



MANAGED LONG TERM CARE PLAN MEMBER HANDBOOK



WELCOME TO ARCHCARE COMMUNITY LIFE

We are pleased to provide you with your ArchCare Community Life Member Handbook. The Handbook covers important information for you to know, such as how to access services including urgent and emergency care. Always remember to contact your ArchCare Community Life Care Manager whenever you need health care services or if you have any questions. You can reach your ArchCare Community Life Care Manager, or another ArchCare Community Life representative, 24 hours a day by calling **1-855-467-9351** (TTD/TTY: 711).

Carry your ArchCare Community Life identification card, which will be sent to you separately, at all times. Keep your ArchCare Community Life identification card with your Medicare and/or Medicaid identification card(s) and any other health insurance card, and show them to your health care providers as described on the back of the ArchCare Community Life identification card.

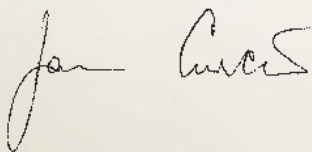
ArchCare Community Life's offices are located at **205 Lexington Avenue, 3rd Floor, New York, NY 10016**. Please feel free to visit us during business hours (Monday – Friday, 8:30 a.m. – 5:00 p.m.) or you can email us at **ACLmembers@archcare.org**. If you do not speak English, ArchCare Community Life will provide you with free assistance through one of our staff members and/or translation services to communicate with you in person or by telephone in whatever language you speak.

If you have special needs such as sight or hearing needs, contact us and we will provide extra assistance. We will help you find the services that will meet your needs from providers who understand and are prepared to help. We also have materials in large print to help make communication easier.

ArchCare Community Life values our members, and we are here to help you. We will ask you for your advice on how we can make the Plan better, how we can make it easier for you to get the care you need, and how we can improve the quality of services that we provide to you. Your input is important to us and important to your care. If you need to tell us something about your care, you can do that at any time by calling Member Services at **1-855-467-9351**.

Together, we will work with you to help you achieve your health goals and provide assistance in arranging the services you need.

Sincerely,

A handwritten signature in black ink, appearing to read "James Curcio".

James Curcio
Vice President
ArchCare Community Life

MEMBER HANDBOOK

TABLE OF CONTENTS

OMBUDSMAN PROGRAM	2	GRIEVANCE AND APPEAL	28
DISCRIMINATION IS AGAINST THE LAW	2	WHAT IS A GRIEVANCE	28
WHAT IS ARCHCARE COMMUNITY LIFE?	4	COMPLAINT AND APPEAL	28
WHO IS ELIGIBLE TO ENROLL IN ARCHCARE COMMUNITY LIFE?	5	WHAT IS A COMPLAINT?	28
IDENTIFICATION CARD	7	THE COMPLAINT PROCESS	28
CAN I CONTINUE TO USE MY OWN DOCTOR?	7	HOW DO I APPEAL A COMPLAINT DECISION?	29
ADVANCE DIRECTIVES	7	WHAT IS AN ACTION?	29
CONFIDENTIALITY	8	TIMING OF NOTICE OF ACTION	29
DO I HAVE TO PAY TO RECEIVE SERVICES?	8	CONTENTS OF THE NOTICE OF ACTION	30
SPENDDOWN/SURPLUS	8	HOW DO I FILE AN APPEAL OF AN ACTION?	30
MEDICARE	9	HOW DO I CONTACT MY PLAN TO FILE AN APPEAL?	30
WITHDRAWAL OF ENROLLMENT	9	FOR SOME ACTIONS YOU MAY REQUEST TO CONTINUE SERVICE DURING THE APPEAL PROCESS	30
DENIAL OF ENROLLMENT	9	HOW LONG WILL IT TAKE THE PLAN TO DECIDE MY APPEAL OF AN ACTION?	31
WHAT SERVICES ARE COVERED BY ARCHCARE COMMUNITY LIFE?	10	EXPEDITED APPEAL PROCESS	31
WHAT SERVICES WILL NOT BE COVERED BY ARCHCARE COMMUNITY LIFE?	18	IF THE PLAN DENIES MY APPEAL, WHAT CAN I DO?	31
CARE MANAGEMENT TEAM	20	STATE FAIR HEARINGS	32
TRANSITIONAL CARE	21	STATE EXTERNAL APPEALS	33
PLAN OF CARE	21	SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS	33
PROVIDER NETWORK	21	DEFINITIONS	33
OUT-OF-NETWORK CARE	21	GENERAL PROVISIONS	34
TRANSITIONAL CARE FROM NETWORK	22	TIMEFRAMES FOR SERVICE AUTHORIZATION DETERMINATION AND NOTIFICATION	34
PROVIDERS	22	OTHER TIMEFRAMES FOR ACTION NOTICES	35
EMERGENCY CARE	22	CONTENTS OF ACTION NOTICES	36
(NON-COVERED SERVICE)	22	IMPORTANT CHANGE FOR MEDICAID MANAGED CARE ENROLLEES APPEALS AND FAIR HEARING RIGHTS	37
OUT-OF-AREA CARE	22	DISCRIMINATION IS AGAINST THE LAW	39
SERVICE	23	MULTI LANGUAGE	40
AUTHORIZATIONS	23		
MEMBER RIGHTS	24		
MEMBER RESPONSIBILITIES	25		
VOLUNTARY DISENROLLMENT	25		
INVOLUNTARY DISENROLLMENT	26		
ARCHCARE COMMUNITY LIFE MAY DISENROLL YOU IF:	27		
WHEN DOES A DISENROLLMENT BECOME EFFECTIVE?	27		
WHAT IS A GRIEVANCE?	27		

OMBUDSMAN PROGRAM

The Participant Ombudsman is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. These services include, but are not necessarily limited to:

- i. providing pre-enrollment support, such as unbiased health plan choice counseling and general program-related information,
- ii. compiling enrollee complaints and concerns about enrollment, access to services, and other related matters,
- iii. helping enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the State level, and assisting them through the process if needed/ requested, including making requests of plans and providers for records, and
- iv. informing plans and providers about community-based resources and supports that can be linked with covered plan benefits.

At this time, the Participant Ombudsman is the Independent Consumer Advocacy Network (ICAN). ICAN is available to answer your questions regarding your rights, Medicare, Medicaid and long term care services. ICAN can also assist you with resolution of any issues related to access to care and with filing appeals and grievances. You have the Right to seek assistance from the Participant Ombudsman program. You can call ICAN to get free, independent, advice about your coverage, complaints, and appeals options. They can help you manage the appeal process. Contact ICAN toll-free to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)

Web: www.icannys.org.

Email: ican@cssny.org

DISCRIMINATION IS AGAINST THE LAW

ArchCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ArchCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ArchCare

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - o Qualified interpreters
 - o Information written in other languages

If you need these services, contact **Victor Fama @ (917) 484-5055 TTY 711**

If you believe that ArchCare has failed to provide these services listed above or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Victor Fama, (917) 484-5055 TTY 711**, or email compliancereport@archcare.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **Victor Fama (917) 484-5055 TTY 711** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available on-line at <http://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-380-2589 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-380-2589 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-380-2589 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-380-2589 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-380-2589 (청각 장애인용 서비스: 711)으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-380-2589 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-380-2589 (телефакс: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-380-2589 (TTY: 711) رقم هاتف الصم والبكم

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-380-2589 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-380-2589 (ATS: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-380-2589 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-380-2589 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-380-2589 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-380-2589 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。（1-855-380-2589 (TTY: 711).まで、お電話にてご連絡ください。

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت 2589-380-855-1 رایگان برای شما بگیریید تماس 1-855-380-2589 (TTY: 711) با باشد می ف.

