2017 Member Handbook

AlphaCare Managed Long-Term Care Plan

ALPHACARE
888-770-7811
AlphaCare.com

AlphaCare by Magellan Health

Welcome to AlphaCare

Dear AlphaCare Member:

Welcome to AlphaCare of New York and thank you for selecting us to service your long-term care needs.

This Member Handbook is your guide to AlphaCare, a managed long-term care plan offering comprehensive home and community based services. It describes who may be eligible for AlphaCare, the benefits of membership, and your rights and responsibilities as an AlphaCare member. In addition, it will help you understand how to obtain services and effectively work with your Care Management Team, headed by your Care Manager a registered nurse or licensed social worker with experience in long term care.

Please review the handbook carefully. It is very important to become familiar with how to make the most of your AlphaCare membership. If after reading the handbook you would like more information or if you have any questions, we encourage you to contact our Member Services Department at **888-770-7811**, Monday through Friday, between the hours of 8:30 am and 5:00 pm.

Finally, we encourage you and your family to be involved in the decisions made concerning your long term care services. Our goal is for you to have an ongoing relationship with your Care Management Team who, along with your primary care physician, will help you receive the health care services you need.

Thank you for choosing AlphaCare. We look forward to serving you.

Sincerely,

AlphaCare of New York,
Member Services

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About AlphaCare

AlphaCare is a managed long term care plan serving the boroughs of Brooklyn, Bronx, Manhattan, Queens and Westchester County. AlphaCare is committed to bringing people and resources together to better plan and deliver high quality health care services for the chronically ill. AlphaCare has developed a network of area providers that are able to deliver the services you may require while enrolled.

The providers in the AlphaCare network have been selected and credentialed by AlphaCare to assure you the best possible care. Enrollment in AlphaCare is entirely voluntary. When you enroll in AlphaCare you are required to use providers in the AlphaCare network and also get authorization from your Care Management Team for services covered by AlphaCare.

AlphaCare is designed for individuals who want to continue to live in their home but need assistance with day-to-day health activities. We encourage our members to take an active part in their own health care, and we offer many choices in services and locations. Our goal is to help you live independently, in your own home, 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 for the population it is authorized to serve. We offer you a wide selection of covered services through our network providers (page 12) and can coordinate other benefits (page 16), including coordination of those services covered by Medicare. As a member of AlphaCare you will benefit from:

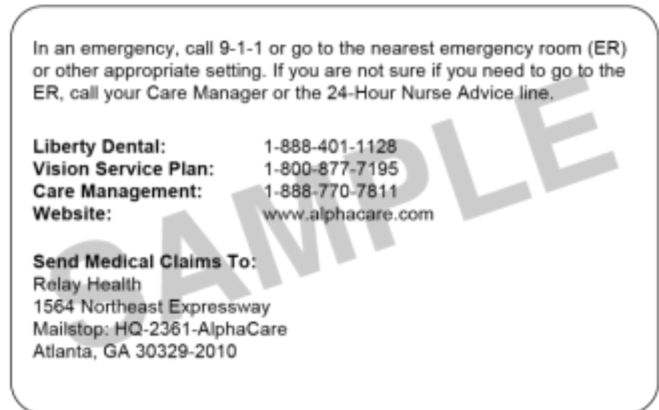
- A Care Management Team that ensures that you are receiving the appropriate care you need. Each Care Manager is a licensed health care professional experienced in caring for individuals with chronic medical needs. The Care Management Team will work cooperatively with your physician as well as other health care professionals (such as nurses and physical therapists) to ensure you receive the services you need. You are matched to a Care Manager who can best meet your individual needs, such as language spoken and the geographic area in which you reside.
- Coordination of all your health care services with your physician(s), and health care providers.
- A plan of care that you, your Care Management Team, and your physician design specifically for you.
- Extensive choices in 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 your questions.

Confidentiality

AlphaCare will only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to combat fraud or abuse. For members who are HIV positive, AlphaCare follows all applicable New York State Laws that govern the disclosure of HIV related information. AlphaCare staff members will ask questions to confirm your identity before we discuss or provide any information regarding your health information. AlphaCare wants to protect your right to privacy and confidentiality. AlphaCare will not release any health information to anyone who is not directly providing your care and AlphaCare will not release any health information to anyone who is not responsible for paying for your care. AlphaCare will release information if we receive written permission from you or from someone you designate.

Your AlphaCare ID Card

Your AlphaCare ID Card identifies you as an AlphaCare member and should be carried by you, along with your Medicaid and Medicare cards and all other health insurance cards, at all times. You will need your card to access certain services that are authorized by AlphaCare.



Discrimination is Against the Law

AlphaCare of New York follows the law. We treat all people equally. We do not discriminate against anyone based on:

- Race.
- Color.
- National origin.
- Age.
- Disability.
- Sex.

We provide free help and services to people with disabilities. We want you to be able to communicate with us easily. We offer:

- Qualified sign language interpreters.
- Written information in many formats.

These may include:

  - Large print.
  - Audio.
  - Accessible electronic formats.
  - Other formats.

We also provide free language services to people whose first language is not English. We offer:

- Qualified interpreters.
- Information that is written in other languages.

Contact us at 1-888-770-7811 (TTY/TDD: 711) if you need any of these services.

If you believe we have not provided these services or discriminated in another way, you can file a grievance with:

Civil Rights Coordinator, Corporate Compliance Department
6950 Columbia Gateway Drive
Columbia MD 21046
800-424-7721
Fax: 410-953- 5207
compliance@magellanhealth.com

You can file a grievance in one of three ways.

- By mail.
- By fax.
- By email.

The civil rights coordinator is available if you need help with any of this.
You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You may do this online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Or you may do this by mail or phone.

