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HAMASPIK CHOICE, INC.
PROVIDER MANUAL
Managed Long Term Care

INTRODUCTION

Welcome and thank you for participating in Hamaspik Choice!

Please keep this manual in a convenient, accessible location and use it when applicable. Its contents are subject to periodic updates and modifications in compliance with federal and state regulations and Hamasspik Choice policy changes.

The Provider Manual is designed to assist participating providers and their office staff in understanding how to function within the Hamaspik Choice Managed Long Term Care provider network. Nothing in this manual is intended to modify either the benefit contract with the member or the executed agreement between the provider and Hamaspik Choice. In the event of a dispute or conflict regarding the contents of this Manual or any interpretations of its contents, the terms of the provider agreement and the member contract will prevail.

If you or your staff have any questions about the policies and procedures in this Manual, please contact the Hamaspik Choice Provider Relations Department at:

(855) 552-4642

SECTION ONE: HAMASPIK CHOICE AND MANAGED LONG TERM CARE

Hamaspik Choice is committed to bringing people and resources together to better plan and deliver accessible, high quality, cost efficient health care services. Hamaspik Choice has developed a network of area providers that are able to provide the services our members may require while enrolled. The providers in the Hamaspik Choice network have been selected and credentialed by Hamaspik Choice to assure our members the best possible care. Enrollment in Hamaspik Choice is entirely voluntary. Individuals enrolled in Hamaspik Choice are required to use providers in the Hamaspik Choice network. Prior authorization from the member's Care Manager is required before services can be rendered.

Hamaspik Choice is a managed long term care plan (MLTCP) designed for individuals who want to continue living at home but require assistance to do so. We encourage our members to take an active part in their own health care and offer a large selection of services and service locations. Our goal is to help our members live independently, in their own homes, for as long as possible.

What Is Managed Long-Term Care And How Does It Work?

A managed long term care plan is an organization that provides, arranges and coordinates health and long-term care services on a capitated basis for its enrollees. At Hamaspik Choice we offer a wide selection of covered services through our network providers and assist in coordination of other services including those covered by Medicare. Benefits to our members include:

- Coordination of all health care services in collaboration with members' physician(s) and other health care providers. Care coordination is provided by Care Managers - registered nurses or social workers whose field of expertise is caring for individuals with chronic medical needs. Care Managers consult with members' physicians and health care providers to ensure they receive the services they need. Members are matched to a Care Manager who best meets their individual needs such as preferred language and area of residence.
- A person centered plan of care designed specifically by and for each member in tandem with his or her Care Manager, physician and circle of support.
- Extensive choice of services, including preventive, rehabilitative and community-based services.
- Health professionals, such as an on-call nurse, who are available 24 hours a day, 7 days a week to answer questions.

SECTION TWO: HAMASPIK CHOICE PROVIDERS

Hamaspik Choice has contracted with a variety of providers to ensure the network adequately serves its members with those services for which Hamaspik Choice is responsible. There are no primary care physicians in the Hamaspik Choice network. Hamaspik Choice providers can be categorized as:

- Long term care services and supports (i.e. Home Care Agencies, Fiscal Intermediaries, DME vendors, Therapists, etc.)
- Health Care Professionals (Dentists, Optometrists, Podiatrists, etc.
- Adult and Social Day Care and Skilled Nursing Facilities
- Transportation Vendors

Non-Discrimination of Provider Participation

Hamaspik Choice does not discriminate, in terms of participation, reimbursement or indemnification, against any health care professional that is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. However, Hamaspik Choice may:

- Refuse to grant participation to health care professionals in excess of the number necessary to meet the needs of Hamaspik Choice's members
- Use different reimbursement amounts for different specialties
- Implement measures designed to maintain quality and control costs consistent with Hamaspik Choice's responsibilities

Professional Advice to Hamaspik Choice Members

Hamaspik Choice may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled in Hamaspik Choice about:

- The patient's health status, medical care, or treatment options (including any alternative treatments that may be self- administered). This includes the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non- treatment
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

However, a provider's discussion of treatment options with the member does not require Hamaspik Choice to provide coverage for benefits not otherwise covered.

Participating providers who wish to communicate with their patients about managed care options must direct patients to the State's enrollment broker for education on all plan options.

Participating providers should not advise patients in any manner that could be construed as steering towards any Managed Care product type, taking in considering ONLY the managed care options that best meet the health needs of the patients. Such advice, whether presented verbally or in writing, must be individually based and not nearly a promotion of one MLTC plan over another.

The New York State Enrollment Broker can provide education and information about available plan options, including Hamaspik Choice.

SECTION THREE: PROVIDER ROLES AND RESPONSIBILITIES

Through the contractual agreement with Hamaspik Choice, participating providers agree to comply with:

Contractual Requirements

Providers must comply with all administrative, patient referral, quality management, health services management and reimbursement procedures outlined in the Hamaspik Choice provider contract as adopted and modified from time to time.

Providers must also cooperate with and participate in all Hamaspik Choice peer review functions, including Quality Management and health services management programs and administrative and grievance procedures. Providers also agree to follow Hamaspik Choice's appeals process as described in this Provider Manual.

Medicaid Enrollment

Providers must enroll in the New York State Medicaid Program In order to participate in the Hamaspik Choice provider network, in accordance with the 21st Century Cures Act Section 5005. Certain provider types may be excluded from this requirement as indicated by the New York State Department of Health on its eMedNY.org website on the Enrollment page.

Non-Discrimination

Providers must not differentiate or discriminate in the treatment of patients on the basis of race, sex, age, religion, sexual orientation, marital status, place of residence, actual or perceived health status or source of payment. Hamaspik Choice providers are obligated to observe, protect and promote the fair and equitable treatment of our members as patients.

Hamaspik Choice and its contracted providers shall ensure compliance with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal Funds.

Cultural Sensitivity

Providers must provide services in such a way as to ensure that members of various racial, ethnic and religious backgrounds, as well as disabled individuals are communicated with in an understandable manner, accounting for different needs. If the provider does not speak the same language as the member, a family member, friend, or other health care professional that speaks the same language as the member may be used as a translator. The member must clearly understand the diagnosis and treatment options that are being presented, and that language, cultural differences, or disabilities are not posing a barrier to communication.

Ethical Medical Practice

Hamaspik Choice providers agree that all services performed will be consistent with the proper practice of medicine. Providers further agree that those practices will be in accordance with the customary rules of ethics and conduct of the American Medical Association and other bodies, formal or informal, governmental or otherwise, from which the provider seeks advice and guidance, or by which they are subject to licensing and control.

Credentialing and Re-Credentialing

Hamaspik Choice maintains a robust credentialing program and credentials providers prior to their admission to the provider network and recredentials providers at least every 3 years. Credentialing/recredentialing includes sanction checks, verification of licensure, insurance coverage, and other service-specific requirements. Participating providers are obligated to notify Hamaspik Choice within two business days should their medical license, DEA certification (if applicable), or hospital privileges (if applicable) become revoked or restricted, or if any reportable action is taken by a City, State or Federal agency. Furthermore, any lapse in malpractice coverage, change in malpractice carrier or coverage amounts must be reported to Hamaspik Choice promptly following any such action.

Since it is imperative that Hamaspik Choice credential all providers of service, we ask that you alert the Provider Relations Department as soon as a new associate is anticipated, so that we may furnish you with the necessary materials to begin the credentialing process.

In addition, any change, addition or deletion of office hours, associate or billing address should be sent in writing at least 60 days in advance so that we may have ample time to reflect the correct information in our directories and databases. All Hamaspik Choice providers are required to provide any and all credentialing/re- credentialing information and supporting documents, as requested by Hamaspik Choice.

Outreach Materials

In accordance with New York State Department of Health guidelines, participating providers are prohibited from displaying Hamaspik Choice’s or any other plan’s outreach materials

Participating providers who wish to communicate with their patients about managed care options must direct patients to the State’s enrollment broker for education on all plan options.

Participating providers should not advise patients in any manner that could be construed as steering towards any Managed Care product type, taking in considering ONLY the managed care options that best meet the health needs of the patients. Such advice, whether presented verbally or in writing, must be individually based and not nearly a promotion of one MLTC plan over another.

Provider Inspections, Evaluations and Audits

Providers must grant the Department of Health or other government agencies access to

records, inspections, reviews or other information for the purpose of an audit.

1) Providers will ensure that relevant records including contracts, books, documents, papers and records of their business operations are available to the Department of Health, Office of the Medicaid Inspector General (OMIG), Department of Health and Human Services (DHHS), the Controller of the State of New York, the Controller General of the United States and the New York State Office of the Attorney General and/or their respective designated representatives for the inspection, evaluation and audit through 10 years from the final date of the Provider Contract or from the date of completion of any audit, whichever is later.

2) Value based payment arrangements between Hamaspik Choice and the provider will be reviewed through 10 years of the final date of the contract.

