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Welcome to Hamaspik CHOICE

Welcome to Hamaspik CHOICE Managed Long Term Care (MLTC) plan. The MLTC plan is especially designed for people who have Medicaid and who need health and Community Based Long Term Services and Supports (CBLTSS), like home care and personal care, to stay in their homes and communities for as long as possible.

We are delighted that you have chosen to join our plan!

This handbook tells you about the benefits that Hamaspik Choice MLTC covers, since you are enrolled in the plan. It also tells you how to request a service, file a complaint, or disenroll from Hamaspik Choice. Please keep this handbook as a reference. It includes important information regarding Hamaspik Choice.

HELP FROM MEMBER SERVICES

You can call us anytime, 24 hours a day, seven days a week, at the Member Services number below. There is someone to help you at Member Services.

Call: 855-552-4642
TTY users, call: 711
Monday through Friday, 9:00 a.m. to 5:00 p.m.

If you need help at other times, call us at the same phone number, and you will be able to reach our on-call staff.

You can receive information in another language, or in other formats if you have vision problems. Please call Member Services, and the staff will be able to assist you. These services are available at no cost to you.

Eligibility and Effective Dates of Coverage

Enrollment in Hamaspik CHOICE is voluntary. You should make an informed decision to enroll and you may choose to end your membership at any time. You are eligible to join the MLTC plan if you:

1) Are age 18 and older,

2) Reside in the plan's service area which includes the following counties in New York:
   - Dutchess
   - Orange
   - Putnam
   - Rockland
   - Sullivan
   - Ulster

3) Have Medicaid,

4) Have Medicaid only **and** are eligible for nursing home level of care, or are age 18-20 with both Medicaid and Medicare.

5) Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, ***and***

6) Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the MLTC Plan for a continuous period of more than 120 days from the date of enrollment:
   - Nursing services in the home
   - Therapies in the home
   - Home health aide services
   - Personal care services in the home
   - Adult day health care
   - Private duty nursing; or
   - Consumer Directed Personal Assistance Services

The coverage described in this Handbook becomes effective on the date of your enrollment in Hamaspik Choice MLTC plan. Enrollment in a MLTC plan is voluntary.

New York Independent Assessor and the Initial Assessment Process

Effective May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) is now known as the New York Independent Assessor (NYIA). The NYIA manages the initial assessment process for all MLTC plans. NYIA will start the expedited initial assessments at a later date.

The initial assessment process includes two assessments:

- **Community Health Assessment (CHA):** The CHA is completed by a nurse, and is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a Managed Long Term Care plan.

- **Clinical Appointment and Practitioner Order (PO):** After the CHA, a clinician from the NYIA will complete a clinical appointment and PO a few days later. The PO documents your clinical appointment and indicates that you:
    - have a need for help with daily activities, **and**
    - that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIA will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIA will complete a clinical appointment and PO a few days later.

Hamaspik Choice will use the CHA and PO outcomes to see what kind of help you need and create your plan of care.

If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIA Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care, and any other medical documentation. If more information is needed, someone on the panel may examine you or discuss your needs with you. The IRP will then make a recommendation to Hamaspik Choice about whether the plan of care meets your needs.

Once NYIA completes the initial assessment steps and determines that you are eligible for Medicaid Managed Long Term Care, you then choose which Managed Long Term Care plan to enroll with.

Enrollment

There are several steps to enrolling in Hamaspik Choice. The process includes you, your family, your physician, NYS Medicaid Choice and Hamaspik Choice. The process includes the following steps:

- Anyone may contact us – you, your family, a friend, a medical provider – to notify us of your interest in Hamaspik CHOICE. When we are informed that you are interested in learning more about the program, a Hamaspik CHOICE staff member will contact you to schedule a visit with one of our enrollment nurses.

- During the enrollment visit, the Nurse will explain more about the Hamaspik Choice MLTC plan, and will provide you with written information about the program. He/she will also explain how to access services in the MLTC plan and will give you a list of Hamaspik Choice network providers.

- Together with your input, a Person Centered Service Plan (or "PCSP") will be designed, in order to meet your health care needs.

- The enrollment nurse or your Care Manager may contact your physician to discuss your PCSP if necessary. If you want us to discuss your PCSP with other individuals who are involved in your care, please let us know.

- If you decide to join Hamaspik Choice, you will sign an Enrollment Agreement. Your enrollment must be approved by New York Medicaid Choice, the local social services department (LDSS) or other entity as designated by the NY State Department of Health.

- Note: If you begin the enrollment process and change your mind, you may withdraw your enrollment agreement by noon on the 20th day of the month prior to the effective date of the enrollment.

You may be denied enrollment for any of the following reasons:

- You do not meet one or more of the eligibility requirements, as listed on page 5;
- You have previously been involuntarily disenrolled from Hamaspik CHOICE, and the circumstances surrounding your disenrollment have not changed.

Hamaspik CHOICE does not unlawfully discriminate in enrollment or the provision of services on the basis of age, sex, race gender identity (including status of being transgender), creed, religion, physical or mental disability

including gender dysphoria, sexual orientation, source of payment, type of illness or condition, need for health services, or place or origin.

Effective Dates of Enrollment

If you sign your Enrollment Agreement before the 20th of the month, and your enrollment is approved by NY Medicaid Choice or entity designated by the DOH, your enrollment becomes effective on the first of the next month. If you sign the Enrollment Agreement after the 20th of the month, your enrollment would take one month later, on the first day of the following month.

