

Transportation Providers are responsible for:

- Arriving within 30 minutes of scheduled pick up time and within 1 hour of will call time;
- Providing all requested in and out of borough transportation requests, including special needs transports;
- Assuring that all transportation is to medical appointments unless specifically noted in the authorization;
- Notifying ArchCare Community Life when a requested trip is to a non-medical destination not noted in the authorization;
- Notifying ArchCare Community Life when a Member cancels or does not show for a pick up;
- Notifying ArchCare Community Life when it is determined, upon arrival, that the driver is unable to transport a Member safely; and,
- Obtaining documentation for each trip provided, including the following:
  (a) Member's name and ID number
  (b) Date of Transport
  (c) Pick up address and time of pick up
  (d) Drop off address and time of drop off
  (e) Vehicle License Plate number

(f) The full printed name of driver

ArchCare Community Life requires that all Ambulette and Car Service participating Providers follow the safety criteria in accordance with the TLC & Safety Emissions of New York when transporting Members, including the following securement systems:

- Tie Down Straps: 4 Tie Down Straps for each Wheelchair Position.
- Seat Belts: A passenger seat belt and shoulder harness shall also be provided for use by mobility aid users for each mobility aid securement device. These belts shall not be used in lieu of a device, which secures the mobility aid itself.

Additional transportation requirements:

Each vehicle must be equipped (installed) as follows:

- Body Fluid/Spill Kit
- Reflector Triangle Kit (3 Triangles)
- First Aid Kit
- Fire Extinguisher

ARCHCARE COMMUNITY LIFE'S RESPONSIBILTIES TO PROVIDERS

ArchCare Community 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 Provider 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 Community 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 Community Life and the Providers. Breaches of those values by either ArchCare Community 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 Community Life trade secret and/or intellectual properties, whether such information is marked confidential without the prior written consent of ArchCare
Community Life. The Provider must take reasonable steps to safeguard ArchCare Community Life's trade secret and intellectual property to prevent unauthorized or improper use or copying.

RETURN OF TRADE SECRET AND INTELLECTUAL PROPERTY

Upon termination of the Provider Agreement for any reason, the Provider promises to return (or destroy at the option of ArchCare Community Life) any and all ArchCare Community Life's trade secret and intellectual property that can reasonably be returned or destroyed to ArchCare Community Life or designee.

TERMINATION OF PROVIDER AGREEMENT

Termination by ArchCare Community Life

ArchCare Community 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 Community Life poses and imminent harm to the Member; b) the Provider cannot deliver the services authorized for the Member; c) a determination by ArchCare Community 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 Community Life defaults in the performance of any material duty or obligation hereunder, the Provider, at their option may give ArchCare Community life written notice identifying the alleged default or breach and if ArchCare Community Life does not cure such default or breach within 30 calendar days, Provider at their option, may terminate the Agreement upon thirty (30) days written notice to ArchCare Community Life.

When a Provider leaves the plan for reasons other than fraud, loss of license, or other final disciplinary action impairing the ability to practice, ArchCare Community 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 Community Life's reimbursement rates as payment in full. The Provider must also agree to adhere to ArchCare Community Life's quality assurance requirements, abide by policies and procedures, and supply ArchCare Community 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 COMMUNITY LIFE

ArchCare Community 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 Community 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 Community 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 Community Life requires staff and committee participants to sign a Conflict of Interest statement on an annual basis. ArchCare Community 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 Community 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 Community Life at the time the services was provided and to the Provider's compliance with the Archcare Community 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 Community Life. Failure to do so may affect claims payment. Note, however, that
Members may retroactively lose their eligibility with Archcare Community Life after the date of service. Therefore, verification of eligibility is not a guarantee of payment by Archcare Community 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 Community 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.

SUBMITTING PAPER CLAIMS

All paper claims must be submitted to:

ArchCare Community 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 Community 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 Community 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 Community Life Payer ID Number **27034 – for EDI Claims Only**	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 Code(s), when required		X

Principal, Admitting, and Other ICD – 9 Diagnosis Codes including 4th and 5th digit, when required		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 Primary Payer

Both in-network and out of network providers should submit all claims within thirty (30) days of 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 the time period set forth in the Provider's agreement with Archcare Community Life. Claims submitted after this time period will not be paid except under the reasons outlined in the Late Claim Submission below. In no event will Archcare Community Life pay claims submitted more than one year from the date of service.

Timely Claim Submission Secondary Payer

When Archcare Community Life is secondary, claims must be submitted within 30 days from when the provider came within the control of primary adjudication. For Secondary coverage, claim submissions must include Explanation of Medical Benefits.