   The New York State Office of the Attorney General (OAG), the Department, OMIG and the State Comptroller (OSC) have the right to audit, investigate, or review the provider and recover overpayments and damages. The OAG also has the right to recover penalties, and other damages as a result of any investigation, audit or action, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et. Seq. or 31 U.S.C. § 3729 et seq and to bring criminal prosecutions.

3) The provider will provide the New York State Office of the Attorney General, the Department, OMIG, the Office of the State Comptroller, DHHS, the Comptroller General of the United States, DHHS, CMS, and/or their respective authorized representatives with access to all the provider's, or the provider's subcontractor's, premises, physical fatalities, equipment, books, records, contracts, computer or other electronic systems relating to Hamaspik Choice's performance under this Agreement for the purposes of audit, inspection, evaluation and copying.

4) The provider will give access to such records on two (2) business days prior notice, during normal business hours, unless immediate access is required pursuant to an investigation, or otherwise provided or permitted by applicable laws, rules or regulations. When records are sought in connection with an audit, inspection, evaluation or investigation, all costs associated with production and reproduction shall be the responsibility of the provider.

(5) The provider must promptly report to Hamaspik Choice if the provider identifies any overpayment related to performance under this agreement.

Compliance Program

Every required provider shall adopt and implement an effective compliance program. The compliance program may be a component of more comprehensive compliance activities by the required provider so long as the requirements of this Part are met. Required providers' compliance programs shall be applicable to:

- Billing
- Payments

- Medical necessity and quality of care
- Governance
- Mandatory reporting
- Credentialing
- Other risk areas that are or should with due diligence be identified by the provider

Upon applying for enrollment in the Medical Assistance Program, and during the month of December each year thereafter, a required provider shall certify to the department, using a form provided by the Office of the Medicaid Inspector General on its website, that a compliance program meeting the requirements of this Part is in place. The Office of the Medicaid Inspector General will make available on its website compliance program guidelines for certain types of required providers.

A required provider's compliance program shall include the following elements:

1. Written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved

2. Designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall report directly to the entity's chief executive or other senior administrator designated by the chief executive and shall periodically report directly to the governing body on the activities of the compliance program

3. Training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member

4. Communication lines to the responsible compliance position, as described in paragraph (2) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified

5. Disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:

    - Failing to report suspected problems;
    - Participating in non-compliant behavior; or

- encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;
- Such disciplinary policies shall be fairly and firmly enforced;

6. A system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance program beneficiaries;

7. A system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the Office of Medicaid Inspector General; and refunding overpayments;

8. A policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections 740 and 741 of the Labor Law.

Billing Requirements

All Hamaspik Choice providers agree to look solely to Hamaspik Choice for compensation of authorized services rendered to covered members. However, as Hamaspik Choice is the payer or last resort, any third party health insurance (TPHI), including Medicare, held by the member must be billed before a claim is submitted to Hamaspik Choice Claims for members with TPHI will not be processed until an Explanation of Benefits (EOB) or Medicare Summary Statement, if applicable, has been received. Claims and/or encounter data must be submitted to Hamaspik Choice no later than 90 days from the end of the month in which services were rendered, or in accordance with Exhibit B of the provider's Hamaspik Choice agreement. At no time may a participating provider balance bill a member for any covered services. The only time a provider can bill a member is when the service is performed with the expressed written acknowledgment that payment is the responsibility of the member and that Hamaspik Choice does not cover the service.

For further information, see the Billing and Reporting Requirements section of this document.

Co-payments

Hamaspik Choice members are not required to pay a co-payment. Your office should not collect a co-payment from the member at the time of service.

For members eligible for both Medicare and Medicaid, co-payments are waived.

A sample copy of the Hamaspik Choice member identification card is located in the Appendix section of this Provider Manual.

Net Available Monthly Income (NAMI)

Unless explicitly stated otherwise in the facility's contract with Hamaspik Choice, all long term care facilities are required to collect the NAMI from all long-term placement residents. Hamaspik Choice will deduct the NAMI amount from claims payments made to the facility.

Records Retention

Hamaspik Choice participating provider offices must maintain medical records in accordance with good professional medical practice and appropriate health management.

Confidentiality

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

- Maintains confidentiality policies based on good practices and legal requirements.
- Requires all employees to sign a confidentiality statement as well as to adhere to Standards of Conduct that prohibit the release of a member's personally identifiable health information
- Releases identifiable patient information only when consent is provided
- Obtained member consent upon enrollment in Hamaspik Choice to use his/her identifiable information for general treatment, coordination of care, quality assessment, utilization review, fraud detection, or accreditation purposes. Member- identifiable information used for any other purpose requires clear and specific consent from the member.

Conflict of Interest

No practitioner in Medical Management may review any case in which he or she is professionally involved. Hamaspik Choice is dedicated to providing quality care and service to each of its members. Hamaspik Choice does not specifically reward practitioners or other individuals performing utilization review for issuing denials of coverage or service. When reviewing cases, Hamaspik Choice bases all Medical Management decisions only on the appropriateness of care and service along with existence of coverage. In addition, staff rendering utilization decisions are not provided with any form of financial compensation that would result in the underutilization of services or rendering of adverse determination.

SECTION FOUR: ENROLLING IN HAMASPIK CHOICE

In order to be enrolled in Hamaspik Choice an individual must:

- Be at least 18 years of age
- Reside in Rockland, Dutchess, Orange, Putnam, Sullivan or Ulster or counties
- Be eligible for Medicaid as determined by the local district of social services (LDSS)
- Be able to return to or remain at home without jeopardy to their health and safety*
- Be eligible for nursing home level of care *
- Be expected to require at least one of the following services and care management from Hamaspik Choice for at least 120 days from the effective date of enrollment: *

    1. Nursing services in the home;
    2. Therapies in the home;
    3. Home Health Aide services;
    4. Personal Care Services in the home;
    5. Adult Day Health care

*Determination will be made based on an assessment by a Care Manager utilizing the Uniform Assessment System of New York (UAS- NY).

If it is determined through the screening process that a person is enrolled in another managed care plan capitated by Medicaid, a Home and Community Based Service Waiver Program, a Comprehensive Medicaid Case Management Program (CMCM), an Office for People with Development Disabilities (OPWDD) Day Treatment Program or is receiving services from a Hospice the individual may be enrolled with Hamaspik Choice upon termination from such other plans or programs.

If the person is expected to be a hospital inpatient or resident of hospitals or residential facilities operated under the auspices of the State Office of Mental Health (OMH), OPWDD or Office of Alcoholism and Substance Abuse Services (OASAS) facility on the first day of enrollment, the person may not begin enrollment unless he/she disenrolls or is discharged from the program/services currently being received. Nursing home residents are eligible to enroll if discharge to the community is planned and expected soon.

Enrollment Process

Eligibility for enrollment in Hamaspik Choice must be established through an assessment process and approved by the LDSS or enrollment broker designated by the New York State Department of Health (SDOH). Participating providers who provide information to Hamaspik Choice members about different managed care plan options must direct individuals to the New York State Enrollment Broker. The Enrollment Broker will provide the member with education and information about available plan options.

Participating providers should not advise members in any way that could be interpreted as steering members toward any managed care type of product.

The application process consists of a comprehensive home visit. Enrollment is voluntary and an individual may choose to withdraw their application at any time. To start the enrollment process, a Care Manager will contact a potential member within five business days of learning of their possible interest in Hamaspik Choice. The Care Manager will confirm that the individual meets the eligibility requirements based on age, county of residence and Medicaid eligibility.

The Care Manager will conduct the in-home assessment. This visit will consist of eligibility review and comprehensive health screening. The individual will be required to present any health insurance cards including their Medicaid card and Medicare card if eligible. It is necessary for the individual to sign a Release of Information, so that Hamaspik Choice may contact the LDSS, their physician and other health care providers. At this time a full explanation of Hamaspik Choice's managed long-term care plan will be discussed and the potential enrollee will have the opportunity to ask questions and to discuss their specific needs. The Care Manager will obtain a health history and perform a clinical assessment in order to determine eligibility.

If the individual is interested in enrolling in Hamaspik Choice the Care Manager will develop a person centered plan of care with the assistance of the individual and their informal supports (i.e. family, etc) and, if necessary, in consultation with the member's physician. Hamaspik Choice will then be able to establish and coordinate the services included in that individualized plan of care. To conclude the enrollment process, the potential enrollee will need to sign an Enrollment Agreement. This information will be shared with the LDSS or designated SDOH entity. Enrollment will begin the first day of the month following approval of the enrollment application by the LDSS or enrollment broker, if such approval was received by the 20th of the month.

Upon enrollment, the new member will be issued a Hamaspik Choice membership card. It is important that they bring this membership card along with their Medicare and Medicaid cards and any other health insurance cards to all appointments.