WHAT IS ARCHCARE COMMUNITY LIFE?

ArchCare Community Life is approved by the New York State Department of Health (DOH) as a Managed Long Term Care Plan (MLTCP) for individuals who need long term care services and who are eligible for Medicaid and Medicare, or eligible for Medicaid only. ArchCare Community Life provides long term care and other health-related services to members within Manhattan, The Bronx, Brooklyn, Queens, Staten Island, Westchester and Putnam Counties. ArchCare Community Life gives you the flexibility and freedom you need to make the right choices that will help you achieve your best possible state of health.

Managed long term care means that a coordinated Plan of Care and coordinated services are provided to individuals who choose to enroll in ArchCare Community Life. Your primary care doctor and/or the ArchCare Community Life Care Manager must order these services. Members obtain these services through a network of ArchCare Community Life participating health care providers. Once enrolled, you can continue to use your own primary care doctor, as long as your doctor is willing to collaborate with ArchCare Community Life. Your Medicare and Medicaid benefits remain in effect.

You must use a provider listed in ArchCare Community Life's Provider Directory when receiving any of ArchCare Community Life's covered services. Your Care Manager can choose or assist you in choosing the providers that meet your needs. If a service is also covered by Medicare, you are free to choose any non-covered ArchCare Community Life health care provider who accepts Medicare payment; however, we encourage you to choose ArchCare Community Life providers so you will not have to change providers later, for example if your treatment exceeds Medicare's coverage limits.

Membership in ArchCare Community Life is voluntary. You can decide on your own, or with ArchCare Community Life's help, whether or not to enroll in ArchCare Community Life, or to initiate disenrollment later for any reason.

ArchCare Community Life makes every effort to be responsive to cultural diversity and communication needs in all of its operations. You have the right to obtain any information from ArchCare Community Life translated into another language if you are not an English speaker. Written materials can also be provided in Spanish. As many participating providers speak languages other than English, please refer to our Provider Directory or call ArchCare Community Life to obtain the most current provider information. If you wish, ArchCare Community Life can also provide specific staff to assist you. For example, staff members are available to verbally translate materials for you on the telephone.

“Staff members are available to assist you in understanding materials in your language of choice”

Plan documents can be provided in alternate formats as well. Staff members are happy to read Plan information to individuals who are visually impaired. Large-type documents for materials such as this Member Handbook can be provided. The Plan can also arrange the services of a professional sign language interpreter on request for individuals who are hearing impaired.

WHO IS ELIGIBLE TO ENROLL IN ARCHCARE COMMUNITY LIFE?

To be eligible to enroll you must be:

- 21 years of age or older
- A resident of Manhattan, The Bronx, Brooklyn, Queens, Staten Island, Westchester or Putnam Counties
- Eligible for Medicaid

We will gather this information by telephone before a visit is arranged. A visit will not occur if you are ineligible for any of the three items listed above (see also Denial of Enrollment). You will be advised that you are not eligible at this time for enrollment in ArchCare Community Life and will be given an opportunity to withdraw your application for enrollment.

You must also be:

- Capable of returning to or remaining in your home and community without jeopardy to your health and safety.
- In need of community-based long term care services and care management from ArchCare Community Life for more than 120 days from the date of enrollment. Long term care services include:
 - nursing services,
 - therapies,
 - home health or personal care aide services,
 - adult day health care.

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.



The CFEEC will ask you a series of questions about how you are currently receiving your healthcare as well as who your providers are. If you are not currently receiving long-term care services they will need to perform an initial assessment to determine whether you qualify for community based long-term care services. Community Based Long Term Care Services (CBLTCS) means health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. CBLTCS is comprised of services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, Personal Care Services.

If you are receiving long-term care services they will educate you on plans available to you. Patients interested in enrolling into ArchCare Community Life need to inform the CFEEC of their plan selection. The CFEEC will then transfer the patient by phone to our member service department where we will confirm your information. Your application will then be assigned to one of our Intake Nurses to schedule an assessment that will determine your Plan of Care upon

enrollment. We must conduct our assessment within 30 days of the referral from the CFEEC or your request to enroll.

An Enrollment Nurse will arrange to visit you to discuss ArchCare Community Life, to assist you with the details of applying for enrollment, and to gather and assess information about your health and long term care needs.

During this visit, the Enrollment Nurse will complete a comprehensive clinical assessment using New York State (NYS) approved forms, and will discuss an initial Plan of Care with you. The Enrollment Nurse will also review your Medicaid and Medicare information, if applicable, and will discuss and provide information about Advance Directives, how to access covered and noncovered services, and your rights as an ArchCare Community Life member. The Enrollment Nurse will give you a copy of this Member Handbook and Provider Directory, and will explain the forms you are required to sign for enrollment: an enrollment agreement/attestation form, an authorization for release of medical information, and a notice of HIPAA privacy practices.

Your enrollment agreement, once signed, is submitted to New York Medicaid Choice/Maximus. It will be reviewed and Medicaid eligibility will be confirmed by New York Medicaid Choice/Maximus. If New York Medicaid Choice/Maximus receives your enrollment agreement by the 20th of the month, your membership will usually begin on the first day of the next month. For example, if New York Medicaid Choice/Maximus receives the enrollment agreement by August 20, enrollment will usually begin on September 1. If New York Medicaid Choice/Maximus receives the enrollment agreement after the 20th of the month, enrollment will usually begin on the first day of the following month. For example, if New York Medicaid Choice/Maximus receives the enrollment agreement on August 24, enrollment will usually begin on October 1.

USEFUL TIP: Remember to carry your ArchCare Community Life identification card at all times.



Once you are enrolled, you will be assigned to a Care Management Team. Members of this team will call and welcome you to ArchCare Community Life after you have signed the enrollment agreement and before the actual start of services to address any questions you may have. The Care Management Team will review your Plan of Care with you and discuss placement of services for the first day of the month or the actual date you will start services.

If you are enrolled for the first day of the month, your services will begin according to your Plan of Care. Your Care Manager may make a visit to review your Plan of Care and the service authorization process if necessary.

Applications for enrollment may be accepted for otherwise eligible inpatients or residents of hospitals or residential facilities operated under the auspices of the State Office of Mental Health (OMH), State Office of Alcoholism and Substance Abuse Services (OASAS), or State Office for People With Developmental Disabilities (OPWDD). Enrollment may only begin upon discharge from these programs or other home and community-based waiver programs to the applicant's home in the community. An applicant who is enrolled in another managed care plan approved by Medicaid, a home and community-based waiver program, or an OPWDD day treatment program, or who is receiving hospice services may be enrolled in ArchCare Community Life only upon termination from the other program.

IDENTIFICATION CARD

After you enroll, your ArchCare Community Life identification card should arrive within 14 to 30 days. Remember to carry your ArchCare Community Life identification card at all times, as well as your Medicare and Medicaid identification cards and any other health insurance card, and show them when you go for care. The ArchCare Community Life identification card is effective from the first day of your membership and will help your health care providers to bill correctly for covered services.