After you enroll, you will receive a Hamaspik CHOICE member identification card. Remember to keep your regular Medicaid, Medicare and third party insurance cards, too. You will need to use these cards for services not covered by Hamaspik CHOICE that may be covered by these other insurance programs.

Continuity of Care

If you are transitioning from a Medicaid community based long-term program, you will continue to receive services under your pre-existing service plan for at least 90 days after enrollment. Your services will be authorized at the same level, scope and amount as you received through Medicaid.

If you enroll in Hamaspik CHOICE because your former MLTC Plan closed, or reduced its service area, or merged with another MLTC Plan, you have the right to keep your previous Person Center Service Plan for up to 120 days after enrollment. Your services will be authorized at the same level, scope and amount as you received through your former MLTC Plan.

During the 90-day or 120-day transition period (depending on the circumstances described above), Hamaspik CHOICE will complete an assessment of your needs. If Hamaspik Choice then decides to change the services authorized, you will receive a notice of action, which articulates your right to file an appeal. You will have the right to continue receiving the same services when you request an appeal or fair hearing.

Service Benefit Package

Care Management Services

As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a health care professional – usually a nurse or a social worker. Your care manager will work with you and your doctor to decide the services you need and develop a care plan. Your care manager will also help you to arrange appointments for any services you need and arrange for transportation to those services.

Our care managers are available 24 hours a day, 365 days a year. If you need assistance when our offices are closed, please call our main phone number (855-552-4642), and the on-call staff will assist you.

Covered MLTC Services

Because you have Medicaid and qualify for MLTC, our plan will arrange and pay for the health care and social services listed below. You may get these services as long as they are medically necessary. This means that the services are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. (For those services, your care manager will help you obtain the information that is needed from your doctor.)

The following services are provided through contracted providers that have agreed to work with Hamaspik CHOICE. They are described in more detail in the next section of this handbook.

- Adult Day Health Care
- Audiology and Hearing Aids
- Consumer Directed Personal Assistances Services
- Dentistry
- Durable Medical Equipment
- Home Care (including nursing, home health aide, physical therapy, occupational therapy, speech pathology, and medical social services)
- Home Delivered meals and Congregate meals
- Non-emergency medical transportation
- Nursing Home Care
- Nutrition
- Optometry and Eyeglasses
- Personal Care
- Personal Emergency Response System
- Podiatry
- Rehabilitation Therapies (Physical Therapy, Occupational, Therapy,

Speech Therapy or other therapies that are provided in a setting other than your home.)
- Respiratory Therapy
- Private Duty Nursing
- Social Adult Day Care
- Social and Environmental Supports

All services listed above require prior approval, except for the following services:

- Audiology – routine examination once per year
- Dental care – routine dental examinations up to twice yearly and emergency dental care
- Optometry exams and eyeglasses – routine optometry examination (which includes refraction), and prescription lenses for eyeglass frames at Medicaid rates once every two years
- Podiatry consultation – once per year for those members whose condition requires it

More about the services and benefits of Hamaspik CHOICE

Adult Day Health Care: Adult Day Health Care services are provided in a residential health care facility or State-approved site. The services provided at an adult day health care may include: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities, dental, pharmaceutical, and other ancillary services.

Consumer Directed Personal Assistance Services (CDPAS): The provision of some or total assistance with personal care services, home health aide services, and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision, and direction of the Member or the Member's designated representative. Personal assistants are paid through a Fiscal Intermediary, which is a company that has a contract with Hamaspik Choice to manage the wages and benefits for these workers.

To participate in the consumer directed personal assistance services, you must meet the following eligibility requirements:

- Have a stable medical condition;
- Be self-directing or, if non self-directing, have a designated representative
- Be willing and able to fulfill the member's responsibilities or have a designated representative who is willing and able to fulfill such responsibilities; and
- Participate as needed, or have a designated representative who participates, in the required assessment and re-assessment process.

When you enroll in Hamaspik CHOICE, we will talk with you about CDPAS as a voluntary health benefit that is available in your MLTC plan. Please talk to your care manager if you want to learn more about CDPAS.

Dental Services: Your Hamaspik CHOICE Care Manager can help you with selecting a dentist or making an appointment, if you wish.

- Hamaspik CHOICE is contracted with the DentaQuest network for dental services
- With the help of your care manager, you may choose a provider in your area that is contracted with Hamaspik CHOICE to provide services to you
- When making appointments, be sure to inform the office that Hamaspik CHOICE is your managed long term care plan (MLTCP)
- Bring your Hamaspik CHOICE ID card to appointment
- No prior approval is necessary for routine dental examinations up to twice yearly and emergency dental care
- You should never be asked to pay out of pocket for any costs associated with your care. Please let your care manager know if you are *ever* asked to make payments to a provider. Your costs should be *fully* covered by Hamaspik CHOICE.

Durable Medical Equipment (DME): Hamaspik CHOICE coordinates the provision of durable medical equipment (DME). DME describes devices and equipment that are ordered by a practitioner for use in the home and are for the treatment of a specific medical condition. DME has the following characteristics:

1. Can withstand repeated use for a protracted period of time
2. Is primarily and customarily used for medical purposes
3. Is generally not useful in the absence of an illness or injury; and
4. Is not usually fitted, designed or fashioned for a particular individuals' use.

This category of services also includes: Medical and Surgical Supplies, Hearing Aid Batteries, Prosthetics, Orthotics, Orthopedic Footwear, Respiratory therapy including oxygen, and Nutritional Supplements.

- **Medical and Surgical Supplies:** Hamaspik CHOICE will coordinate with your health care professionals on required medical and surgical supplies. These are items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or

orthopedic footwear that have been ordered by a practitioner in the treatment of a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value

- **Oxygen and Respiratory Therapy:** Hamaspik CHOICE will ensure that these services are provided by a qualified respiratory therapist.