Disenrolling from Hamaspik Choice

If an individual chooses to end their membership, they should call the Member Services Department or their Care Manager and inform Hamaspik Choice of their desire to disenroll. A disenrollment form will be provided to the individual. If they do not wish to fill it out, a Hamaspik Choice representative can fill it out for them. The form must then be submitted to:

Hamaspik Choice
58 Rt. 59, Suite 1
Monsey, NY 10952
Attn: Manager of Clinical Services

The Care Manager will then meet with the member to discuss their decision and help them plan for their care following disenrollment. The date on which their disenrollment from Hamaspik Choice will take effect and the discharge plan selected to best meet the individual's future care needs is determined by the LDSS or designated SDOH enrollment broker. Hamaspik Choice will forward the request for disenrollment to the LDSS or enrollment broker as soon as the completed documents are received from the member.

Oral requests for disenrollment require the same amount of time to process as written requests. The disenrollment date will be the last day of the month after the LDSS or enrollment broker has processed the disenrollment and arranged any further services. Services provided through Hamaspik Choice will not be interrupted until the effective disenrollment date. If the enrollee is transferring to another MLTC or MMC plan, Hamaspik Choice will provide the receiving plan with the individual's current service plan to ensure a smooth transition.

Hamaspik Choice will make every effort to inform all providers in the event that a member is disenrolled from the Plan to ensure that services are stopped, but it is the Provider's responsibility to verify eligibility, either through roster verification, if provided, or by checking eligibility through Hamaspik Choice or eMedNY.

Hamaspik Choice will not pay for services provided for a member who has disenrolled from the Plan. If we learn about a member's retroactive disenrollment from Hamaspik Choice, we may be required to recoup money that was paid to the provider for dates of services past the official disenrollment date.

Membership Cancellation (Involuntary Disenrollment)

If Hamaspik Choice believes it is necessary to disenroll a member involuntarily, we must obtain the approval of the LDSS or designated SDOH entity. An eligible member will not be involuntarily disenrolled on the basis of health status. All members will be notified of their appeal rights by the LDSS or designated SDOH entity.

Hamaspik Choice must initiate involuntary disenrollment within 5 business days if:

- The member no longer resides in the service area
- The member is absent from the service area for more than (30) thirty consecutive days
- The member is hospitalized or enters an OMH, OPWDD or OASAS residential program for (45) forty-five days or longer.
- The member is no longer eligible to receive Medicaid benefits.
- The member clinically requires nursing home care, but is not eligible for such care under the Medicaid Program's institutional eligibility rules.
- The member is no longer eligible for a nursing home level of care as determined by UAS-NY (or, for dual eligible, no longer requires community based longer term care services) unless the LDSS or designated SDOH entity and Hamaspik Choice determine that termination of services would result in the member being eligible for the nursing home level of care within the next six-month period.

- The member is incarcerated
- A member provides Hamaspik Choice with false information, otherwise deceives Hamaspik Choice, or engages in fraudulent conduct with respect to any substantive aspect of their membership.

Hamaspik Choice may initiate involuntary disenrollment if:

- A member or one of their family members or an informal caregiver engages in conduct or behavior that seriously impairs Hamaspik Choice's ability to furnish services to either themselves or other members. Hamaspik Choice must make and document reasonable efforts to resolve the problems presented by the individual. Hamaspik Choice may not request disenrollment because of an adverse change in the member's health or because a member needs more services, or because of diminished mental capacity or uncooperative or disruptive behavior resulting from the member's special needs.
- A member fails to pay any amount owed as a Medicaid surplus to Hamaspik Choice within thirty (30) days after it becomes due, provided Hamaspik Choice makes reasonable efforts to collect the amount.
- A member's physician refuses to work with Hamaspik Choice in developing and implementing the member's plan of care and the member does not wish to change physicians, then Hamaspik Choice may initiate disenrollment from the plan.

SECTION FIVE: CARE COORDINATION

Upon enrollment, the coordination of the member's care will begin with an individually assigned Care Manager who will collaborate with the member, member services coordinators, and medical director as needed to perform quality care management. Together, they will work with the member, their informal supports and primary care physician to ensure that they receive the appropriate level of services. If, at any time, the Care Manager becomes aware of a change in the member's health status, or if the member or concerned advocate informs the Care Manager of such, the Care Manager will address the problem and confer with the primary care physician.

Care Manager

Each Care Manager is a registered nurse or social worker whose field of expertise is caring for individuals with chronic medical needs. The Care Manager will confer with the member to develop an initial long-term plan of care and will coordinate all of their health care needs for covered and non-covered services. The Care Manager will work in collaboration with the physician, who, if indicated, approves the plan of care as well as other health care professionals (such as nurses and physical therapists) to ensure that members receives the services they need. The Care Manager will arrange for Hamaspik Choice authorization for covered services. The member is paired with a Care Manager that best meets their individual needs such as preferred language and the geographic service area in which the member resides.

Social Services

A member of the Entitlement Department will be available to assist the member with applying for any entitlements (i.e. Home Energy Assistance Program, Medicaid, and/or Food stamps) and other benefits for which the member is eligible. The worker will also assist in maintaining eligibility through the certification process of all entitlements.

Medical social services are also available through Hamaspik Choice's provider network to advise members and their families on how to cope with chronic illness and social problems.

Member Services Department

Member services coordinators are available by telephone to assist members with any questions that they may have regarding Hamaspik Choice, including the benefit package, what services are or are not covered, scheduling appointments, or if the member needs to arrange transportation. These staff members work with the care team to schedule appointments and order the supplies and services that are needed. They will work with the Care Manager and vendors to ensure that the member receives the services they need and help resolve any problems the member has with their services. Both Member Services coordinators and Care Managers are available to answer any questions regarding the plan of care.

Selection of A Primary Care Provider

With Hamaspik Choice, the member continues to use their own primary care physician. The physician must be willing to work in collaboration with Hamaspik Choice and the Care Manager. If a physician will not work with Hamaspik Choice and the member does not wish to change physicians then Hamaspik Choice may initiate disenrollment from the plan. The Care Manager will work with the primary care physician to coordinate all of the member's health care needs. If a member needs help finding a physician, our referral network can help locate a highly qualified physician in the community.

Care Management Program

The purpose of the Care Management Program is to maximize quality of care while providing services in the most efficient and cost effective manner as well as to ensure Medicare maximization. The Program includes ongoing planning and managing of services provided to Hamaspik Choice members. Collection, review, and analysis of data generated by the Care Manager are used to ensure that Hamaspik Choice's resources are properly allocated and efficiently utilized to improve the quality of care provided to members.

The Care Management Program is a comprehensive, systematic, and dynamic initiative. The Program incorporates prospective, concurrent and retrospective review to meet program objectives. The program ensures that accessibility to care is maximized and that covered services rendered are appropriate for the member. All covered services and referral patterns are reviewed by the Clinical Services Department on an ongoing basis. Identification and evaluation of high- risk members is also an ongoing initiative.

Transitional Care

Hamaspik Choice has specific policies that address transitional care; when a new member currently undergoing a course of treatment with a non-participating provider joins the plan or when a Hamaspik Choice physician leaves the plan either voluntarily or involuntarily.

New Member

When a new member is currently undergoing a course of treatment with a non-participating provider upon or prior to enrollment with Hamaspik Choice, the member will have the option of continuing care for up to 90 days of their enrollment date to allow for consultations, medical record transfer, and stabilization of their medical condition. After the 90-day period, the transition must be complete and care must be received from participating providers. The Medical Management Department will assist with and coordinate the transition of care plan.

Participating Provider Leaves the Plan

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

SECTION SIX: ELDER ABUSE

Whenever it is suspected that a member is being abused, Hamaspik Choice will provide a full assessment in partnership with the member's primary care physician. The following are types of elder abuse /maltreatment/neglect to which all health care providers must be alert. They are:

- Physical Abuse – The infliction of physical pain or bodily harm to an older person. Examples: Beating, hitting, pushing, and restraining
- Sexual Abuse – Any form of sexual contact or exposure without the older person's consent or when the older person is incapable of giving adequate consent.
- Psychological/Emotional Abuse – The infliction of mental anguish. Examples: threatening, humiliating, intimidating, isolating, infantilizing
- Financial/Material Abuse – The illegal or improper exploitation and/or use of funds or other resources. Examples: stealing possessions, money or property, misusing money.
- Neglect – Refusal or failure to fulfill a care taking obligation including abandonment or isolation, denial of food, shelter, clothing, medical assistance or personal needs, or the withholding of necessary medications or assistive devices (e.g. hearing aids, glasses).

Abuse and neglect can be intentional or unintentional. Intentional refers to the conscious and deliberate attempt to inflict physical, emotional or financial harm. Unintentional refers to an inadvertent action, which results in physical, emotional, or financial harm usually due to ignorance, inexperience or lack of desire or inability to provider proper care.