If you need care before you receive your card, lose your identification card or need to change or correct information on your card, contact your Care Management team.



Effective Date:

Eff Date:

Date of Birth:

DOB:

Subscriber #:

SUBSCR MEDITU

Member Name:

Member Name:

Medicaid Number:

Medicaid Number:

Member Services & After Hours Call: 1-855-467-9351

New York Managed Long Term Care Benefits Only

MEMBERS: Please carry this card at all times. Show this card before you receive any covered Managed Long Term Care services. You do not need to show this card before you receive emergency care. If you have an emergency, call 911 or go to the nearest emergency room. If you have questions, call Member Services at 1-855-467-9351. Transportation request 844-544-1395 and TTY 866-288-3133

PHYSICIANS: This individual is enrolled in a new York State approved Managed Long Term Care plan that provides coverage for long term care. Physician services will be paid directly by Medicaid fee-for-service or Medicare. If the member has Medicare and/or other private insurance, their benefits are not affected by their Managed Long Term Care coverage.

HOSPITALS: This individual is enrolled in a New York State approved Managed Long Term Care plan that provides coverage for long term care. Please notify us of any inpatient activity incurred by this member as we are responsible for discharge planning. Pre-admission certification is not required. Your claim will be paid directly by Medicaid, Medicare and/or other private insurance.

CAN I CONTINUE TO USE MY OWN DOCTOR?

Yes, with ArchCare Community Life you choose your own doctor. Your Care Manager will work closely with your physician to arrange the services you need, as long as your doctor agrees to work with ArchCare Community Life. The Care Manager will also work with both network and non-network providers to coordinate all your health care services.

If you do not currently have a primary care doctor, would like to change your doctor, or if your doctor does not wish to work with ArchCare Community Life, your Care Management Team can help you locate a primary care doctor in your area. The Care Manager can also assist you with obtaining specialty doctor services, if needed.

ADVANCE DIRECTIVES

You have the right to let us and your family know how you would want to be taken care of if you became seriously ill or injured and could not communicate with your physician. Your instructions can be stated in a document called an Advance Directive. ArchCare Community Life encourages you to think about this now before an extreme situation occurs. Please speak with us and get information about how to formulate your Advance Directive.

Examples of such documents include a signed and witnessed statement with your instructions are called a Living Will, a "Do Not Resuscitate" (DNR) order, or a form called a Health Care Proxy. New York State has a law that allows you to appoint a Proxy who is someone you trust, for example a family member or close friend, to decide about your treatment if you lose the ability to decide for yourself. Be sure to discuss your wishes with your agent(s) to make certain that he or she acts in accordance with your wishes. You may also use the NYS Health Care Proxy form we give you to indicate your wishes regarding organ donation in the event of your death.

CONFIDENTIALITY

ArchCare Community Life is committed to respecting your privacy. We keep your health records confidential, making them accessible only to appropriate health professionals, health care providers, and authorized personnel as necessary for your proper care as a member of ArchCare Community Life. All of ArchCare Community Life's procedures are in compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In order to protect your privacy, we will not discuss your enrollment or care with anyone who you do not designate as an "Authorized Representative". At the time of assessment, you will be asked to complete an "Authorized Representative Form" to list anyone you give us permission to discuss your care with.

DO I HAVE TO PAY TO RECEIVE SERVICES?

ArchCare Community Life provides and coordinates services that are typically covered by Medicaid. If you are eligible for Medicaid, you will pay nothing to ArchCare Community Life. If you are eligible for Medicaid with Spend-Down you pay the monthly spend-down amount to ArchCare Community Life.

However, if you choose to access services on your own that are not covered or obtain services of a non-participating provider that are not authorized by ArchCare Community Life, you may be responsible for payment of these services.

SPENDDOWN/SURPLUS

If you are required to pay a monthly spenddown/surplus in order to receive Medicaid benefits, the Human Resource Administration (HRA) will determine the spend-down amount to be paid by you to ArchCare Community Life. If you have a spenddown/surplus, a bill will be sent to you each month requesting payment. If your bill is not paid on time, we will make an effort to collect payment by sending you another copy of the bill and making a follow-up call. If these efforts fail, you will receive a letter letting you know that you may no longer be able to continue enrollment in ArchCare Community Life. Your spend-down payment or NAMI, by check or money order, should be sent to the following address:

ArchCare Community Life
Attn: Finance Dept., 2nd Floor
205 Lexington Ave.
New York, NY 10016

If payment cannot be sent by mail, please contact us Monday through Friday, 8:30 a.m. to 5:00 p.m. at 1-855-467-9351, so that other arrangements can be made.



MEDICARE

If you have Medicare and/or Medicare Supplementary coverage and benefits, they do not change when you join ArchCare Community Life, and you are free to choose Medicare providers for ArchCare Community Life's covered services and non-covered services. If both Medicare and ArchCare Community Life cover a service, Medicare will be billed first. If Medicare doesn't cover the service and ArchCare Community Life does, this service will be billed from ArchCare Community Life's provider network directly to ArchCare Community Life. If a provider is not in the provider network, you should contact your Care Management Team prior to using that provider to avoid getting billed for unauthorized services after your Medicare coverage has been exhausted.

If Medicare does not cover the entire cost of a service which is also within ArchCare Community Life's list of covered services, any Medicare Supplement or other health insurance coverage you have will be billed for deductibles or co-insurance prior to payment by ArchCare Community Life.

If your Medicare or related coverage becomes exhausted, you will need to change to providers in ArchCare Community Life's network.

WITHDRAWAL OF ENROLLMENT

You may withdraw your application at any time during the enrollment process. You may elect to withdraw your application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment by advising us orally or in writing, and we will confirm your withdrawal in writing.

DENIAL OF ENROLLMENT

Enrollment will be denied if, after assessment by ArchCare Community Life, you do not meet the criteria:

1. Capable of returning to, or remaining in your home and community without jeopardizing your health and safety.
2. In need of community-based long term care services and care management from ArchCare Community Life for more than 120 days from the date of enrollment.

Enrollment will be denied by New York Medicaid Choice/Maximus if, after assessment by ArchCare Community Life, you do not meet these criteria.

If you do not meet the eligibility criteria for age, county of residence, and Medicaid eligibility, you may not be assessed for enrollment. If you choose to pursue enrollment even though you are not eligible, we will send this information to New York Medicaid Choice/Maximus for review and eligibility determination.

WHAT SERVICES ARE COVERED BY ARCHCARE COMMUNITY LIFE?

Below is the list of services covered by ArchCare Community Life. Your care must be “medically necessary” as determined by your physician and your Care Management Team. This means that the services you get are needed to prevent, diagnose, correct, or cure any conditions that you might have that cause acute suffering, endanger your life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant disability.