- **Prosthetics and Orthotics:** Hamaspik CHOICE will coordinate the provision of prosthetic appliances and devices. Prosthetic appliances and devices are devices that replace any missing part of the body. Orthotic appliances and devices are devices used to support a weak or deformed body part, or to restrict or eliminate motion in a diseased or injured part of the body. Orthopedic footwear are shoes, shoe modifications, or shoe additions which are used to correct, accommodate, or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot, or to form an integral part of a brace.
- **Enteral Formula and Nutritional Supplements:** Based on Medicaid guidelines, coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and only in the following conditions:
  (1) Tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and
  (2) Individuals with rare inborn metabolic disorders, who require specific medical formulas to provide essential nutrients that are not available through any other means.
  (3) Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

Eye Exams and Glasses: Hamaspik CHOICE is contracted with the EyeQuest networks for vision services including optometry services such as eye exams and eyeglasses.

- With the help of your care manager, you may choose a provider in your area that is contracted with Hamaspik CHOICE to provide your services
- When making appointments, be sure to inform the office that Hamaspik CHOICE is your managed long term care plan (MLTCP)
- You are eligible for one eye exam and one pair of eyeglasses every two years

Hearing Exams and Hearing Aids: Hearing exams and hearing aids are provided by audiologists. You may visit an audiologist for a routine hearing exam once a year without an authorization. However, if you think you may need a hearing exam, kindly consult with your care manager. We may ask you to see your doctor first, in order to be sure that another health problem is not affecting your ability to hear.

- If you require an evaluation for hearing aids, you must obtain a referral from your doctor prior to receiving the evaluation
- If you need hearing aids or any other audiology services, please speak to your care manager about obtaining authorization for those services.
- Products included with hearing aids include:
    - Hearing aids;
    - Ear molds;
    - Batteries;
    - Special fittings; and
    - Replacement parts.

Home Delivered Meals: Hamaspik CHOICE can authorize home-delivered meals or congregate meals provided in accordance with your PCSP.

Home Health Care Services: Hamaspik CHOICE will coordinate the provision of services, which may include care from nurses, social workers, nutritionists, physical therapists, occupational therapists and speech therapists. These services are provided to help prevent, rehabilitate, guide and/or support your health.

Non-Emergency Medical Transportation. Hamaspik CHOICE will arrange and pay for your non-emergency transportation services, in order to receive necessary medical care that is reimbursed by Hamaspik CHOICE, Medicaid, or Medicare. Services will be provided by car service, ambulette, or ambulance, depending on your needs. If you need transportation by ambulette or ambulance, Hamaspik CHOICE will only use approved Medicaid providers.

Please follow these important instructions for requesting transportation:

- Transportation provided by Hamaspik CHOICE is for non-emergency medical appointments. If you are ill and need to go to the hospital or emergency room right away, please call 911 immediately.
- All requests for transportation must be made at least 2 business days in advance
- When calling to request transportation, kindly have the doctor's name,

specialty and phone number available. We will need this information to schedule your trip.

- Confirmation of appointment will be made by our member services department by calling the service location to verify your appointment.
- Please call our transportation department as soon as possible, if there are any changes made to your appointment time/date
- We try to accommodate requests for specific transportation vendors; accommodation is always based on vendor availability
- If you need to see a specialist out of county, your local PCP will need to complete an *Out of County Form* that explains the reason for why it is necessary for you to travel out of county for your services. Requests for out of county trips should be made at least 10 days in advance.
- To schedule your trip, please call during business hours Monday through Friday, 9:00 AM-5:00 PM
- You can also schedule your transportation online on our website www.hamaspikchoice.org

Nursing Home Care: There may be times when Hamaspik CHOICE, in consultation with you, your family and your physicians determine that it is necessary for you to stay in a nursing home. If this occurs, your Care Manager will help arrange for you to enter a nursing home in a semi-private room. Private rooms are covered only if medically necessary. Hamaspik CHOICE does not cover non-medical items such as telephone charges or television rental. If you should require permanent placement in a nursing facility, your Medicaid eligibility will be converted from "community" to "institutional". If the Local Department of Social Services (LDSS) determines that you are not eligible for institutional coverage, Hamaspik CHOICE is required to initiate an involuntary disenrollment.

- Note: Nursing Home Care is covered for individuals who are considered a permanent placement for at least three months. Following that time period, your nursing Home Care may be covered through regular Medicaid, and you will be disenrolled from Hamaspik Choice.

Nutritional Services: Hamaspik CHOICE's in-network nutritionists can assess your dietary needs to ensure that your diet meets your needs.

Personal Care: Hamaspik CHOICE will coordinate the provision of personal care and help you with such activities as bathing, personal hygiene, dressing, preparing meals and eating, and other in-home support, as determined by an assessment of your needs.

Personal Emergency Response System (PERS): PERS is an electronic device that enables you to call for assistance in an emergency without having to reach for a telephone

Private Duty Nursing (PDN): Hamaspik CHOICE will coordinate PDN services to enrollees at their permanent or temporary place of residence, by licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders.

Rehabilitation Therapy: Hamaspik CHOICE Outpatient Rehabilitation services may be provided at outpatient locations, based on your needs. These services include: Physical Therapy, Occupational Therapy, and Speech-Language Pathology which are rehabilitation services, occupational therapy, or speech language pathology for the purpose of maximum reduction of physical or mental disability and restoration to your best functional level.