Reporting Possible Elder Abuse

If you suspect Elder Abuse, you should immediately notify the Hamaspik Choice Care Management Department at (855) 552-4642. In addition, you must initiate the proper notifications to any agency or authority that are required by the law in effect at the time. Providers are encouraged to contact Adult Protective Services at 1- 800-342-3009, option 6 or contact your local Department of Social Services Adult Protective Services.

SECTION SEVEN: MEMBERSHIP VERIFICATION

All providers must verify a member's eligibility at the time of service. All Hamaspik Choice members are instructed to present their membership card each time they obtain medical services. However, because Hamaspik Choice may not retrieve membership cards from members when they disenroll or lose coverage, a membership card alone is **NOT** a guarantee of eligibility.

Please note that failure to verify member eligibility could result in denial of payment for services.

To verify membership eligibility:

- Call Hamaspik Choice at (855) 552- 4642, follow the prompt for eligibility verification and speak with a representative.
- Capitated providers or providers with ongoing authorizations (i.e. Personal Care Workers, etc.) can consult their membership roster for the present month to ensure the member appears on their list. If the member is on the capitation list, the provider has received the monthly capitation payment for that member.

SECTION EIGHT: REFERRALS AND PRIOR AUTHORIZATION

The referral management process is designed to address medical necessity and appropriateness, referral patterns, and the appropriate use of Hamaspik Choice network providers. The Care Manager is responsible for coordination of the outpatient referral management process for covered services to ensure that appropriate care is provided when medically necessary. The authorization form assures the specialist that Hamaspik Choice has approved the member's care. It also authorizes Hamaspik Choice's Claims Department to process the claim for payment.

In no event will the conditions listed in this section be construed to require Hamaspik Choice to provide coverage for benefits not otherwise covered or contained within the member's benefit plan.

Referral Guidelines

Initial referrals will only include the initial office visit. Any subsequent visits, procedures or services/equipment that is provided must be amended to the original authorization by calling the Hamaspik Choice Member Services Department at (855) 552-4642. The specialist must give all applicable information for the authorization including diagnosis, units, and procedure codes at the time of the authorization. **Services performed that have not been authorized will not be reimbursed by Hamaspik Choice.**

Services That Require A Referral or Prior Authorization:

- Nursing home care
- Home health care:
  - Nursing
  - Home Health Aide
  - Physical therapy (PT)
  - Occupational therapy (OT)
  - Speech therapy (ST)
  - Medical social services
- Adult day health care
- Personal care
- Medical equipment and oxygen
- Prosthetics and Orthotics
- Rehabilitation therapies (PT, OT, ST) provided in settings other than the home
- Personal Emergency Response Systems – PERS
- Non-emergency transportation
- Podiatry-foot care (aside from the initial visit)
- Dental care (other than initial exam, cleaning and x-rays)
- Optometry (other than an annual eye exam, including glaucoma screening,

and eye exam eyewear)
- Audiology
- Home delivered and congregate meals
- Social day care
- Respiratory therapy
- Nutritional counseling
- Social and environmental supports
- Chore service and housekeeping
- Members are NOT required to obtain Hamaspik Choice's pre-authorization or prior authorization to get emergency care.

To ensure continuity of care, upon request from Hamaspik Choice, the specialist is required to submit a consult report within 15 days.

If the specialist determines that treatment beyond the scope of the initial referral is necessary, Hamaspik Choice must be consulted prior to recommending treatment to the member or proceeding with the treatment plan.

For additional information regarding servicing members with degenerative conditions, please refer to the "Continuity of Care" section of this manual.

Services That Do Not Require A Referral Or Prior Authorization:

The services listed below must be provided by a Hamaspik Choice participating provider. (For all non-participating provider service requests, please contact the Care Management Department at (845) 552 4642 to obtain prior authorization.)

Direct Access Services:

- Podiatry – initial visit
- Optometry services including an annual eye exam (including glaucoma screening) and eye exam eyewear
- Annual hearing exam (including evaluation for hearing aid)
- Dental services (initial exam, cleaning and x-rays)
- Hearing exam

Out of Network Referrals

If a particular specialty/specialist is not listed in the Hamaspik Choice, Inc. provider directory, or is not within a reasonable travel distance from the member's home, please contact the Provider Relations Department at (855) 552-4642 for assistance in locating a provider with the required specialty. If the Hamaspik Choice network does not have a participating provider with the appropriate training and experience to meet the needs of a member, Hamaspik Choice will work with the member to coordinate care with a non-participating provider.

Such services will be provided at no additional cost to the member.

All requests for non-participating providers require prior authorization and must be directed to the Hamaspik Choice Care Management Department where they are reviewed for appropriateness.

MEDICAL REVIEW PROCESSES

Review Methodologies

Prospective Review:

Prospective review is the process of evaluating requested medical services before the services are rendered, in order to:

- Establish adequacy of the member benefits
- Determine appropriateness of the provider/facility
- Evaluate the proposed treatment plan
- Determine if care is medically necessary
- Identify alternatives to proposed care
- Ensure care is rendered at the most appropriate level
- Identify and refer cases that may benefit from additional management programs
- Identify quality of care issue
- Assign length of stay
- Coordinate the discharge plan

Hamaspik Choice's Care Management Department should be notified at least three days in advance of a scheduled admission to a nursing home or procedure date wherever possible.

Payment to a provider will be denied if:

- The requested clinical information is not provided or is insufficient for screening.
- If length of stay or period of time exceeds the authorized length of stay or period of time, and an approval for extension is not obtained from Hamaspik Choice.

In the event that prior authorization for a service is required during non-business hours, the provider should arrange for or provide the necessary services and contact the Care

Management Department for authorization the next business day.

Concurrent Review:

Concurrent review focuses on the effective allocation of resources during an inpatient or outpatient episode of care, and is conducted by the Clinical Services Department.

Additionally, Hamaspik Choice must be notified within 48 hours of any emergency admission. Notification may come from the member or representative of that member, from staff at the admitting facility, or from the specialist/provider's office.

Inpatient concurrent review consists of:

- Discharge planning – Begins prior to admission, except with emergency admissions, where it is initiated upon receipt of the first review of the case. Discharge planning facilitates moving a member efficiently through the health care system.

- Continued Stay review – Conducted to ensure that inpatient care continues to be appropriate. Continued stay reviews are conducted prior to the expiration of the initially assigned length of stay.

- Discharge review – Is conducted to ensure the member's stability and discharge readiness to the most appropriate and safe setting.

Outpatient concurrent review is conducted prior to the expiration of the authorization period for all outpatient services requiring prior authorization. Examples may include home health services, physical therapy, and DME rentals.

Retrospective Review:

Retrospective review involves reviewing health care services that have already been provided and for which an initial determination has not been rendered. Additionally, a retrospective review may be triggered by claims/encounter data, deficiency in the prior authorization process, pre-defined focused reviews, or to validate the concurrent review process.

Hamaspik Choice's Responsibility When Denying Services

If a service or continued use of a service is not medically necessary or is not covered by Hamaspik Choice, a decision may be made to deny coverage of a service or deny authorization of further services for that episode of care. Such decisions are based upon a review of the clinical findings by the Care Manager and the Clinical Services Management Staff (and can include the Medical Director), and follow discussions with the attending physician. Hamaspik Choice will not exercise an adverse determination denial option until all efforts have been made to resolve the issues with the attending physician and all denials will be sent to the Medical Director for review.

When the decision is made to deny coverage of a service or authorization for further service for an episode of care, the appropriate parties (physician, facility representative,

member, member's family or legal guardian) will be notified in writing of the denial. The notification will include the reason for the denial and the right to appeal the decision. The physician adverse determination letter informs the physician about the opportunity to discuss the denial.

Expedited Initial Determination Process

Members or providers may request an expedited initial determination involving continued/extended health care services, procedures/treatments or additional services for members undergoing a course of continued treatment, including inpatient care or circumstances in which a health care provider believes an immediate determination is warranted and a delay would significantly increase the risk to the member's health.

Expedited initial determinations may be filed in writing, in person, or by telephone. All such requests are tracked for timeliness of processing. To request an expedited initial determination, please contact the Hamaspik Choice Care Management Department immediately at (855) 552-4642.

Organization Determinations

Types of Organization Determinations

- A **standard organization determination** is a determination to pay for, provide, authorize, deny, or discontinue a service.

- An **expedited organization determination** is a determination to provide, authorize, deny, or discontinue a service as expeditiously as the member's health condition requires, but no later than 72 hours, unless a delay to obtain additional information would benefit the member. In these cases, applying the **standard timeframe** for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Time Frames for Organization Determinations

Determinations for a concurrent review and expedited organization determinations are made within 72 hours or earlier if the member's health condition requires. Standard organization determinations are made within 14 calendar days or earlier if the member's health condition requires.

The timeframe for expedited or standard organization determinations may be extended by up to 14 calendar days if the member requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the member.

Pre-payment retrospective reviews are completed within 30 days of the receipt of medical record information.