Covered services are provided to you through a network of ArchCare Community Life participating health care providers as listed in our Provider Directory. The following services are covered by ArchCare Community Life:

SERVICE	COVERAGE RULES
Care Management Your Care Manager will assess your health care needs on an ongoing basis with your Care Management Team. Your Care Manager will also be responsible for the coordination and delivery of planned services.	Every member will be assigned to a Care Manager. Care management includes referral to and coordination of other necessary medical, social, educational, financial and other services of the person centered service plan that support the Enrollee’s psychosocial needs irrespective of whether such services are covered by the Plan. Care management means a process that assists the Enrollee to access necessary covered services as identified in the Person Centered Service Plan (PCSP). Care management services include referral, assistance in or coordination of services for you to obtain needed medical, social, educational, psychosocial, financial and other services in support of the PCSP, irrespective of whether the needed services are included in our Benefit Package.

SERVICE	COVERAGE RULES
Non-Emergency Transportation Non-emergency Transportation is transport by ambulance, ambulette, taxi, livery service or public transportation at the appropriate level for the member's condition to obtain necessary medical care and services reimbursed through the Medicaid or Medicare programs. To schedule non-emergency transportation, you must call Logisticare, ArchCare's Transportation dispatch vendor, directly at 1-844-544-1395 (Monday through Friday, 8 a.m. – 5 p.m. (TTY: 1-866-288-3133). You must request your regular transportation at least 72 hours in advance. To schedule a return trip from your appointment, or if your ride does not arrive when you have scheduled it, you can request assistance by calling the "Where's My Ride" number: 1-844-544-1396. You can also schedule online at: https://member.logisticare.com	You must receive Non-Emergency Transportation from the ArchCare Community Life Provider Network.
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. When a service is covered by Medicare, you may get the care from a provider that is not in the ArchCare Community Life Provider Network. When your care is covered by Medicaid, you will have to use an in-network provider and obtain authorization from the Plan. <i>Your doctor will need to provide signed written orders to the provider.</i>
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.	You must receive Personal Care from the ArchCare Community Life Provider Network, and you must obtain authorization from the Plan. <i>Your doctor will need to provide signed written orders to the agency providing care.</i>

DID YOU KNOW: Covered services are provided to you through a network of ArchCare Community Life participating health care providers as listed in our Provider Directory.

SERVICE	COVERAGE RULES
Consumer Directed Personal Assistance Services (CDPAS) CDPAS is some or total assistance with personal care tasks, home health aide tasks and/or skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or designated representative. There is flexibility and freedom in choosing the consumer directed personal assistant or caregiver.	You must obtain authorization from the Plan and you must work with a “fiscal intermediary” who is in contract with ArchCare Community Life to administer the wage and benefit for your consumer directed personal assistant(s). Your doctor will need to provide signed written orders to the Plan.
Veteran’s Homes	If you are a veteran, spouse of a veteran, or Gold Star parent in need of long term placement, you are eligible for placement in a veteran’s home. Currently St. Albans, Jamaica, NY (Queens County) and Montrose (Westchester County) are in our network. Call the CFEEC at 1-855-222-8350 for more information about veteran’s homes. If you wish to receive care from a veteran’s home, we will pay for an out-of-network veteran’s home that is in our service area until you are transferred to an MLTC Plan with an in-network veteran’s home.
Physical Therapy, Occupational Therapy, Speech Pathology in a setting outside the home Physical therapy (“PT”) is rehabilitation services provided by a licensed and registered physical 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. PT, OT, SP or other therapies provided in a setting outside the home are limited to 20 visits of each therapy type per calendar year.	You must receive Physical Therapy, Occupational Therapy and/or Speech Pathology from the ArchCare Community Life Provider Network, and you must obtain authorization from the Plan. <i>Your doctor will need to provide signed written orders to the rehabilitative care provider.</i>

SERVICE	COVERAGE RULES
Institutional Long Term Services and Supports (ITLSS) ITLSS mean Residential Health Care Facility (Nursing Home) services as included in the Benefit Package and provided by us when medically necessary.	Short term rehabilitative stays may be covered by Medicare. If your stay in a nursing home is covered by Medicare, you may get care from a nursing home that is not in the ArchCare Community Life Provider Network. If your Medicare benefits expire, your stay would become Medicaid-covered. If that should happen, you will have to use an ArchCare in-network provider and obtain authorization from the Plan. Long Term placement (Permanent Placement) Status means the status of an individual in a Residential Health Care Facility (RHCF) when the CFEEC determines that you are not expected to return home based on medical evidence affirming your need for long term (permanent) RHCF placement. You may be covered only if you are eligible for institutional Medicaid. Your Care Manager can help you apply for this. If you are covered, you must use an in-network provider and obtain authorization from the Plan. Your 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, you 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.	You must receive Adult Day Health Care from the ArchCare Community Life Provider Network, and you must obtain authorization from the Plan. Your 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.	You must receive Social Day Care from the ArchCare Community Life Provider Network, and you must obtain authorization from the Plan.

SERVICE	COVERAGE RULES
Optometry/Eyeglasses Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.	You 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 two years unless you have diabetes or services are medically needed more frequently. <i>Your doctor will need to provide signed written orders.</i>
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 hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.	Audiology exams may be covered by Medicare. When a service is covered by Medicare, you may receive the care from a provider that is not in the ArchCare Community Life Provider Network. When the service is covered by Medicaid, you will have to use an in-network provider. <i>Your doctor will need to provide signed written orders.</i>
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 a necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, 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, you may receive the care from a provider that is not in the ArchCare Community Life Provider Network. When the service is covered by Medicaid, you will have to use an in-network provider. <i>Your doctor will need to provide signed written orders.</i>
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, you may receive the care from a provider that is not in the ArchCare Community Life Provider Network. When the service is covered by Medicaid, you will have to use an in-network provider.
Home-Delivered or Congregate Meals	You must receive Home-Delivered or Congregate Meals from the ArchCare Community Life Provider Network, and you must obtain authorization from the Plan.

SERVICE	COVERAGE RULES
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.	You must receive Respiratory Therapy from the ArchCare Community Life Provider Network, and you must obtain authorization from the Plan. Your doctor will need to provide signed written orders to the therapist providing care. <i>Your doctor will need to provide signed written orders to the respiratory care provider.</i>
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.	You must receive Nutritional Services/Counseling from the ArchCare Community Life Provider Network, and you must obtain authorization from the Plan.
Medical and Surgical Supplies/Enteral Feeding and Supplies/Parenteral Nutrition and Supplies Medical and surgical supplies are items for medical use other than drugs, such as prosthetic or orthotic appliances and devices 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, you may receive the item from a provider that is not in the ArchCare Community Life Provider Network. When the item is covered by Medicaid, you will have to use an in-network provider. <i>Your doctor will need to provide signed written orders to the provider.</i>
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 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, you may receive the item from a provider that is not in the ArchCare Community Life Provider Network. When the item is covered by Medicaid, you will have to use an in-network provider. <i>Your doctor or podiatrist will need to provide signed written orders to the provider.</i>