Podiatry/ Foot Care: Foot care is provided by licensed podiatrists listed in the Hamaspik CHOICE Provider Network. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet may be covered if deemed necessary by Hamaspik CHOICE's clinical department. No prior approval or authorization is necessary for podiatry consultation once per year for those members whose condition requires it.

Social and Environmental Supports: Social and environmental supports include but are not limited to: respite care, home maintenance tasks, chore services, pest control and housing modifications to improve safety.

Social Day Care: Social day care is a structured program that provides you with socialization, supervision, monitoring and nutrition in a protective setting. You may also receive services such as enhancement of daily living skills, personal care, transportation and caregiver assistance.

Paying Providers for Covered Services

Hamaspik CHOICE is responsible for paying for approved covered services. You are not responsible for payment for covered services, as long as they are authorized for you. If you ever receive a bill for covered services, please let your care manager know as soon as possible, so that we may promptly correct this error.

Also, if you have third party health insurance, please let us know so that we can coordinate your benefits for covered services.

Medicaid Services Not Covered by Our Plan

There are some Medicaid services that Hamaspik Choice does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 855-552-4642, if you have a question about whether a benefit is covered by Hamaspik Choice or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

- Most prescription and non-prescription drugs, as well as compounded prescriptions are covered by regular Medicaid or Medicare Part D if you have Medicare.

Certain Mental Health Services, including:

- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospital Care not covered by Medicare
- Rehabilitation Services to those in community homes or in family-based treatment
- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Intellectual and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services including:

- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Family Planning (including certain medically necessary ovulation enhancing drugs, when criteria are met)

Services Not Covered by Hamaspik Choice or Medicaid

You must pay for services that are not covered by Hamaspik Choice or by Medicaid, if your provider tells you in advance that the service is not covered AND you agree to pay for the service. Examples of services not covered by Hamaspik Choice or Medicaid include:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a Provider that is not part of the plan (unless sends you to that provider)

If you have any questions, call Member Services at 855-552-4642.

Accessing Services

You can access Hamaspik CHOICE, 24 hours a day, 7 days a week, and 365 days a year by calling (855) 552-4642 at any time. Your Person Centered Service Plan (or "PCSP") specifies the services you will receive. Please see the Care Management section of this handbook for more information about your PCSP. Hamaspik CHOICE will also coordinate the services you require, whether or not they are covered services.

Hamaspik CHOICE requests that you notify us of any non-covered service you are receiving within two business days of receiving the service, so that this information can be included in your PCSP. If we are notified at least 48 hours in advance, we can arrange appropriate transportation to and from the service provider and ensure seamless delivery of services. If you are hospitalized, it is important for you to let us know, because we can coordinate your discharge plan and ensure that you receive the services that you need when you come home.

Urgent Care

If you need urgent care, please call your physician. Urgent care is any service that is medically necessary in order to prevent a serious deterioration in your health resulting from an unforeseen illness or injury, when you must be seen sooner than a routine medical visit can be scheduled.

Let us know as soon as possible that you have required urgent care so we can make any necessary changes to your PCSP.

Emergency Care

Emergency Services refers to medically necessary services required to evaluate and stabilize an emergency medical condition. An emergency condition means that you have a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate medical attention could: (1) result in placing your health in serious jeopardy, or, in the case of a behavioral condition, place the health of you or others in serious jeopardy; (2) seriously impair your bodily functions; (3) result in serious dysfunction of any body organ or part of you; or (4) seriously disfigure you.

You are not required to get prior approval from Hamaspik CHOICE for treatment of emergency medical conditions. If you require Emergency Services, please call 911 immediately. Listen to the questions carefully, answer their questions, and follow any instructions that you are given. If the

dispatcher determines that you have a medical emergency, they will arrange an ambulance to transport you to the nearest hospital emergency room.

If You Are Hospitalized

If you are hospitalized, it is important that you, a family member or a friend call your Hamaspik CHOICE care manager or call Hamaspik CHOICE as soon as possible. (Please call us at: 1-855-55-CHOICE.) Our staff will re-arrange any scheduled services you might miss during this time, and your care manager will begin making any necessary changes to your PCSP. When you are discharged from the hospital, we will help you avoid any unnecessary gaps in the services you need. Your care manager will also review your PCSP, and will authorize any new services that may be required upon discharge.

Getting Help During Non-Business Hours

We always encourage you to call your Care Manager for any assistance. Your Care Manager knows you and your needs best. However, if you have any urgent questions or need for assistance after hours or on weekends or holidays, just call us at the 24-hour toll-free number – 855-552-4642 – and an on-call representative will help you.

Services Outside the Service Area

If you have any changes in your health status while you are outside of our service area, you should call your Care Manager or Hamaspik CHOICE's general number and ask to speak with a nurse. The nurse will assist you in coordinating the services you need.

Any time you plan to be away from the area, you should notify your Care Manager so that we can help you arrange for services that are medically necessary while you are away from the area and we can suspend your regularly scheduled service until you return, and be sure that the services are available upon your return when you need them. You may not be absent from the service area for more than 30 consecutive days and remain enrolled in Hamaspik CHOICE. We are required to start the involuntarily disenrollment process when you are absent for more than 30 consecutive days (see Termination of Coverage section for more information).

Selecting Providers

For covered services, Hamaspik CHOICE has a network of providers who provide high quality care and are committed to the Hamaspik CHOICE mission of helping you to be as independent as possible. A list of Hamaspik CHOICE providers is given to you upon initial assessment and is available on our website at www.hamaspikchoice.org. The Provider Directory is updated with all new providers on a monthly basis. Additionally, an updated Provider Directory can be mailed to you, upon request.