All organization determinations are documented and appropriate oral and written notifications are provided within mandated timeframes. All adverse organization determination notices include appeal rights.

Parties to the Organization Determination

- The member, including his or her authorized representative
- An assignee of the member, a physician or other provider who has furnished a service to the member and formally agrees to waive any right to payment from the member for that service
- The legal representative of a deceased member's estate
- Any other provider or entity determined to have an appealable interest in the proceeding.

Adverse Organization Determinations

A Plan Action is the organization's decision to:

- Refuse to pay for, provide or authorize a service
- Discontinue or reduce a service when the member communicates that he/she believes that continuation of the services is medically necessary

If a request is denied in whole or in part, this is considered an action.

When the Clinical Services Department issues an adverse organization determination for a request for service, the member and other parties with an appealable interest are notified in writing. The written notice of an adverse organization determination includes the following:

- States the reason for the denial
- Uses approved notice language in a readable and understandable form
- Informs the member of his/her right to a reconsideration, including the right to an expedited reconsideration
- Includes information explaining that physicians may act on behalf of a member in time-sensitive situations
- Explains the 30-calendar day appeal process for service denials
- Explains the 60-day calendar day appeal process for payment denials
- Explains the 48 hour expedited appeals process for requests for service(s) where waiting for the standard time frame could jeopardize the member's life or health, or ability to regain maximum function (service denials only)

Procedures Specific to Expedited Organization Determinations:

A request for an expedited organization determination may be made orally or in writing

by the member or by a physician (regardless of whether the physician is affiliated with Hamaspik Choice).

A request to expedite is granted when one of the following criteria is met:

- The life or health of a member or a member's ability to regain maximum function is jeopardized.
- A non-coverage decision for an in-patient stay, in or out of area, other than for situations for which immediate Peer Review Organization (PRO) is available, is required.
- The member or member's legal representative feels that the decision to discharge the member from a SNF may jeopardize a member's life, health or ability to regain maximum function.
- A decision to discontinue services in the home or outpatient setting, when a longer review time could jeopardize a member's life, health, or ability to regain maximum function, is made. No reduction in services will occur until an organizational determination has been made.
- The request by a physician, either participating or non- participating, is required.

If the request to expedite is approved, the member, the member's legal representative and/or the provider shall be notified orally. The notification of determination will be made within the time frames indicated above.

If the decision to expedite an organizational determination is denied, the member, the member's legal representative and/or provider will be notified verbally that the request will be processed according to the standard determination time frame. He/she will be informed verbally and in writing of their right to file a grievance regarding the decision not to expedite.

Written notification is generated within three (3) calendar days.

If the member requests an extension or a need for additional information is justified in the best interest of the member, the time frame for both expedited and standard requests may be extended by as much as 14 days.

When the timeframe is extended, a written notice is sent to the member stating the reasons for the delay and informing the member of his/her right to file a grievance if he/she disagrees with the organization's decision to extend the timeframe.

Procedures Specific to Retrospective Review

The timeframe for completing pre-payment retrospective reviews is 30 days from receipt of the medical record information. Post- payment reviews are completed within 60 days of receipt of the medical record information.

If the pre-payment or retrospective review results in an approval of the services, the Care Management Coordinator updates the authorization to reflect approval, and advises the

Claims Department to process the claim and issue the organization determination.

If the pre-payment retrospective review results in a full or partial denial of services, the Retrospective Review Coordinator updates the authorization, notifies the provider in writing and includes appeal rights information.

In the case of post-payment retrospective denials, the provider is notified of the denial and his/her appeal rights as outlined on page 39.

SECTION NINE: MEDICAL MANAGEMENT PROGRAMS

Program Overview

As a Managed Long-Term Care Plan (MLTCP) Hamaspik Choice's mission is to prevent or delay unnecessary institutionalization of members with chronic illness and disabilities. We strive to ensure that the highest quality, most appropriate and cost-effective health and human services are utilized. This is done through an integrated medical and social care model designed to meet the management challenges of a complex frail and elderly population.

The programs provide support to our members and physicians through a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the individual member's health care needs. The Care Manager integrates the chronic care services with the other services provided under the basic Hamaspik Choice benefit package, develops a plan of care, and manages these services across settings so that care for needs are assessed independently and an individualized care plan is developed in conjunction with the member and the PCP.

Medical Management programs all focus on members who are at risk for adverse health events and may benefit from interventions and monitoring. Qualifying members may be identified during the initial enrollment process, the authorization process, concurrent review, or in response to a referral generated by a provider, member or informal caregiver, or data from specific targeted reports. The Programs are designed to provide:

- Improved member care
- Identification options in health care delivery
- Identification and coordination of appropriate plan benefits
- Creation, review and update of a care plan approved by the PCP
- Monitoring of quality of care and timeliness of services delivered
- Improved communication among members, the member's caregiver, health care providers, the community, and Hamaspik Choice.
- Increased physician and member knowledge and skill in the care of a member confronting end of life illness
- Education regarding health prevention, management, and disease processes to members and their caregivers
- Empowerment to members to articulate preferences about desired care as well as the kinds of treatment they do not want.

The Medical Management Programs include:

- Health Education
- Care Management

Health Education Program

The Health Education Program addresses the needs of all members through education

initiatives and wellness programs that include primary, secondary and tertiary prevention. Topics of interest are featured on our website with the goal of educating members on the latest developments and research in medicine and healthcare.

Care Management Programs

The goal of all Care Management programs is to maintain members safely in their homes at the highest level of functioning, delaying or avoiding chronic placement in a nursing home facility.

The Care Manager and other health care professionals function as a team to facilitate and coordinate the member's care.

Based on an initial in-home assessment, the Care Manager develops an individualized and comprehensive plan of care. The assessment and care plan are updated every six months or if there is a change in the member's condition. The care plan is a collaborative effort created to best meet the member's functional, medical, behavioral, financial, and emotional needs. The team provides education for the member and caregiver including, but not limited to: health prevention/maintenance, life planning, various disease processes, and accessing Hamaspik Choice benefits and community resources. The care plan is developed in collaboration with the PCP and the member and based on the member's right to make individual decisions about his/her health care. Hamaspik Choice coordinates community programs, federally funded programs, service delivery organizations and support groups to develop a comprehensive plan of care.

The written care plan is reviewed and agreed to by the member and caregiver. Implementation of the care plan encompasses all the interventions that are directed toward meeting the pre-established goals, resolving problems and meeting the member's health care needs and pre-determined outcomes.

SECTION TEN: ANCILLARY SERVICES

Hamaspik Choice members have a broad range of ancillary services available to them. The following section explains what services are available and how they may be obtained.

Audiology Services

Hamaspik Choice members are entitled to one hearing examination every 12 months without a referral when using a provider within the Hamaspik Choice network. Hearing aids are covered by Hamaspik Choice, but must be authorized prior to supplying. When the member is in your office, please call (855)552-4642 to update the authorization, indicating the services you will be providing during the visit. All codes must follow Medicaid guidelines. If this authorization is not updated, payment for these services may be denied.

Dental Services

All dental services, exclusive of the office visit, require an authorization from Hamaspik Choice. When the member is in your office, please call (855) 552-4642 to update the authorization, indicating the services you will be providing during the visit. All codes must follow Medicaid guidelines. If this authorization is not updated, payment for these services may be denied.

Durable Medical Equipment (DME) and Medical Supplies

Durable Medical Equipment services (excluding Medicaid Fee For Service covered supplies) require prior authorization by the Hamaspik Choice Medical Management Department.

Once approved, Hamaspik Choice:

- Orders the equipment from the contracted provider
- Arranges for delivery and pick up of equipment as needed.
- Monitors compliance to Plan standards for delivery of needed equipment.

Optometry Services

Hamaspik Choice members are entitled to one routine vision examination every year, without a referral, when using a participating provider who is part of the Vision Service Plan (Eyequest) network

This benefit is not available for tinting, thinner lenses, or other cosmetic items.

Podiatry Services

Members may make appointments to obtain foot care services from their Podiatrist without a referral. A Plan provider must render the services. All podiatry services, exclusive of the office visit, require an authorization from Hamaspik Choice. When the member is in your office, please call (855) 552-4642, to update the authorization, indicating the services you will be providing during the visit. All codes must follow Medicaid guidelines. If this authorization is not updated, payment for these services may be denied.

Transportation

Members may use a participating Car Service or Ambulette for medically necessary transportation to and/or from medical appointments. The level of transportation needed by each member is determined as part of the member assessment process and is documented in the member's care management record.

Members must contact Hamaspik Choice Member Services at (855) 552-4642 for medically necessary transportation. Members who qualify may only use the transportation for the approved visit. The Member Services coordinator arranges transportation with our contracted vendor and sends an authorization with an agreed upon rate based on the contract.