Late Claim Submission

In certain circumstances, Archcare Community Life will process claims submitted after the time period required under the Provider's agreement with Archcare Community Life. 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 the time period required.

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 ninety (90) calendar days from the time of notification of eligibility (submit with documentation substantiating the delay)
Member's Enrollment with ArchCare Community 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 Community 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 Community Life is Always the secondary Payer in the Following Circumstances

- Workers compensation
- Automobile medical
- No-fault or liability auto insurance

Archcare Community 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 Community Life will use the same guidelines as Medicare for the determination of primary and secondary payer. As a result, Archcare Community 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 Community 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. In-network providers are granted access to 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 Review and Reconsideration of a

Claim

Please note that the process described here does not apply to utilization management determinations concerning medical necessity.

A Provider may be dissatisfied with a decision made by Archcare Community 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 Community Life must submit a written request for review and reconsideration with all supporting documentation **within sixty (60) business days** from Archcare Community Life's initial date of action that led to the dispute, to the following address:

Archcare Community 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 Community Life's Member identification number
- Date(s) of service
- The Archcare Community Life claim(s) number
- A copy of the original claim or corrected claim, if applicable

Archcare Community 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 **45** calendar days from the date of receipt of the Provider's request for review and reconsideration.

Archcare Community 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 utilizing 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 Community Life
205 Lexington Avenue, 8th Floor
New York, NY 10016
Attention: Provider Disputes

Plan Identification

Archcare Community 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 Community Life may identify instances when we have overpaid a Provider for certain services. When this happens, Archcare Community Life provides notice to the Provider and recoups the overpayment consistent with Section 3224-b of the New York State Insurance Law.

Archcare Community 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 Community Life has underpaid any claim(s) to a Provider, Archcare Community Life may offset any underpayments that may be owed against past overpayments made by Archcare Community Life dating as far back as the claim underpayment.

Notice of Overpayments Before Seeking Recovery

If Archcare Community Life has determined that an overpayment has occurred, Archcare Community 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 Community Life within 30 calendar days from the date the overpayment notice was mailed by Archcare Community 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 Community 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 Community 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 Community Life and include all supporting documentation in accordance with the Provider appeal procedure.

If upon reviewing all supporting documentation submitted by a Provider, Archcare Community Life determines that the overpayment determination should be upheld, Providers may initiate arbitration pursuant to their Provider agreement. Archcare Community 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 Community Life, within 30 calendar days from the date the overpayment notice was mailed the Provider will have acknowledged and accepted the amount requested by Archcare Community Life. Archcare Community Life will offset the amount outstanding against current and future claim remittance(s) until the full amount is recovered by Archcare Community Life.

NOTIFYING ARCHCARE COMMUNITY LIFE 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

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COMPLAINTS, GRIEVANCES, APPEALS AND COMPLIMENTS

ArchCare Community 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 Community Life offers assistance to Members and their representatives in all phases of the grievance, appeal and compliance process.

ArchCare Community Life will try to resolve any complaint that a Member may have. ArchCare Community 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 Community 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 Community 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 Community 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 Community 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 Community 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 Community 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 15 days of request
- Urgent care appointments — within 24 hours of request
- Non-urgent care appointments — within 7 calendar days
- 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 Community 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 Community Life's QAPI Plan are available from the Director of Quality

Management. The QAPI Plan includes the following:

- The plan involves all ArchCare Community Life employees, Providers, Members and their support systems in our CQI efforts.
- The plan is to systematically improve, monitor, evaluate the care provided and maximize Member satisfaction.
- The plan defines ArchCare Community 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 Community Life's QAPI Plan is the responsibility of the Board of Directors of ArchCare Community Life.

COMPLIANCE & FRAUD WASTE AND ABUSE

Overview

ArchCare Community Life is committed to preventing and detecting fraud, waste and abuse. As an ArchCare Community 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 Community 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 Community Life Compliance Department, upon request.

Audit Cooperation

It is the responsibility of Provider staff to cooperate with ArchCare Community Life, and any of its subsidiaries or affiliates as necessary, to support ArchCare Community Life in carrying out its monitoring responsibilities, including but not limited to, allowing ArchCare Community 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 the following, to ensure none of its employees, vendors or contractors are excluded from the:

- OIG exclusion list database;
- OMIG excluded Provider list; and
- EPLS excluded Provider list

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 Community 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 Community Life's Compliance Hotline at 800-443-0463**, or the ArchCare Community 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.