If you wish to change providers, call your care manager, who will help you identify another provider in our network. We want you to be satisfied with the services you receive. If there are other providers that you would like to have us include in our network, please let us know and we will explore this option.

Hamaspik CHOICE strives to build and maintain a provider network that can deliver services in a culturally competent manner. Our provider network includes organizations and people who are able to work with members who do not speak English, and who come from diverse cultural and ethnic backgrounds, and religious faiths. If Hamaspik CHOICE does not have a provider in its network with the training and expertise to meet a specialized health care need included in your PCSP, we will approve services from a provider outside of our network.

If a network provider that you are using is no longer going to be in the network, we will let you know immediately and will assist you in choosing another provider from our network. If you are in the middle of a course of treatment, you may continue with the provider for a period of up to 90 days. If you are a new member, you may continue an ongoing course of treatment with an out-of-network provider for an interim period of up to 60 days. In either case, Hamaspik CHOICE permission is required and is dependent upon the provider's willingness to accept payment from Hamaspik CHOICE, and to comply with our policies and procedures.

If you need a Medicare services, you have the freedom to choose providers for these services. However, when Medicare stops paying for these services, you must use a network provider in order for Hamaspik CHOICE to continue to cover the service.

Care Management

Hamaspik CHOICE's care management program ensures that your services are provided in a way that is designed meet your individual needs and is appropriately coordinated. Care management means a process that assists you with accessing necessary covered services as identified in the Person Centered Service Plan (PCSP), described on the next page. Care management services include referral, assistance in or coordination of services for you, and monitoring your services to be sure they are effective in meeting your needs.

Care management focuses on your medical, social, educational, psychosocial, financial and other services in support of the PCSP, regardless of whether the needed services are included in the Benefit Package, or provided by somebody else.

Hamaspik CHOICE Care Managers include staff who represent a range of backgrounds and have relevant degrees – such as nurses and social workers – as necessary to meet your needs. Our staff come from diverse cultural and ethnic backgrounds, and religious faiths. If you are ever unhappy with your care manager, you may ask for a change, and we will make every attempt to accommodate your request.

The care management program includes the following components:

- Provides you with a minimum of one care management telephone contact per month
- Provides you with a minimum of one care management home visit every six (6) months
- Ensures that the level and degree of care management, and your Person Centered Service Plan (PCSP) address your needs and are based upon the acuity and severity of your physical and mental conditions;
- Monitors your plan of care to be sure you are getting the services that are included, and to be sure that the services are meeting your needs;
- Discusses with you the service options that are available, when creating the Plan of Care with you;
- Has a maximum one business day response time to enrollee/member contacts.

You can access Hamaspik CHOICE care management staff, 24 hours a day, 7 days a week, and 365 days a year by calling (855) 552-4642 at any time, for information or emergency consultation services.

Person Centered Service Plan (PCSP)

Person centered service planning is an important part of care management. Each Hamaspik CHOICE member has an individual Person Centered Service Plan, which is your written care plan that outlines your health and long term care needs and goals and includes all services authorized to meet your needs. Person centered service planning includes consideration of your current and unique psychosocial and medical needs and history, as well as your individual strengths, personal preferences, and support systems.

When developing your PCSP, your care manager will speak with you about your goals and your needs, as well as your preferences for how you want to receive your services. Your care manager may also talk with your family or other caregivers, as well as your doctor, to get their input. If there are specific people who you want your care manager to consult with, please let him/her know. Your care plan will be developed within fifteen (15) days of enrollment or each re-assessment. Your care manager will ask you to sign your care plan, and you will receive a copy for your records.

Service Authorizations, Actions, and Appeals

When you ask for approval of a treatment or service, it is called a **service authorization request**. To request a service authorization request, you should contact your care manager. You can reach your care manager by dialing our Member services number at 855-552-4642. Your provider may also call this number to request a service authorization on your behalf.

In addition, you or your provider can request an authorization in writing. Please send your request to:

Hamaspik Choice
Attention: Utilization Management
58 Route 59, Suite #1
Monsey, NY 10952

We will authorize services in a certain amount and for a specific period of time. This is called an **authorization period.**

Prior Authorization

Some covered services require prior authorization (or approval in advance) from Hamaspik Choice, before you receive them, or in order to be able to continue receiving them. You or your provider, or someone you trust can ask for this. You can contact your care manager at the address or phone number listed above to request a prior authorization. The following services must be approved before you can get them:

- Home health care (including nursing, rehabilitation therapies, social work, and home health aide services)
- Personal care
- Consumer directed personal assistance services (CDPAS)
- Adult day health care
- Social adult day care
- DME (including Medical/Surgical Supplies, Enteral and Parenteral Formula, Hearing Aid Batteries, Prosthetics, Orthotics, and Orthopedic Footwear)
- Personal emergency response system (PERS)
- Physical therapy, occupational therapy, or speech therapy, provided in an outpatient setting
- Non-emergency transportation
- Hearing aids and related products
- Respiratory therapy
- Nutrition services
- Private duty nursing
- Home delivered meals, or meals in a congregate setting
- Social and environmental supports

Concurrent Review

You can also ask Hamaspik Choice to get more of a service than you are getting now. This is called **concurrent review**.

Retrospective Review

Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

What happens after we get your service authorization request?

The plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or ***fast track*** process. You or your doctor can ask for a *fast track* review if it is believed that a delay will cause serious harm to your health. If your request for a *fast track* review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than indicated below.