SECTION ELEVEN: EMERGENCY CARE AND URGENTLY NEEDED SERVICES

Emergency Services

Emergency Services include inpatient and outpatient services that are furnished by a provider qualified to render services to evaluate or stabilize an emergent medical condition.

Hamaspik Choice will cover services furnished by a participating or non-participating provider when an emergency medical condition exists, or a Plan provider instructs the member to seek emergency services within or outside the Plan.

Prior authorization for treatment of emergency medical conditions and out-of-area urgently needed care is not required. In the event of an emergency medical condition, the member is encouraged to go to the closest emergency room or the nearest hospital, or to call 911 for assistance. Members are requested to contact Hamaspik Choice and/or their Primary Care Physician within 48 hours of the emergency, or as soon as reasonably possible as instructed on their membership identification card and in their Member Handbook.

SECTION TWELVE: QUALITY MANAGEMENT

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

Provider performance measures include, but are not limited to, member related grievances, appointment availability, adherence to clinical guidelines, compliance to medical record documentation standards, and overall cooperation with mandated Quality Improvement projects. These measures are constantly reviewed.

Credentialing

Hamaspik Choice fully credentials all providers. The process is comprehensive and includes verification of the provider's credentials. The credentialing process is done upon initial contracting and is repeated every three years.

Time sensitive credentialing documents such as copies of license registration, and malpractice insurance must be updated without waiting for re-credentialing and sent to Hamaspik Choice to keep individual files current at all times. A site visit may also be performed based on the provider's specialty.

Internal Quality Issues and Incident Reports

When concerns about the quality of care given to Hamaspik Choice members occurs, a medical record review or incident report may be required as part of the investigation. After investigating the concern, Hamaspik Choice may refer the matter for further action to the Quality Improvement Committee. If quality concerns are substantiated, the Committee may direct the Quality Management Coordinator to continue to monitor the situation, or it may require that a corrective action plan be implemented. **Incident Reports that are requested must be submitted to Hamaspik Choice within two business days of the request.**

Investigation and Resolution of Complaints and Grievances

Hamaspik Choice respects the rights of their members and families and encourages them to bring concerns or complaints to our attention promptly so that issues can be addressed in a timely manner.

- Care Managers and the Compliance Analyst will manage "on-the spot" resolutions regarding member problems or concerns.
- Members can file a complaint either in writing or verbally. Hamaspik staff will record the complaint and appropriate plan staff will review the complaint. All serious complaints or allegations are reported to the Compliance Department.

- The Vice President for Compliance and Regulatory Affairs will monitor the complaint resolution process to ensure that proper procedures and timelines are in compliance with regulatory requirements.
- Complaints are investigated and resolved in collaboration with the department and staff, and/or providers who were involved.
- The member complaint investigation process and resolutions are confidential. Hamaspik Choice staff who investigate a complaint will discuss the compliant only with those staff members who are involved with the member and his/her complaint or staff who are needed to supply necessary background information or advice.
- Members will receive a letter to notify him/her of the plan's receipt of the complaint.
- Hamaspik will notify members 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.
- Hamaspik's response will describe what we found when we reviewed the complaint and our decision about the complaint.

Documentation

- Each complaint/grievance is documented in the member's care management record. Patient complaint/grievance reports are kept in a confidential file maintainted by the Compliance Department.

Clinical Focus Studies

Hamaspik Choice conducts clinical focus studies that identify high-risk, high-volume clinical areas for review and improvement. Hamaspik Choice works with IPRO for these studies and has found that the end result is a positive impact to our members' health.

Hamaspik Choice works with participating providers regarding quality improvement standards. Participating providers comply with Hamaspik Choice's policies, procedures and programs. As applicable, providers may also be asked to participate in focused quality improvement projects. Examples of recently Hamaspik Choice quality improvement projects include:

- Reducing avoidable hospitalizations and emergency room visits,
- Increasing our members understanding and use of advance directives, and
- Improving the rates for the provision of preventative care services

Access To Care Standards

The Hamaspik Choice guidelines for access to care for its members are in compliance with the Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) access requirements. Hamaspik Choice providers must accommodate the following types of appointments within the indicated time frames:

- Preventive care appointments within 15 days of request
- Routine care appointments within 15 days of request

- Urgent care appointments within 24 hours of request
- Non-urgent care appointments within 7 calendar days
- Appointments for specialty care within 7 calendar days

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

Members should be notified in advance, if the situation permits, of any appointment cancellations or postponements and should be given the opportunity to reschedule cancelled appointments.

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

To meet the needs of our members, Hamaspik Choice provides medical language interpreter services during scheduled appointments, medical visits and arranged encounters by a third-party interpreter who is employed or contracts with the medical provider.

Hamaspik Choice will advise members if they are entitled to the receipt of language interpreter services. Interpreter services include language and speech services. Upon a member's request for interpreter services, there will not be a charge.

Interpreter services must be provided face to face, by telephone and/or video interpreter technology.

All interpreters must demonstrate competency and skills in medical interpretation techniques, ethics and technology. It is recommended, but not required that interpreters be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State, whenever possible.

SECTION THIRTEEN: MEDICAL RECORDS

Medical Record Policy

Hamaspik Choice participating physicians' offices must maintain medical records in accordance with good professional medical practice and appropriate health management. The medical record should reflect all health care provided to the member. The physician's office is responsible for:

- Maintaining medical records in a manner that is current, detailed, organized, and permits effective patient care and quality review.
- Maintaining medical records in a safe and secure manner that ensures member confidentiality in accordance with all State and Federal confidentiality and privacy laws, including HIPAA.
- Assuring that information contained in the medical record is kept confidential in accordance with Plan policies and procedures and applicable laws.
- Making the medical record available when requested to the Plan and regulatory agencies.
- Keeping medical records for six years after the death or disenrollment of a member from Hamaspik Choice. The record shall be kept in a place and form that is acceptable to the Department of Health and in accordance with New York State regulations.

Medical Record Documentation Criteria:

- Each page of the Medical/Clinical record must contain the patient’s name or ID number.
- All entries must contain author identification and professional title.
- All entries must be dated.
- All entries must be in ink or computer generated.
- The record must contain a pertinent history and physical (if applicable).
- Significant illnesses and medical conditions must be indicated on the problem list.
- The treatment plan must be consistent with the patient’s diagnosis.
- A return visit date and follow up plan must be documented for each encounter.
- Problem(s) from previous visits must be addressed.
- Evidence of diagnostics must be documented and reviewed.
- Documentation of coordination and continuity of care with consultants must be noted.
- Documentation of medication allergies and adverse reactions must be prominently noted.
- The record must be legible to someone other then the writer.
- Documentation of advanced medical directives addressed.

Accessing Medical Records

Providers are required to allow member's medical information to be accessed by Hamaspik Choice, the New York State Department of Health, and the Centers for Medicare and Medicaid Services in compliance with Hamaspik Choice's confidentiality policy. Providers must also adhere to the appeals/expedited appeals procedures for Medicare enrollees including gathering and forwarding information on appeals as necessary.

Release of Information to Members

- Members are entitled access to, or copies of, records concerning their health care. All or part of the medical record may be released upon written authorization from the member or other "qualified person" in accordance with applicable state and federal law.

- Qualified persons other than the member who may request access or copies on behalf of the member include, but are not limited to:

    - Court-appointed committee for an incompetent person
    - Court appointed guardian
    - Other legally appointed guardian

Members Requesting Records

- A written request, either in the form of a letter or an authorization form signed by the patient should include:

    - Name of the physician from whom the information is requested
    - Name and address of the institution, agency, or individual that is to receive the information
    - Member's full name, address, date of birth, and Hamaspik Choice identification number
    - The extent or nature of the information to be released, including dates of treatment
    - The date of initiation of authorization
    - Signature of member or qualified person

Member requests should be honored within 10 days of the date of receipt of the written authorization.

Access to member information may be denied only if the provider determines that access can reasonably be expected to cause substantial harm to the member or others, or would have a detrimental effect on the provider's professional relationship with the patient or his or her ability to provide treatment.

The physician may place reasonable limitations on the time, place, and frequency of any inspections of the patient information. Personal notes or observations may be excluded from any disclosure based on the provider's reasonable judgment

Special authorizations, forms and procedures are required for HIV- related testing (both before and after the test is performed) and for release of any HIV-related information from the medical record. The informed consent form and the authorization for release of confidential HIV-related information must be the New York State Department of Health approved forms or must be forms that have been approved by the New York State Department of Health. All authorizations requesting the release of mental health records must specify that the information requested concerns mental health treatment.

SECTION FOURTEEN: PATIENT SELF-DETERMINATION ACT AND ADVANCED MEDICAL DIRECTIVES

Hamaspik Choice complies with the federal Patient Self- Determination Act (PSDA) and related New York State laws. The laws protect the rights of patients to make decisions regarding their own medical care, including the right to accept or refuse treatment and to appoint someone to make decisions on their behalf.