SERVICE	COVERAGE RULES
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	You must receive social and environmental supports from the ArchCare Community Life Provider Network, and you 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.	You must receive PERS from the Provider Network, and you must obtain authorization from the Plan.
Private Duty Nursing Private duty nursing services are medically necessary services provided to you at your permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies.	Private Duty Nursing may be covered by Medicare. When a service is covered by Medicare, you may receive the care from a provider who is not in the ArchCare Community Life Network. When the service is covered by Medicaid, you will use an ArchCare Community Life Network provider. <i>Your doctor will need to provide signed written orders to the Private Duty Nurse provider.</i>
Telehealth Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee. Telehealth provider means: physician, physician assistant, dentist, nurse practitioner, registered professional nurse (only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring), podiatrist, optometrist, psychologist, social worker, speech language pathologist, audiologist, midwife, certified diabetes educator, certified asthma educator, certified genetic counselor, hospital, home care agency, hospice, or any other provider determined by the Commissioner of Health pursuant to regulation.	Telehealth may be covered by Medicare. When a service is covered by Medicare, you may receive the care from a provider who is not in the ArchCare Community Life Network. When the service is covered by Medicaid, you will use an ArchCare Community Life Network provider. <i>Your doctor will need to provide signed written orders to the Private Duty Nurse provider.</i>

SERVICE	COVERAGE RULES
Money Follows the Person (MFP)/Open Doors This section will explain the services and supports that are available through Money Follows the Person (MFP)/Open Doors. MFP/Open Doors is a program that can help enrollees move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP if they: • Have lived in a nursing home for three months or longer • Have health needs that can be met through services in their community	MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with enrollees in the nursing home and talk with them about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help enrollees by: • Giving them information about services and supports in the community • Finding services offered in the community to help enrollees be independent • Visiting or calling enrollees after they move to make sure that they have what they need at home For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

If Medicare covers any of the above services, then Medicare will be billed first. If you have any additional insurance (other than Medicare or Medicaid), which covers any of the above services, the other insurance will be billed after Medicare. Medicaid will be billed last.

When one of the services listed above is covered by Medicare, you have the freedom to choose your own provider. However, when the service stops being covered by Medicare and is covered by Medicaid, you will have to switch to a network provider. To ensure continuity of care, it is always best to use a network provider, even when the service is covered by Medicare or another insurance. You can always call Member Services at 1-855-467-9351 if you have any questions about coverage for above services.

ArchCare Community Life reimburses providers for each individual service provided to a member on a fee-for-service basis.



USEFUL TIP: To ensure continuity of care, it is always best to use a network provider, even when the service is covered by Medicare or another insurance.

WHAT SERVICES WILL NOT BE COVERED BY ARCHCARE COMMUNITY LIFE?

Below is a list of the services that ArchCare Community Life does not cover, but which you can still receive. Medicare and/or Medicaid may cover these or any other non-covered service that you need from a provider who accepts Medicare and/or Medicaid. Although you can obtain these services yourself without ArchCare Community Life

authorization, we may assist you in obtaining these services and in making appointments and arranging non-emergency transportation and follow-up care, if needed. These services may be included in your Plan of Care and coordinated by your Care Manager

SERVICE	DESCRIPTION
Inpatient and Outpatient Hospital Care	Includes care you may receive while hospitalized or in a hospital clinic.
Physician Services	Includes care rendered by an MD, physician assistant or nurse practitioner.
Laboratory and Diagnostic Tests	Includes such tests as blood tests, urine tests, and electrocardiograms.
Radiology and Radio-Isotope X-rays	Includes X-rays, bone scans, CAT scans and MRIs.
Hospice	Includes hospice home visits and inpatient hospice care.
Hospital Emergency Room Care	Includes visits to the emergency room, renal dialysis, including hemodialysis or peritoneal dialysis.
Mental Health Services	Includes inpatient and outpatient treatment for mental health problems such as, but not limited to, depression and schizophrenia.

SERVICE	DESCRIPTION
Alcohol and Substance Abuse	Includes care received for treatment of alcohol or drug abuse. This would include hospitalization or outpatient treatment.
Office for People with Developmental Disabilities	Includes services received through the New York State Office for People with Developmental Disabilities (formerly the Office of Mental Retardation and Developmental Disabilities) such as day programs and vocational training.
Emergency Transportation	Includes emergency ambulance transportation service.
Family Planning	Medical treatment such as vasectomies or tubal ligation.
Prescription Drugs, Compound Prescriptions and Non-Prescription Drugs	

Services not covered by ArchCare Community Life may be covered by another insurer. Your Care Manager will assist you in coordinating and obtaining these services, even though ArchCare Community Life does not cover them.

You can contact providers for services not covered by ArchCare Community Life directly, without a referral or authorization from ArchCare Community Life. So we can coordinate and manage your care in the best way possible, please let your Care Manager know about any appointments you have with providers of services not covered by the Plan.

If you require non-emergency transportation to any health-related appointment, you must call ArchCare Community Life so we can arrange and provide you with non-emergency transportation.

As a member of ArchCare Community Life you must have Medicaid. Your Medicaid identification card remains active provided you maintain Medicaid eligibility. As a Medicaid recipient, you may continue to receive all services covered by Medicaid, even those not covered by ArchCare Community Life.

CARE MANAGEMENT TEAM

When you enroll, you and your Care Management Team (your doctor, your Care Manager, your caregiver(s) and other health care providers) will work together to develop a Plan of Care that meets your needs. The Plan of Care is a written description of all the services you need. It is based on an assessment of your health care needs, the recommendation of your doctors and your personal preferences. You will be given a copy of the Plan of Care for your records at your request. You will also receive a copy of your Service Plan which will include a listing of how often and how long you will receive the services included in your Plan of Care.

Your Care Manager will follow up with you on a regular basis to check on your health care status, including, depending on your needs and the severity of your health conditions, a minimum of one telephone call per month and one home visit every six months. Your Care Manager will work with your doctor and other health care providers to ensure you are receiving all needed and ordered services as well as help connect you to community resources.

When you join ArchCare Community Life, you will be assigned a Care Manager who will assist you in accessing the services that you need in order to remain as independent and as healthy as possible. Your Care Manager will also:

- Call you and visit with you and your family or other individuals who may be assisting you on a regular basis to assure that you are satisfied with the care and services you are receiving;
- Work with your primary care doctor to obtain the medical orders needed for covered services in your Plan of Care;
- Work with you and your providers to authorize covered services based on medical necessity;
- Talk to your primary care doctor about changes or updates to your Plan of Care;
- Arrange and coordinate services that are covered by ArchCare Community Life;
- Help arrange for services you need but are not covered by ArchCare Community Life or are not available within ArchCare Community Life's existing network;

- Be available to you, or provide coverage by another Care Manager, 24 hours a day to assist you with urgent care or other issues.
- Educate and inform you about Consumer Directed Personal Assistance Services (CDPAS) and other service options;
- Respond to your contacts within 48 hours or less, depending on your needs and the request

If you have a life-threatening disease or condition or a degenerative or disabling condition on enrollment, you may continue an ongoing course of treatment with a non-network health care provider for up to 90 days after enrollment. In addition, if you are transitioning from a Medicaid community-based long term care program, we will continue to provide services authorized under your pre-existing service plan at the same level, scope and amount for a minimum of ninety (90) days or until your Person Centered Care Plan is in place, whichever is later. . The provider must accept payment at the ArchCare Community Life rate, adhere to ArchCare Community Life quality assurance and other policies and procedures, and provide ArchCare Community Life and your primary care doctor with medical information about your care. ArchCare Community Life's Medical Director may review these circumstances.