Timeframes for prior authorization requests

- **Standard review**: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

- **Fast track review**: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

- **Standard review**: We will make a decision within 1 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.

- **Fast track review**: We will make a decision within 1 workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 workday if we need more information.

If we need more information

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. If this happens, we will:

- Write and tell you what information is needed. If your request is in a *fast track* review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 855-552-4642, or by contacting your care manager. You can also request an extension in writing, by sending your request to:

Hamaspik Choice
Attention: Utilization Management
58 Route 59, Suite #1
Monsey, NY 10952

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

If our answer is YES to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

If our answer is NO to part or all of what you asked for, we will send you a written notice that explains why we said no. See ***How do I File an Appeal of an Action?*** on the next page, which explains how to make an appeal if you do not agree with our decision.

What is an Action?

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

Timing of Notice of Action

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

Contents of the Notice of Action

Any notice we send to you about an action will:

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

The notice will also tell you about your right to an appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing;
- It will say that that you must file an appeal before asking for a Fair Hearing; ***and***
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on the notice. If we are reducing, suspending or terminating and authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 855-552-4642. Or you can send us your appeal in writing at:

Hamaspik Choice
Attention: Utilization Management
58 Route 59, Suite #1
Monsey, NY 10952

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension or termination of services that you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We are required to continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later. (To find out how to ask for a plan appeal, and to ask for aid to continue, see "***How do I File an Appeal of an Action?"*** above.)

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

How Long Will It Take the Plan to Decide My Appeal of an Action?

Unless your appeal is fast tracked, we will review your appeal of the action taken by us as a standard appeal. We will send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information,

and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. We will also send you your records that are part of the appeal review.

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

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases, you may request a "*fast track*" appeal. (See "**Fast Track Appeal Process"** section below.)

Fast Track Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for a *fast tracked* review of your appeal of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

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

If the Plan Denies My Appeal, What Can I Do?

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

Note: **You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.** If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes that are outlined in the section ***"How Long Will It Take the Plan to Decide My Appeal of an Action?"*** *above*, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice.
If we are reducing, suspending or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

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

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance (OTDA) in any of the ways listed below:

- Online Request Form: Request Hearing | Fair Hearings | OTDA (ny.gov)

- Mail a Printable Request Form to:
  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023

- Fax a Printable Request Form to: (518) 473-6735

- Request by Telephone:
  - Standard Fair Hearing line – 1 (800) 342-3334
  - Emergency Fair Hearing line – 1 (800) 205-0110
  - TTY line – 711 (Request that the operator call 1-877-502-6155)

- Request in Person:
  - In New York City:
    14 Boerum Place, 1st Floor
    Brooklyn, New York 11201
  - In Albany:
    40 North Pearl Street, 15th Floor
    Albany, New York 12243

For more information on how to request a Fair Hearing, please visit:
http://otda.ny.gov/hearings/request/

State External Appeals

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

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

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

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called a fast track external appeal. The external appeal reviewer will decide a fast track appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

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

Complaints and Complaint Appeals

Hamaspik Choice will always try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. However, if you have a problem with any of the services that you receive from our plan, we want to hear about it, so we can help you resolve it. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

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

To file a complaint, please call: 855-552-4642, and the Member Services staff will connect you to our complaints department. You can also file your complaint by writing to:

Hamaspik Choice
Attention: Grievances
58 Route 59, Suite #1
Monsey, NY 10952

When you contact us, you will need to give us your name, address, telephone number and the details of the problem. If your complaint is about a provider, please let us know the name of the provider too.

What is a Complaint?

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

The Complaint Process

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

- If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process must be completed within 7 days of the receipt of the complaint.

- For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.
- The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

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

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision, we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal orally or in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial compliant decision.

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

Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MLTC plan like Hamaspik Choice. This support includes unbiased health plan choice counseling and general plan related information. Contact ICAN to learn more about their services:

- Phone: 1-844-614-8800 (TTY Relay Service: 711)
- Web: www.icannys.org Email: ican@cssny.org

You or someone you trust can also file a complaint about Hamaspik Choice or your services with the New York State Department of Health, by calling 1-866-712-7197.

Disenrollment from Hamaspik Choice

You will not be disenrolled from the Hamaspik Choice MLTC Plan based on any of the following reasons:

- High utilization of covered medical services
- An existing condition or a change in your health
- Diminished mental capacity or uncooperative or disruptive behavior resulting from your special needs unless the behavior results in your becoming ineligible for MLTC.

Voluntary Disenrollment

You can ask to leave Hamaspik Choice at any time for any reason. To request disenrollment, call 855-552-4642 to request that we disenroll you. You can also write to us at:

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

We will provide you with written confirmation of your request. We will include a voluntary disenrollment form for you to sign and send back to us. It could take up to six weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require community-based long term care services (CBLTSS), like personal care, you must join another MLTC plan, Medicaid Managed Care plan, or Home and Community Based Waiver program, in order to receive CBLTSS.

Transfers

You can try our plan for 90 days. You may leave Hamaspik Choice and transfer and join another plan at any time during that time. If you do not leave in the first 90 days, you must stay in Hamaspik Choice for nine more months, unless you have good reason (good cause.) The "good cause" reasons include:

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving Hamaspik Choice is best for you.
- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the State

If you qualify, you can change to another type of managed long term care plan like Medicaid Advantage Plus (MAP) or Programs of All-Inclusive Care for the Elderly (PACE)

at any time without good cause.

To change plans: Call New York Medicaid Choice at 1-888-401-6582. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. Hamaspik Choice will continue to provide the care you need until then.