Hamaspik Choice provides its members with information regarding options provided under the Patient Self-Determination Act. Members may obtain copies of the Hamaspik Choice Patient Self-Determination Act (PSDA) Information packet by calling the Hamaspik Choice Member Services department at (855) 552-4642.

Primary Care Physicians and Specialists should be prepared to answer member questions regarding their choices under the PSDA. Physicians with questions about the Patient Self-Determination Act may contact the Hamaspik Choice Provider Relations Department at (855) 552-4626.

SECTION FIFTEEN: ORGANIZATION: DETERMINATIONS AND RECONSIDERATION PROCESS

Member Appeals Process

Hamaspik Choice members may appeal the following determination made by the Plan:

- A denied request for service.
- An adjustment in service such as a change in personal care hours, the request for a motorized wheelchair and receipt of a standard wheelchair, etc.
- A denied payment.

Appeals may be submitted by any of the following:

- Member
- Member's estate
- Member's representative, when a signed appointment of representative statement is submitted,
- Provider of Service when; 1) acting on behalf of the member, at which time a signed appointment of representative statement must be submitted, 2) when a denial of payment is made, at which time a signed waiver of payment statement must be submitted.

Appeal requests must be made within 45 days of the postmark date of an adverse determination notice. If the time frame for submission exceeds the 45 day timeframe, supporting documentation and a letter explaining the reason for delay must be submitted to the Hamaspik Choice Appeals Coordinator, who will review the reason and make a determination as to the acceptability of the reason. Some acceptable exceptions to this requirement are:

- Long term hospital admission
- Nursing home admission
- Lengthy illness and/or convalescence
- Member's incapacitation

Timeframe for Processing Standard Member Appeals

Appeals for the denial of a payment must be processed within 60 days of receipt of written request. Hamaspik Choice's Initial Adverse Determination (IAD) notice includes instructions for the member, if they wish to request an appeal. The IAD form includes the Appeal Request Form, which members may use. All appeals must be requested in writing.

Appeals for the denial of a service must be processed within 30 days of receipt of written request.

Members are required to exhaust the Hamaspik Choice internal appeal process before seeking an external appeal or fair hearing. The member has up to 120 days after the Final Adverse Determination to request a fair hearing. The FAD notice includes detailed instructions that the member can follow if they wish to appeal the decision further.

The member can contact Member Services if they have any questions about the appeals and fair hearing process as well as aid continuing.

Aid Continuing

If the denial (either first level or on appeal) is related to the reduction, suspension, or termination of a service that had been previously authorized, the member may request "aid continuing" while the appeal is pending. Aid continuing will allow members to keep the services they are currently receiving while their appeal is pending.

The denial notice that is sent to the member includes instructions for requesting aid continuing. The member must request the internal appeal within ten days of the date on Initial Adverse Determination notice to receive aid continuing. All requests for aid continuing that are received prior to this deadline are automatically approved.

Member Review of Appeals and Appeals Determination

All appeals are reviewed by a different utilization review nurse than the individual(s) who were involved in the initial denial. If upon review, the nurse's recommendation is to uphold the initial decision, the documentation is reviewed by a different medical director or peer reviewer than the individual(s) who were involved in the initial decision.

If the determination is overturned, the payment will be made, or service will be supplied and the appeal will be closed. If the determination is upheld, the member will be informed of all appeal rights, including State Fair Hearing and External Appeals rights.

If the State Fair Hearing or External Appeal agent determines that the initial determination should be overturned, they will notify Hamaspik Choice to pay the claim or implement the service.

If the State Fair Hearing or External Appeal agent determines that the initial determination should be upheld, the member will be notified of the determination in writing by the reviewing agency.

Requests for Expedited Appeals

A member or servicing provider may request an expedited (72 hour) appeal when he/she feels that the time frame for processing a standard appeal may be detrimental to their health. The request may be made when he/she receives a verbal or written denial of service. Appeals for the denial of claims payment do not fall within the expedited appeals process.

Timeframe for Processing Expedited Appeals

The process begins as soon as the member or servicing provider makes a request for expedited appeal. The member or servicing provider must then follow up the verbal request with a written request. Any request, either verbal or written, must be forwarded, immediately, to the Hamaspik Choice Appeals & Grievances Department, by telephone:

Hamaspik Choice has 2 business days from the date that all information in received, but no later than 3 business days to make a determination on an expedited appeal. The result of the decision will be given to the member both telephonically and in writing.

A fourteen (14) day extension may be granted if the extension is in the best interest of the member to obtain additional records or have additional tests performed, which may help in the determination.

When Member Appeals are Expedited

A request for an expedited appeal will be honored when:

- Any physician requests that the appeal be expedited.
- The Medical Director determines that the request falls within the guidelines outlined in the policy and procedure.

Appeals which are not approved to be expedited will be automatically transferred to the standard (30 day) appeals process.

Any questions regarding the member appeals process may be directed to Hamaspik Choice’s Appeals Coordinator at (855) 552-4642.

SECTION SIXTEEN: MEMBER GRIEVANCE REVIEW PROCESS

Hamaspik Choice members should use the Hamaspik Choice Grievance Review Process for complaints that do not involve coverage decisions such as denial of claims payment or the denial of a service. If a member has a question about what type of complaint process to use, he/she can call the Hamaspik Choice Member Services Department at (855) 552- 4642, between the hours of 9:00 a.m. and 5:00 p.m. Monday through Friday. (TTY users, call 711.)

Members have the right to file a complaint -- also called a grievance -- about problems such as:

- Complaints about the quality of services that he/she receives;
- Complaints about issues such as office waiting times, physician behavior, adequacy of facilities, or other similar member concerns;
- Involuntary disenrollment situations;
- If he/she disagrees with Hamaspik Choice's decision to process his/her request for a service or to continue a service under the standard 14 calendar day time frame rather than the expedited/72 hour time frame;
- If he/she disagrees with Hamaspik Choice's decision to process his/her appeal request under the standard 30-day time frame rather than the expedited/72 hour time frame.

The Grievance Review Process

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

A grievance can be verbal or in writing. Grievances that can be resolved the same day do not need to be responded to in writing. If the grievance cannot be resolved the same day, Hamaspik Choice will initiate a formal grievance review and the member will receive a written acknowledgement of the grievance within fifteen (15) days of receipt. Grievances will be decided as fast as the member's condition requires, but no more than seven (7) days from receipt of the grievance in the case of an expedited review and sixty (60) days from receipt of the grievance in the case of a standard review. In some instances, Hamaspik Choice will need additional time to address the concern. If additional time is needed, Hamaspik Choice will keep the member informed of how his/her grievance is being handled.

Members will always be informed of their right to file a complaint with the New York State Department of Health or Department of Insurance.

SECTION SEVENTEEEN: PARTICIPATING PROVIDER APPEALS

Hamaspik Choice provides the following information to participating providers about the grievance and appeal systems:

1. The right of the enrollee or, with the enrollee's written consent, a provider or an authorization representative, to file grievance and appeals;
2. The requirements and timeframes for filing a grievance or appeal;
3. The availability of assistance in the filing process;
4. The right to request a State fair hearing after the Hamaspik Choice has made a determination on an enrollee's appeal which is adverse to the enrollee; and the fact that, when requested by the enrollee, benefits that Hamaspik Choice seeks to reduce or terminate will continue if the enrollee files an appeal or request for a State fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

Hamaspik Choice, Inc, will ensure that punitive action is not take against a provider who requests and expedited resolution or supports a member's service authorization request, appeal or grievance.

A participating provider has sixty (60) days from the date of the Explanation of Payment determination to file a request for reconsideration. In the event that there is a dispute concerning the original submission of a claim (i.e. your records indicate that services were billed but Hamaspik Choice has no record of the claim being submitted), you will be given **150 days** from the date of service to submit the request for payment.

Appeals must be submitted in writing to:

Hamaspik Choice
58 Rt. 59, Suite 1
Monsey, NY 10952
Attn: Provider Appeals

Requests should contain any additional information that would support the provider's request to overturn the initial determination.

Upon receipt, the request will immediately be logged and an acknowledgement letter will be sent to the provider. Hamaspik Choice has sixty (60) days to respond to a provider's request for reconsideration.

The claim and all related information, including the additional information submitted on reconsideration will be forwarded to the appropriate department at Hamaspik Choice for review and a reconsideration determination:

- For technical denials (i.e.: missing CPT codes, diagnosis codes) or questions of payment the Hamaspik Choice Claims Department will

perform the reconsideration review.

For denials for medical necessity, the Hamaspik Choice Medical Director will perform the reconsideration review. Upon determination, Hamaspik Choice's Claims Department will send out a written notification of the determination to the provider.

No further appeal rights are available after a determination is made.