TRANSITIONAL CARE

For those members who are 21 years of age and older in need of long term placement in a nursing facility you should have received a notice from the New York State Medicaid Office informing you that you are required to enroll in or remain enrolled in a Managed Long Term Care Plan (MLTCP) in order to receive nursing home benefits. You will be able to access nursing home benefits through the ArchCare Community Life network providers. Should you choose to select a nursing home outside the ArchCare Community Life provider network you will require authorization from ArchCare Community Life.

ArchCare staff are here to provide you with a coordinated plan of care and coordinated services. Please contact us whenever you need assistance or if you have questions regarding nursing home benefits.

PLAN OF CARE

You, your family, your doctor, and your Care Manager will work together to develop a Plan of Care that meets your needs. The Plan of Care is a written description, including the amounts, frequency, and duration of all the services you need. It is based on ArchCare Community Life's assessment of your health and preferences, and the recommendations and medical orders of your doctors and other caregivers. Your Care Manager will work with you and your providers to obtain authorization for services and payment to network providers.

You will receive a copy of your Plan of Care. At your request, you will also receive a copy of your Service Plan. As your needs change you may require different services or a change in the amount of services you receive. Your doctor, Care Manager and network providers will work together and implement any changes to your Plan of Care. They will periodically evaluate it with you to ensure that the services you are receiving continue to meet your needs.

You are an important member of the Care Management Team, so it is important for you to talk with your doctor and Care Manager if you have a need for any service you are not receiving or wish to change your Plan of Care in any way. For example, you may request to be seen by a Physical Therapist more often than was authorized originally, or you may be receiving services that you feel you no longer need. Also, please let your Care Manager know if you are not taking your prescribed medications or have made any medication changes on your own.

PROVIDER NETWORK

When you require covered services, your Care Manager will select or assist you in selecting providers from ArchCare Community Life's Provider Directory and will make and/or assist you with the arrangements, for you to receive the needed services. Your Care Manager will also offer to coordinate any non-covered services. If you are dissatisfied with a specific provider, you may call your Care Manager and request a change and he or she will help you select a new provider in time for your next scheduled or requested appointment.

OUT-OF-NETWORK CARE

You may receive services from a health care provider outside the ArchCare Community Life network when it is determined that you require a service that a provider in our network cannot provide. Your Care Manager will coordinate these arrangements in the same manner as with a network provider. If the out-of-network service is normally an ArchCare Community Life covered service, Medicare (if you have Medicare) and/or Archcare Community Life will pay for the service.

TRANSITIONAL CARE FROM NETWORK PROVIDERS

Should your ArchCare Community Life network provider leave ArchCare Community Life during an ongoing course of treatment, your Care Manager can arrange payment for the continuation of medically necessary treatment from this provider for a transitional period of up to 90 days. ACL will make available to you other in-network options that can provide the service. We will ensure that you are kept updated on new service providers and their availability by issuing new listings or yearly updates, or more often as needed.

EMERGENCY CARE (NON-COVERED SERVICE)

An emergency is a sudden onset of a medical or behavioral condition that manifests itself by symptoms of sufficient severity including severe pain that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

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

Emergency services are services needed to evaluate or stabilize an emergency medical condition, and are **not** subject to prior authorization by ArchCare Community Life.

If you have an emergency:

- Call 911; or,
- Go to the nearest emergency facility, and show your Medicare and/or Medicaid identification card(s) and any other health insurance card.

You or someone on your behalf should notify ArchCare Community Life and your doctor as soon as possible afterward so we and/or your doctor can provide or help you obtain any services you may need after your condition is stabilized.

OUT-OF-AREA CARE

If you plan to be away from home or outside the service area of the county where you live, please notify your Care Manager as early as possible so that he or she can help arrange any appropriate services you may need in the area you will be visiting. ArchCare Community Life will work with you to plan for your needs and continue to provide non-emergency covered services to the extent that they can be arranged with the area providers. You can use your Medicare or Medicaid identification card or any other health insurance card to access noncovered services in the service area and outside of the service area, if the health care provider accepts Medicare or New York State Medicaid.

If you are out of the area and have an emergency, go to the nearest emergency facility.

You or someone on your behalf should notify ArchCare Community Life as soon as possible afterward.

An urgent medical or behavioral condition happens unexpectedly, and usually care or services are needed within 24 to 48 hours. If you are outside the service area and become ill and it is urgent but not an emergency, please telephone your Care Manager for guidance or seek the care you need and notify ArchCare Community Life as soon as possible afterward. This will enable your Care Manager to change your Plan of Care if necessary, arrange follow-up care if needed, and coordinate services for you.

SERVICE AUTHORIZATIONS

ArchCare Community Life Care Managers will work with you, your providers and the ArchCare team to obtain authorization of covered services for specific amounts and periods of time based on your needs and requests or the requests of your network providers.

Prior Authorization is request from you or from your provider on your behalf for authorization for a new service in a new or existing authorization period, or a change of service in the Plan of Care in a new authorization period. A **Concurrent Review** is a request by an ArchCare Community Life member or provider on the member's behalf for additional services (more of the same services) that are currently authorized in the Plan of Care. You may also request that ArchCare Community Life expedite the decision about a change in your Plan of Care. ArchCare Community Life must decide whether to make the requested changes and must notify you by phone and in writing as fast as your condition requires, but in no more than the timeframes below. If the provider indicates or we determine that a delay would seriously jeopardize your life, health or your ability to attain, maintain or regain maximum function, we will expedite the review. Should we deny the request from you to expedite our review, we will notify you and will handle it as a standard review.

For Prior Authorizations, we will decide and notify you as fast as your condition requires or within three business days after we receive the necessary information, but in no more than 14 days after we receive the request for services. If expedited, we will decide and notify you as fast as your condition requires or within three business days after we receive the request.

For Concurrent Reviews, we will decide and notify you as fast as your condition requires or within one business day after we receive the necessary information, but in no more than 14 days after we receive the request for services. If expedited, we will decide and notify you as fast as your condition requires or within one business day after we receive the necessary information, but in no more than three business days after we receive the request.

You or your provider may request an extension of up to 14 calendar days. ArchCare Community Life may initiate an extension of up to 14 calendar days if the reason is in your interest and well documented and justified.

If your Care Manager agrees with the request for a new service or change to your current service, we will change your Plan of Care. Should ArchCare Community Life decline to authorize a service or intend to reduce, suspend, or terminate an authorized service, we will advise you in writing, and you or your provider may file an appeal or Fair Hearing of the denial. Any decision that denies any part of a service requested by you or your providers is a **Notice of Initial Adverse Determination**. You or your provider may appeal a Notice of Action. (See Filing an Appeal)



MEMBER RIGHTS

Your Member Rights include the following specifics, and you have the ability to exercise your rights and be free from retaliation.

- You have the right to receive medically necessary care.
- You have the right to timely access to care and services.
- You have the right to privacy about your medical record and when you get treatment.
- You have the right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the right to get information in a language you understand and get verbal translation services free of charge.
- You have the right to receive from your providers necessary information to give informed consent before the start of any procedure or treatment.
- You have the right to be treated with respect and dignity.
- You have the right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the right to take part in decisions about your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

- You have the right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the right to be told where, when and how to get the services you need from ArchCare Community Life, including how you can get covered benefits from out-of-network providers if the services are not available in our provider network.
- You have the right to complain to NYS DOH or HRA and the right to use the NYS Fair Hearing System or in some instances request a NYS External Appeal.
- You have the right to appoint someone to speak for you about your care and treatment.
- You have the right to make advance directives and plans about your care.