Call New York Medicaid Choice if you need to ask for faster action because the time it takes to transfer plans will be harmful to your health. You can also ask them for faster action if you have told New York Medicaid Choice that you did not agree to enroll in Hamaspik Choice.

Involuntary Disenrollment

An involuntary disenrollment is a disenrollment initiated by Hamaspik Choice. If do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) business days from the date we know you meet any of involuntary disenrollment reasons.

You Will Have to Leave Hamaspik Choice if:

- You are no longer are Medicaid eligible.
- You permanently move out of Hamaspik Choice service area.
- You are out of the plan's service area for more than 30 consecutive days.
- You need nursing home care but are not eligible for institutional Medicaid.
- You are hospitalized or enter an Office of Mental Health, Office for People with Developmental Disability or Office of Alcoholism and Substance Abuse Services residential program for forty-five (45) consecutive days or longer.
- You no longer have a functional or clinical need for (CBLTSS) on a monthly basis, based on your assessment.
- You have Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- You receive Social Day Care as your only service.
- You no longer require, and receive, at least one CBLTSS in each calendar month.
- At the point of any reassessment, while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- You are incarcerated.
- You provide the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

We Can Ask You to Leave Hamaspik Choice if:

- You or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs the plan's ability to furnish services
- You fail to pay or make arrangements to pay the amount money, as determined by the Local Department of Social Services, owed to the plan as spenddown/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, Hamaspik Choice will obtain the approval of New York Medicaid Choice (NYMC) or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which you become ineligible for enrollment. If you continue to need CBLTSS you will be required to choose another plan, or you will be automatically assigned (auto-assigned) to another plan.

Medicaid Spend-Down

The spend down amount you are required to pay to Hamaspik CHOICE depends on the determination made by Medicaid. When LDSS reviews your financial status for purposes of determining your Medicaid eligibility it may determine that you must "spend-down" a portion of your monthly income in order to meet the income requirements for eligibility for Medicaid. If Medicaid determines that you must "spend-down" a certain amount, you must pay this amount to Hamaspik CHOICE each month. LDSS will inform you and us of the exact amount of your "spend-down" that must be paid each month to us.

If Medicaid determines that you have no spend-down obligation, then you do not pay Hamaspik CHOICE anything each month.

The amount you must "spend-down" or pay directly to Hamaspik CHOICE may change with your periodic Medicaid eligibility certification process or admission into a Nursing Facility.

If you have a spend down, that amount must be paid by the first of each month starting with the month of enrollment. Please make your payment payable to the order of Hamaspik CHOICE, Inc. and send it to:

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

If you have a problem meeting this responsibility, it is important that you discuss the situation with our designated spend-down representative. If you do not pay your spend-down amount within 30 days after the date it is due, we will notify you in writing of your arrears in payment. We have the right to involuntarily disenroll you from the program for failure to make spend-down payments due.

Veterans Protections

There are currently no accessible veteran's homes operating within the Hamaspik CHOICE service area. If an applicable enrollee desires to receive care from a veteran's home, Hamaspik CHOICE will allow the enrollee to access the veteran's home services and will pay out of network until the enrollee has transferred to an MLTC Plan with an in-network veteran's home.

Cultural and Linguistic Competency

Hamaspik CHOICE honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all members. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

Rights and Responsibilities

As a member of Hamaspik CHOICE, you have the right to:

- Receive medically necessary care;
- Timely access to care and services;
- Privacy about your medical record and when you get treatment;
- Get information on available treatment options and alternatives presented in a manner and language you understand;
- Get information in a language you understand - you can receive verbal translation services free of charge;
- Get information necessary to give informed consent before the start of treatment;
- Be treated with respect and due consideration for your dignity;
- Obtain a copy of your medical records and ask that the records be amended or corrected;
- Take part in decisions about your health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Receive care without regard to sex, (including gender identity and status of being transgender), race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to get the services you need from us, including how you can get covered benefits from out-of-network providers if they are not available in our network;
- Complain to the New York State Department of Health or your Local Department of Social Services;
- Use the New York State Fair Hearing System and/or New York State External Appeal, where appropriate;

- Appoint someone to speak for you on your behalf about your care and treatment;
- Seek assistance from the Participant Ombudsman program.

Your exercise of these rights will not adversely affect the way you will be treated.

As a member of Hamaspik CHOICE, you have the responsibility to:

- Receive covered services through Hamaspik CHOICE;
- Use the Hamaspik CHOICE network providers for covered services;
- Obtain prior authorization for covered services, except for pre-approved services. Refer to specific service in the Service Benefit Package section of this handbook to find out if a specific service requires prior approval;
- Share complete and accurate health information with your health care providers;
- Inform Hamaspik CHOICE staff of any change in your health, and make it known if you do not understand or are unable to follow instructions;
- Follow your plan of care, as recommended by the Hamaspik Choice staff (with your input);
- Cooperate with and be respectful to Hamaspik CHOICE staff and not discriminate against Hamaspik CHOICE's staff on the basis of race, color, national origin, mental or physical ability (other than mandated physical eligibility for the program), religion, age, sex, sexual orientation or marital status;
- Notify Hamaspik CHOICE within 2 business days before receiving either non-covered services or pre-approved covered services.
- Notify Hamaspik CHOICE in advance whenever you will not be home to receive service or care that has been arranged for you;
- Inform Hamaspik CHOICE before permanently moving out of the service area or of any absence from the service area;
- Take responsibility for your actions if you refuse treatment or do not follow Hamaspik CHOICE instructions; and
- Pay your financial obligations, if any.