SECTION EIGHTEEN: BILLING AND REPORTING REQUIREMENTS

All participating providers must submit claims and encounter information to Hamaspik Choice for each service provided, regardless of whether the service is reimbursed on a fee-for-service or capitated basis. This information is used to meet the data element requirements of Hamaspik Choice claims processing and utilization reporting systems as well as the reporting requirements of New York State and a variety of other governmental agencies. It is essential that this information be submitted in a timely and accurate manner. The following are procedures for the submission of claims and encounter data.

Payment for Services

All payments for services rendered to Hamaspik Choice members constitute payment in full. Providers may not bill members for the difference between their actual charges and the reimbursed amounts, except for applicable copayments or coinsurance. Unless explicitly stated otherwise in the facility's contract with Hamaspik Choice, all long term care facilities are required to collect any member-specific Net Available Monthly Income (NAMI) from all long-term placement residents. Hamaspik Choice will deduct the NAMI amount from claims payments made to the facility.

Third party health insurance (TPHI) must be billed prior to submission of claims to Hamaspik Choice. An Explanation of Benefits/Payment (EOB/EOP) from the other insurer must be submitted along with the claim to Hamaspik Choice before payment of the balance will be considered. Hamaspik Choice may pursue retroactive recovery of overpayments made to providers up to six (6) months from the later of the date the TPHI information has posted in eMedNY or the Hamaspik Choice payment date.

Payment is subject to the member's eligibility, authorization requirements at the time of service, and all other applicable administrative procedures.

Providers may call Hamaspik Choice at (855) 552-4642, to obtain information regarding the status of their claims.

Recovery of Overpayments

1. Hamaspik Choice and the participating providers agree that where Hamaspik Choice has previously recovered overpayments, by whatever mechanism utilized by the plan, from a Participating Provider, said overpayment recovery shall not be recovered from that Participating Provider for any such previously recovered identifiable claims that are the subject of a further investigation, audit or action commenced by any governmental agencies, including but not limited to the New York State Department of Health (DOH), the New York State Department of Financial Services (DFS), the New York State Office of the Medicaid Inspector General (OMIG), the U.S. Health and Human Services Administration (HHS).

2. Hamaspik Choice and the participating providers agree that where the plan has recovered overpayments from a Participating Provider, the plan shall retain said recoveries, except where such recoveries are made on behalf of OMIG or the DOH or a combined audit...

3. Hamaspik Choice requires and has a mechanism in place for its Participating or Non-Participating Providers to report to the plan when the Participating or Non-Participating Provider has received an overpayment, to return the overpayment within 60 days of the date of the identification of the overpayment, and to notify the plan in writing of the reason for the overpayment.

4. OMIG or the DOH has the right to request that Hamaspik Choice recover an overpayment, penalty or other damages owed to the Medicaid program, including any interest, from its Participating Provider consistent with the requirements of Insurance Law § 3224-b. In such cases OMIG or the DOH may charge the Participating Provider a collection fee as set forth in State Finance Law, in an amount to be determined by OMIG or the DOH in its sole discretion. Hamaspik Choice shall remit, on a monthly basis, to the DOH all amounts collected from the Participating Provider. Upon collection of the full amount owed to the Medicaid program, Hamaspik Choice may retain the collection fee to account for the Hamaspik Choice's reasonable costs incurred to collect the debt. Hamaspik Choice shall report the amounts recovered in its Quarterly Provider Investigative Report in accordance with Section F(3)(t) of Article VIII of Hamaspik's agreement with the DOH. OMIG will only request that Hamaspik ChoiceChoice, Inc. recover an overpayment, payment or other damage where there has been a final determination. For purposes of this section, a final determination is defined as:

   - a Notice of Agency Action issues by OMIG pursuant to 18 NYCRR Part 515;
   - a Notice of Agency Action issued by OMIG pursuant to 18 NYCRR Part 516;
   - a Final Audit Report issued by OMIG pursuant to 18 NYCRR Part 517;
   - a stipulation of settlement or repayment agreement resolving any outstanding audit, investigation, or review; or
   - an Administrative Hearing Decision issued by the Department pursuant to 18 NYCRR Part 519: however, only a timely request for an administrative hearing, as defined in 18 NYCRR 519.7, shall delay OMIG's request pending a decision.

5. Consistent with 18 NYCRR § 517.6(g) OMIG may enter into an agreement with Hamaspik Choice, Inc. to conduct a combined audit or investigation of the Plan's Participating Provider, Non-Participating Provider, or subcontractor. Such agreement shall be executed by the parties prior to the commencement of the audit or investigation. The portion of any recoveries as a result of a combined audit or investigation that is not owed to the federal government shall be shared between Hamaspik Choice, Inc. and OMIG as provided for in the combined audit or investigation agreement. In no event shall Hamaspik Choice, INC. share in any recovery which results from the referral of a pending investigation of a credible allegation of fraud by the State to the New York State Office of the Attorney General or other law enforcement organization pursuant to 42 C.F.R. § 455.23 Other Pertinent Authority.

Guidelines for Claims Submission and Reimbursement

Claims must be submitted according within the timeframe specified in Exhibit B of the Hamaspik Choice provider agreement. To ensure timely claims adjudication, the preferred process for claims submission is electronically (EDI) in HIPAA 837 format. The clearinghouse must have updated payer ID and Hamaspik Choice group number information in order to route the claim correctly. Providers can contact the Hamaspik Choice Provider Relations Department for assistance in obtaining this information at (855) 552-4642. Detailed billing information can also be found on our website, www.hamaspikchoice.org. It is recommended that providers run a test claim in order to ensure that claims are being received by Hamaspik Choice's Claims Department correctly. Please contact Provider Relations to request a test run.

Claims received electronically will be processed within thirty (30) days of receipt, although providers should allow an additional 5-7 business days for receipt of payment or determination notice. Paper claims will be processed within forty-five (45) days.

Claims received without an authorization number will be denied. Providers may re-submit the claim, along with the correct authorization number, within 60 days of the notice of denial for payment reconsideration.

Claims will be reviewed for completeness and correctness. Claims with missing information will be denied.

Paper Claims – CMS-1500 and UB-04

Claim forms should be typed or printed legibly with black ink in order to reduce delays in processing. Please mail claim forms to:

Claims Processing Department
Hamaspik Choice
58 Route 59, Suite 1
Monsey, NY 10952

All CMS-1500 Claims must include:

1. Member name
2. Hamaspik Choice Member ID number
3. Date of Birth
4. Provider name, tax ID and NPI number
5. Date of Service (must fall within the effective and expiration date printed on the authorization if applicable)
6. Valid Place of Service code
7. Service Code such as HCPCS/CPT (must match the code listed on the authorization)
8. Number of units
9. EOB of co-insurance, if applicable
10. Valid Diagnosis Code

11. Hamaspik Choice Member ID number
12. Date of Birth
13. Provider name, tax ID and NPI number
14. Date of Service (must fall within the effective and expiration date printed on the authorization if applicable)
15. Valid Place of Service code
16. Service Code such as HCPCS/CPT (must match the code listed on the authorization)
17. Number of units
18. EOB of co-insurance, if applicable
19. Valid Diagnosis Code
20. Hamaspik Choice Member ID number
21. Date of Birth
22. Provider name, tax ID and NPI number
23. Date of Service (must fall within the effective and expiration date printed on the authorization if applicable)
24. Valid Place of Service code
25. Service Code such as HCPCS/CPT (must match the code listed on the authorization)
26. Number of units
27. EOB of co-insurance, if applicable
28. Valid Diagnosis Code

All UB-04 Claims must include:

1. Member name
2. Hamaspik Choice Member ID number
3. Date of Birth
4. Provider name, tax ID and NPI number
5. Date of service (must fall within the effective and expiration date printed on the authorization if applicable)
6. Service Code such as HCPCS/CPT (must match the code listed on the authorization)
7. Number of units
8. EOB of co-insurance, if applicable
9. Valid Bill Type
10. Valid Diagnosis Code
11. Valid Revenue Code

SECTION NINETEEN: HAMASPIK CHOICE DEPARTMENT REFERENCE GUIDE

Have a question? Not sure where to send a form? Feel free to contact Hamaspik Choice. The following departments are here to provide assistance:

Plan Address:

Hamaspik Choice
58 Route 59, Suite 1
Monsey, NY 10952

Main Telephone Number:

855.55 CHOICE (855-552-4642)

TTY Number: 711

24-hour emergency hotline:
HAMASPIK CHOICE (855) 552-4643

After dialing Hamaspik Choice's main telephone number **(855) 552-4642**, providers should press **Option 4** then select one of the following:

1. **Care Management/Plans of Care/Authorizations:**
   caremanagement@hamaspikchoice.org

2. **Claims/Billing:**
   finance@hamaspikchoIce.org

3. **Eligibility, Member Services and Enrollment/Referrals:**
   memberservices@hamaspikchoice.org

4. **General Provider Inquiries:**
   providerrelations@hamaspikchoice.org

APPENDIX

- ***SAMPLE HAMASPIK CHOICE IDENTIFICATION CARD***