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

2. 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 Community 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.
- Failure to report sanctions.

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

- 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 unlawful 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 Community 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 Community 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.

MEDICAL RECORDS

Maintenance and Retention of Medical Records

Providers must maintain adequate medical records for all ArchCare Community 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 Community 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 Community 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 Community Life and NYSDOH. Microfilm or electronic copies of records may be substituted for the originals with the prior written approval of Archcare Community 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 Community Life contract is active and for a period of ten (10) years thereafter, Providers must provide Archcare Community 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 Community 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 Community Life of any request for access to any records maintained pursuant to their contract with Archcare Community Life. All provisions of your Agreement with Archcare Community 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.

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 Community Life abides by a zero-tolerance against non-compliance.

HIPAA

ArchCare Community Life is concerned with protecting Member privacy and is committed to complying with the Health Insurance and Portability Act (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.

HITECH Act

The Health Information Technology for Economic and Clinical Health (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 healthcare 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:

When the breach happened, when the event was discovered, and a brief statement about what happened

What type of PHI was breached?

Things that the individual can do in order "to protect themselves from potential harm resulting from the breach"

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.

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. 1If 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.

ARCHCARE COMMUNITY LIFE/PROVIDER PARTNERSHIP

ArchCare Community Life views every vendor as a partner in care. Our staff works with Provider staff to facilitate the right services, in the right place, with the right amount of services/hours based upon individual Member needs.

Selected vendors also participate in committee work and quality improvement initiatives. When Providers identify clients they feel will both qualify for and benefit from the unique services that ArchCare Community Life provides, more plan information can be obtained.

The steps for a Provider to obtain information:

- Call the Marketing Team at 646-678-2819, or,
- Fax form to 646-289-7791.

Assessment process – An Enrollment Specialist will contact the potential applicant and provides information to an Entitlement staff Member who will ensure Medicaid eligibility. The Enrollment RN will make a visit and do a detailed assessment, prepare an initial plan of care and communicate with the Member's Primary Care Provider. Once completed, the outcome of the enrollment will be communicated to the referral source.

Participating Providers who wish to communicate with their patients about managed care options must direct patients to the State's Enrollment broker for education on all plan options. Participating Providers shall not advise patients in any manner that could be construed as steering towards any Managed Care product type. taking into consideration Participating Providers are prohibited from displaying the Contractor's outreach materials.

archcare
Community Life

REFERRAL FORM

For information about ArchCare or to make a referral, please contact:

Office: 646-289-7700 Cell: 646-678-2819 Fax: 646-289-7791 Website: www.archcare.org

REQUIRED INFORMATION:

Name of Patient: _____ Phone: _____

Referrer: _____ Referrer Phone: _____

Organization: _____ Date of Referral: _____

REFERRAL INFORMATION:

Address:

Date of Birth: Gender: Male Female SSN#: _

Current Location: Home Nursing Home Hospital Other: _____

Lives with: Alone Family Other: _____

Medicaid Status: _____ Eligible _____ May be eligible Medicaid #: _____ Medicare #: _____

Other Insurance:

FAMILY OR CAREGIVER INFORMATION

Name: _____ Relationship _____

Address: _____

Phone: _____

REASON FOR REFERAL

- Chronic Conditions Yes No _____
- Disabilities Yes ____ No _____
- Requires Assistance Yes No _____
- Primary Diagnosis: _____

Patient requesting: _____

Receiving home care services: _____ Yes ____ No ____ Don't know

If so, please specify service and Provider contact info: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone: _____

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 PHONE NUMBERS AND FORMS

ARCHCARE COMMUNITY LIFE QUICK REFERENCE GUIDE	
Member Eligibility	Telephone: 855.467.9351 Option 2
Care Management	Telephone: 1-855-467-9351
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.

Where to Get More Information:

- Provider Directory
- Provider Manual
- Member Handbook for Members who live in the NYC or Westchester
- Notice of Privacy Practices
- Archcare Code of Conduct

http://www.archcare.org

DEFINITIONS

1. Enrollment Agreement is the document issued to a Member by ArchCare Community Life that describes the covered services the Member is entitled to receive as a Member of ArchCare Community Life; and its obligations to arrange for the delivery of those services to ArchCare Community 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 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 Community 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, PACE Center manager, home health care coordinator, home health aides/personal care attendants, and drivers.

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

10. Primary Care Provider 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.

11. 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 Community Life's credentialing criteria.

12. Quality Assurance Performance Improvement (QAPI): ArchCare Community 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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