Money Follows the Person (MFP)/Open Doors

This section will explain the services and supports that are available through Money Follows the Person (MFP)/Open Doors. MFP/Open Doors is a program that can help enrollees move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP if they:

- Have lived in a nursing home for three months or longer
- Have health needs that can be met through services in their community

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with enrollees in the nursing home and talk with them about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help enrollees by:

- Giving them information about services and supports in the community
- Finding services offered in the community to help enrollees be independent
- Visiting or calling enrollees after they move to make sure that they have what they need at home

For more information about MFP/Open Doors, or for assistance to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 844-545-7108. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

Your Hamaspik CHOICE Care Manager can also help you to set up a visit from a Transition Specialist or Peer. You can contact your Care Manager at 855-552-4642.

Advance Directives

Advance Directives are written instructions regarding your health care. Advance directives are developed by adults before the decision making capability is lost. Advance directives allow you to make your choices known, and to appoint someone you trust to carry out your choices, or make decisions if you are unable to do so. They ensure that your requests are fulfilled in the event you cannot make decisions for yourself.

These documents can provide instructions on what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf. It is your right to establish advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury.

It is the policy of Hamaspik CHOICE to support your right to participate in health care decision making. Hamaspik CHOICE encourages you, your family members, and your health care practitioners to discuss values and preferences that should guide your health care decision making if you are unable to do so yourself. For the purpose of this policy and procedure, advance directives will include:

- Health Care Proxy
- Non-hospital Order Not to Resuscitate (DNR Order)
- Living Will
- Medical Order for Life-Sustaining Treatment (MOLST).

Hamaspik CHOICE respects your right to choose and, in order to assure implementation of the policy to protect those rights, will provide the necessary documents and guidance to allow you to develop an appropriate plan.

As part of the enrollment process and before any care is rendered to you, the enrolling nurse will provide you with the following documents:

- Deciding About Health Care – A Guide for Patients and Families
- Appointing Your Health Care Agent – New York State's Proxy Law
- Health Care Proxy form
- Medical Orders for life Sustaining Treatment form

Your Hamaspik CHOICE Care Manager will provide you with education regarding Advance Directives. Education will be provided upon initial assessment, upon re-assessment, and during your monthly phone contacts.

This includes:

- You will be educated on the benefits of executing advance directives.
- You will be notified of your rights in regards to advance directives
- You will be provided with documents to assist in this process.
- When setting up initial assessment visit and re-assessment visit, Hamaspik Choice will encourage you to have family present as it is beneficial to have family included in the discussion regarding Advance Directives.
- Health Care Proxy educational forms and MOLST forms will be distributed during the initial assessment visit.
- Upon re-assessment, the Nurse Assessor will re-educate and review your health Care Proxy educational forms and MOLST forms.
- You will be asked if you have executed an advance directive. The response will be noted in your member record. If you have advanced directives, you will be asked to provide a copy. The copy will be filed in your record.
- If you notify us that you have on file with your physician, your care manager will reach out to your physician to obtain a copy of these forms to have on file with Hamaspik CHOICE.
- Your Care Manager will coordinate with the physician that this be discussed at members next scheduled MD visit.
- If you express interest in advance directives at your initial or reassessment visit, your Care Manager will provide you with additional follow up on the forms with either a phone call or in home visit as requested. Follow up will include discussion with you and your family on importance of forms, and coordination with MD for forms completion.
- Hamaspik CHOICE will document and keep track of which members have been educated on Advance Directives, have expressed interest in Advance Directives, and have provided a copy of their Advance Directives. The reported information will afford Hamaspik Choice with ability to continue educating and providing guidance to its membership on the subject of advance directives.
- Hamaspik CHOICE may provide copies of the advance directive on file to designated health care professionals, upon your request.

Additional Information Available Upon Request

If you request it, you may receive the following information:

- A list of the names, business addresses and official positions of the members of the Board of Directors and officers of Hamaspik CHOICE, Inc.
- A copy of Hamaspik CHOICE, Inc.'s most recent annual certified financial statements.
- A copy of Hamaspik CHOICE's written procedures for protecting the confidentiality of medical records and other member information.
- A copy of Hamaspik CHOICE's written procedures for making decision about the experimental or investigational nature of medical devices or treatments in clinical trials.
- A copy of Hamaspik CHOICE's written procedures for making service authorization decisions.
- A copy of Hamaspik CHOICE's written application procedures and the minimum qualifications for health care providers to be considered for becoming participating providers within our network.
- A written description of our organizational arrangements and ongoing procedures for the quality assurance program.

We Want Your Feedback

Each year, we will ask your opinion about the services you receive from our network providers and we will provide confidential feedback to providers to improve services. When you receive this survey, we hope you will participate. Your feedback is very important to us.

Appendix: Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

We can use and disclose your information to run our organization and contact you when necessary.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

You can ask to see or get a copy of your health and claims records and other health information we have about you. You may request this by describing the information you want to review and the format in which you want to receive it in writing to Hamaspik CHOICE at:

58 Route 59, Suite #1
Monsey, NY 10952.

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may refuse your request in certain limited instances. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Contact us by phone if you have questions about how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your privacy rights by contacting the Hamaspik CHOICE Compliance Officer by phone at: 845-503-0569, or by email at: corporatecompliance@hamaspikchoice.org.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following circumstances, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Additional Information. If you have any questions or would like additional information about this notice, please contact the Hamaspik CHOICE Compliance Officer by phone at: 845-503-0569, or by email at corporatecompliance@hamaspikchoice.org

Effective Date. This Notice of Privacy Practices is effective July 21, 2014.