USEFUL TIP: If you have special needs such as sight or hearing needs, contact us and we will provide extra assistance.

MEMBER RESPONSIBILITIES

- Provide accurate and complete health information regarding your past illnesses, hospitalizations, medications taken, allergies, and other details as needed.
- Work with the people who take care of you in developing and carrying out your Plan of Care. If you have questions or concerns about your Plan of Care, you should discuss them with your health care providers and your Nurse Care Manager.
- Receive all your covered services through ArchCare Community Life's Provider Network, and obtain authorization from your Care Manager for each of these medically necessary services.
- Notify ArchCare Community Life of changes in your condition.
- Notify ArchCare Community Life if you move.
- Notify ArchCare Community Life as soon as possible when you need to change an appointment.
- Use the health care providers listed in ArchCare Community Life's Provider Directory for covered services.
- Pay your monthly spenddown/surplus or NAMI amount, if any, as determined by New York Medicaid Choice/Maximus, to ArchCare Community Life in a timely manner.
- Be cooperative with the people that are providing you with care.

VOLUNTARY DISENROLLMENT

You may request to voluntarily leave ArchCare Community Life at any time, for any reason by letting ArchCare Community Life know verbally or in writing. This request starts the process to leave ArchCare Community Life and arrange care through New York Medicaid Choice/Maximus. Voluntary disenrollment requests are sent to New York Medicaid Choice/Maximus for processing.

Call ArchCare Community Life at 1-855-467-9351. ArchCare Community Life and your Care Manager will assist you in completing any necessary documents, arranging care for you, and obtaining New York Medicaid Choice/Maximus approval.

INVOLUNTARY DISENROLLMENT

Involuntary Disenrollment means that ArchCare Community Life has decided that you are no longer able to be a member. There are circumstances under which ArchCare Community Life must disenroll you, and other circumstances under which ArchCare Community Life may disenroll you. ArchCare Community Life will not discriminate based on health status, change in health status, or the need for or the cost of covered services.

ArchCare Community Life **must** disenroll you if:

1. ArchCare Community Life is aware that you no longer live in the ArchCare Community Life service area;
2. You moved within the ArchCare Community Life service areas and you are denied continued enrollment by the receiving enrollment agency (Local Department of Social Services (LDSS) or New York Medicaid Choice/Maximus) evaluating our assessment of eligibility for continued enrollment;
3. You leave the ArchCare Community Life service area for any reason for more than 30 consecutive days;
4. You lose your Medicaid eligibility;
5. You are hospitalized or enter an OMH, OPWDD, or OASAS residential program for more than 45 days;
6. You clinically require nursing home placement but do not qualify for institutional Medicaid.
7. You are assessed as no longer demonstrating a functional or clinical need for community-based long term care services;
8. You do not have Medicare, and you no longer meet the nursing home level of care;
9. You refuse long term care services;
10. You are receiving only Social Day Care services.



ARCHCARE COMMUNITY LIFE MAY DISENROLL YOU IF:

1. You fail to pay for or make arrangements with ArchCare Community Life to pay any amount owed, for example, a Medicaid spenddown/surplus, within 30 days after the amount first becomes due.
2. You or your family/caregiver or others in your home engage in conduct or behavior that seriously impairs ArchCare Community Life's ability to furnish services to you or to other enrollees, and we have made and documented reasonable efforts to resolve the situation (unless the conduct or behavior is related to an adverse change in your health status or service usage, diminished mental capacity, or a result of your special needs).
3. You knowingly fail to complete and submit any necessary consent or release which is reasonably requested by ArchCare Community Life to obtain covered services.
4. You provide false information, deceive, or defraud ArchCare Community Life.
5. Your doctor refuses to collaborate with ArchCare Community Life on developing and implementing your Plan of Care, and you do not wish to change doctors. Collaborate means being willing to refer to network providers or write orders for covered services.

Involuntary disenrollment requests are sent to New York Medicaid Choice/Maximus for review and approval.

WHEN DOES A DISENROLLMENT BECOME EFFECTIVE?

If you have Medicaid, the effective date of disenrollment from ArchCare Community Life will be the first day of the month following the month in which the disenrollment request is received and is processed by New York Medicaid Choice/Maximus. Generally, a signed request form must be received by ArchCare Community Life by the 15th of the month for a disenrollment to become effective the next month. For example, if a form is received on May 3, you would be disenrolled June 1. If a form is received May 20, you would be disenrolled on July 1. This applies to both voluntary and involuntary disenrollments.

ArchCare Community Life will provide services until the effective disenrollment date. ArchCare Community Life will also assist you by making referrals and helping you arrange for services through New York Medicaid Choice/Maximus, with other providers or another MLTCP.

WHAT IS A GRIEVANCE?

A grievance is any communication to us by you or by a provider on your behalf expressing dissatisfaction about the care and treatment you receive through ArchCare Community Life which does not involve a change in the scope, amount, or duration of service. For example, if someone was rude to you or you do not like the quality of care or services you have received, you can file a grievance with us.

COMPLAINT AND APPEAL

The following language relating to the managed long term care demonstration complaint and appeal process must appear in the Contractor's Member Handbook.

ArchCare Community Life will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by ArchCare Community Life staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint, please call: 1-855-467-9351 or write to:

ArchCare Community Life 205 Lexington Avenue, 3rd Floor, New York, NY 10016. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

WHAT IS A COMPLAINT?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us..

THE COMPLAINT PROCESS

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.



HOW DO I APPEAL A COMPLAINT DECISION?

If you are not satisfied with the decision we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal by calling 1-855-467-9351 or by writing to ArchCare Community Life, 205 Lexington Avenue, 3rd Floor, New York, NY 10016. It must be filed within 60 business days of receipt of our initial decision about your complaint.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

WHAT IS AN ACTION?

When ArchCare Community Life denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

TIMING OF NOTICE OF ACTION

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

CONTENTS OF THE NOTICE OF ACTION

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

HOW DO I FILE AN APPEAL OF AN ACTION?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our letter notifying you of the action.

HOW DO I CONTACT MY PLAN TO FILE AN APPEAL?

We can be reached by calling 1-855-467-9351 or writing to: ArchCare Community Life 205 Lexington Avenue, 3rd Floor, New York, NY 10016.

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

FOR SOME ACTIONS YOU MAY REQUEST TO CONTINUE SERVICE DURING THE APPEAL PROCESS

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while your appeal is being decided. We must continue your service if you make your request no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later.

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

Although you may request a continuation of services while your appeal is under review, if the appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

HOW LONG WILL IT TAKE THE PLAN TO DECIDE MY APPEAL OF AN ACTION?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases you may request an “expedited” appeal. (See Expedited Appeal Process Section to the right.)



EXPEDITED APPEAL PROCESS

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 72 hours. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

IF THE PLAN DENIES MY APPEAL, WHAT CAN I DO?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

STATE FAIR HEARINGS

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

Your benefits will continue until you withdraw the Fair Hearing; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- **Online Request Form:**
<http://otda.ny.gov/oah/FHReg.asp>
- **Mail a Printable Request Form:**
NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023
- **Fax a Printable Request Form:**
(518) 473-6735
- **Request by Telephone:**
Standard Fair Hearing line - 1 (800) 342-3334
Emergency Fair Hearing line - 1 (800) 205-0110
TTY line - 711 (request that the operator call 1 (877) 502-6155)
- **Request in Person:**
New York City
14 Boerum Place, 1st Floor
Brooklyn, New York 11201
Albany
40 North Pearl Street, 15th Floor
Albany, New York 12243

For more information on how to request a Fair Hearing, please visit:

<http://otda.ny.gov/hearings/request/>

STATE EXTERNAL APPEALS

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS

DEFINITIONS

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee's behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such service is provided to the Enrollee.

Concurrent Review: review of a request by an Enrollee, or provider on Enrollee's behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Expedited Review: An Enrollee must receive an expedited review of his or her Service Authorization Request when the plan determines or a provider indicates that a delay would seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.



TIMEFRAMES FOR SERVICE AUTHORIZATION DETERMINATION AND NOTIFICATION

GENERAL PROVISIONS

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered health care professional when such determination is based on an assessment of the Enrollee's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit when coverage is dependent on an assessment of the Enrollee's health status, and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals, and out-of-network services.

The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance. The Contractor shall utilize the Department's model MLTC Initial Adverse Determination and 4687 ML TC Action Taken notices.

1. For Prior Authorization requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:
 - a. Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request
 - b. Standard: Fourteen (14) days after receipt of request for Service Authorization Request.
2. For Concurrent Review Requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:
 - a. Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request
 - b. Standard: Fourteen (14) days of receipt of the Service Authorization Request
 - c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

3. Up to 14 calendar day extension. Extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.
 - a. The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination and help the enrollee by listing potential sources of the requested information.
 4. Enrollee or provider may appeal decision - see Appeal Procedures.
 5. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.
 - a. The Contractor must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee's service request will be reviewed in the standard timeframe.
- giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);
 - iii. the Enrollee's admission to an institution where the Enrollee is ineligible for further services;
 - iv. the Enrollee's address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;
 - v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or
 - vi. the Enrollee's physician prescribes a change in the level of medical care.
 - c. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1 (a)-(b).
 - i. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a nonbusiness day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals

OTHER TIMEFRAMES FOR ACTION NOTICES

1. When the Contractor intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:
 - a. the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or
 - b. the Contractor may mail notice not later than date of the Action for the following:
 - i. the death of the Enrollee;
 - ii. a signed written statement from the Enrollee requesting service termination or
- d. The Contractor must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,
- e. When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

CONTENTS OF ACTION NOTICES

1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.
2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:
 - a. the date the restriction will begin;
 - b. the effect and scope of the restriction;
 - c. the reason for the restriction;
 - d. the recipient's right to an appeal;
 - e. instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
 - f. the right of Contractor to designate a primary provider for recipient;
 - g. the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;
 - h. the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
 - i. the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;
 - j. the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
 - k. the name and telephone number of the person to contact to arrange a conference;
 - l. the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
 - m. the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;
 - n. the right of the recipient to examine his/her case record; and
 - o. the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This information is generally referred to as "claim detail" or "recipient profile" information.

Important Change for Medicaid Managed Care Enrollees Appeals and Fair Hearing Rights

What is changing on May 1, 2018?

New federal Medicaid managed care rules take effect in New York State. These rules change the way Medicaid managed care plans make decisions about health care services and Plan Appeals.

These rules change how you can ask the State for a Fair Hearing about plan decisions. Starting May 1, 2018, if you think a plan decision is wrong, you must first ask for a Plan Appeal **before** asking for a Fair Hearing. If your care is changing, and you want to keep your services the same while your case is reviewed, you must first ask for a Plan Appeal **before** asking for a Fair Hearing.

How does this change affect me?

For some services, you have to ask the plan for approval before you get them. This change means that the plan will make some of these approval decisions faster than they did before. If you think your plan's decision about your health care is wrong, you can ask the plan to look at your case again. This is called a Plan Appeal. This change means **you must first ask for Plan Appeal before you ask for a Fair Hearing**. You will have 60 days to ask for a Plan Appeal.

What if the plan's decision is changing a service I am getting now?

If you want to keep your services the same, this change means **you must first ask for a Plan Appeal** within 10 days or by the date the decision takes effect, whichever is later. Your services will stay the same until there is a decision. If you lose your Plan Appeal, you may have to pay for the services you got while waiting for the decision.

Can someone ask for a Plan Appeal for me?

If you want someone, like your provider, to ask for the Plan Appeal for you, this change means you and that person must sign and date a statement saying this is what you want.

What happens after I ask for a Plan Appeal?

After you ask for a Plan Appeal, this change means the plan will send you your case file, with all the information they have about your request. The plan will then send you their decision about your appeal. This change means if you do not receive a response to your Plan Appeal or the decision is late, you can ask for a Fair Hearing without waiting for the plan's decision.

What if I think the Plan Appeal decision is still wrong?

If you think the plan's decision about your appeal is wrong, you can ask for Fair Hearing. You will have 120 days to ask for Fair Hearing. If the plan said the service is not medically necessary, you can still ask the State for an External Appeal. You will have four months to ask for an External Appeal. If you ask for both, the Fair Hearing decision will always be the final answer.

If the plan is changing care you are getting right now, and you want your services to stay the same, you must ask for a Fair Hearing within 10 calendar days from the appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same until the fair hearing decision. If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision.

How long can the plan take to decide?

If you request approval for a service, your plan has 14 days to make a decision. If your health is at risk, your plan must fast track your request and decide in 72 hours. The decision may take longer if the plan needs more information. If your plan covers prescription drugs, the plan must make decisions about your prescriptions in 24 hours.

If you ask for a Plan Appeal, the plan has 30 days to make a decision. If your health is at risk, your plan must fast track your appeal and decide in 72 hours. The decision may take longer if the plan needs more information.

Where can I get more information?

Call member services at 1-855-380-2589 (TTY: 711). See your member handbook for full information about your appeal rights.

You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)

Web: www.icannys.org | **Email:** ican@cssny.org

Discrimination is Against the Law

ArchCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ArchCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ArchCare

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact **Victor Fama at (917) 484-5055 TTY 711**

If you believe that ArchCare has failed to provide these services listed above or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Victor Fama, (917) 484-5055 TTY 711**, or email compliancereport@archcare.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **Victor Fama (917) 484-5055 TTY 711** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available on-line at <http://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-380-2589 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-380-2589 (TTY: 711).

注意：如果□使用繁體中文，□可以免費獲得語言援助服務。請致電 1-855-380-2589 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-380-2589 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-380-2589 (청각 장애인용 서비스: 711)으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-380-2589 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-380-2589 (телетайп: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-380-2589 (711:YTT) رقم هاتف الصم والبكم

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-380-2589 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-380-2589 (ATS: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-380-2589 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-380-2589 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-380-2589 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-380-2589 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
(1-855-380-2589 (TTY: 711).まで、お電話にてご連絡ください。

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما. بگیرید تماس 1-855-380-2589 (TTY: 711). با باشد می ف.

NOTES:

[illegible][illegible]

NOTES:

[illegible][illegible]



1-855-467-9351 (TTD/TTY: 711)

205 Lexington Avenue, 3rd Floor, New York, NY 10016