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019
TDD: 800-537-7697

Complaint forms are available online.
You may find them at:
http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-770-7811 (TTY/TDD: 711).

(Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-770-7811 (TTY: 711).

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-770-7811 (TTY: 711).

(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-770-7811 (телетайп: 711).

(French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-770-7811 (TTY: 711).

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-770-7811 (TTY: 711) 번으로 전화해 주십시오.

(Italian) ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-770-7811 (TTY: 711).

(Yiddish) אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-888-770-7811 (TTY: 711).

(Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপল আছে। ফোন করুন 1-888-770-7811 (TTY: 711)

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-770-7811 (TTY: 711).

(Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1187-077-888-1. 117: هاتف الصم والبكم:

(French) ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-888-770-7811 (TTY: 711).

(Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-888-770-7811 (TTY: 711). کریں

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-770-7811 (TTY: 711).

(Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-770-7811 (TTY: 711).`

(Albanian) KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-770-7811 (TTY: 711).

Important Information about Advance Directives

You have a right to make your own health care decisions. Sometimes, as a result of a serious accident or illness, that may not be possible. You can prepare for situations when you are unable to make important health care decisions on your own by filling out and submitting an Advanced Directives Packet. Preparing Advance Directives will help in insuring that your health care wishes are followed. There are many different types of Advance Directives:

- Living will
- Power of Attorney
- Durable Power of Attorney for Health
- Health Care Proxy
- Do Not Resuscitate Orders

It is your choice whether you wish to complete an Advance Directive and which type of Advance Directive is best for you. The law forbids any discrimination against you in medical care based on your advance directive decisions.

For more information regarding Advance Directives, please speak with your Care Manager or your primary care physician. AlphaCare will provide written information about Advance Directives. Forms are available if you wish to complete an Advance Directive. AlphaCare staff is also available to answer questions you may have concerning Advance Directives.

What to Do In a Medical Emergency

Call 911 or go to the nearest Emergency Room. You do not need to inform AlphaCare before seeking emergency medical treatment.

Emergency Care

You are NOT required to get AlphaCare's permission or prior authorization to obtain emergency care.

Definition of an Emergency

An emergency is a sudden or unexpected illness, severe pain, accident or injury that could cause serious injury or death if it is not treated immediately. If you have an emergency and need immediate medical attention, Call 911 - OR - Rush to the nearest hospital Emergency Room. If possible, call your physician or your Care Manager at AlphaCare.

After An Emergency

Notify your physician and AlphaCare within 24 hours of the emergency. Your Care Management Team will assist you in getting the correct services in place before you are discharged to ensure that you get the best care possible.

If You Are Hospitalized

If you are hospitalized, a family member or a friend should contact AlphaCare as soon as possible. AlphaCare will cancel your home care services and other services. If you are in the hospital, be sure to ask your physician or hospital discharge planner to contact AlphaCare. We will work with the physician, hospital discharge planner and you to plan for your care upon discharge from the hospital.

"Emergency Medical Condition" is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (I) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

How to contact the Participant Ombudsman

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

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

The Participant Ombudsman for the state of New York is the Independent Consumer Advocacy Network (ICAN), an independent network of consumer advocacy organizations. ICAN is available to answer long-term care enrollee's questions regarding enrollee rights, Medicare, Medicaid and long term care services. ICAN can also assist enrollees with resolution of any issues related to access to care and with filing appeals and grievances. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.

Member Services

AlphaCare wants you to understand your managed long-term care plan and receive the best possible care. The Member Services Department was established for this purpose. If you have any questions about benefits, services or procedures or have a concern about any aspect of AlphaCare, please let us know. Our Member Service Coordinators are available to help you in any way regarding your membership. We welcome any ideas or suggestions you might have regarding AlphaCare. Your comments help us improve the services we provide for you. Member Services can be reached by telephone:

Monday through Friday from 8:30 a.m. to 5:00 p.m.
toll free at 888-770-7811

Interpreter Services

AlphaCare has many employees who speak your language and we are able to access interpreter services. We also have written information in the most prevalent languages of our members. Currently written materials are available in English and Spanish. If interpretation is required, please feel free to call Member Services toll free at **888-770-7811** and request to speak to an interpreter or request written materials in your language.

Services for Hearing Impaired Members

Hearing impaired members with TTY/TDD ability who want to speak with a Member Services representative should first contact a relay operator by dialing 711. They will then facilitate calls between TTY/TDD users and voice customers.

Services for Visually Impaired Members

AlphaCare has a large print handbook or an audio version of the handbook available upon request for those members who are visually impaired. Please contact Member Services to request a copy. AlphaCare is always available if you need the handbook, or any other AlphaCare documents and forms read to you. AlphaCare will arrange an appointment for this at your convenience.

Non-Business Hours On-Call Service

If you need help after business hours, on a weekend, or on a holiday, a member of our staff will assist you. An on-call nurse will answer your questions regarding your medical condition and help you decide on a course of action. The nurse may also refer you to a hospital, contact your physician or Care Manager, and follow up ifthere is a problem with a provider or service. To contact AlphaCare during nights, weekends or holidays**, just call Member Services toll-free at 888-770-7811.**

NOTE: You are not required to call AlphaCare prior to obtaining emergency care. (See page 24)

Eligibility and Enrollment

In order to be enrolled in AlphaCare you must meet the following requirements:

- **You are a minimum of 21 years of age**
- **You reside in the Bronx, Brooklyn, Manhattan, Queens or Westchester County**
- **You are eligible for Medicaid as determined by the New York City Human Resources Administration (HRA) or your Local Department of Social Services (LDSS)**
- **You are able to return to or remain at home without jeopardy to your health and safety**
- **You are expected to require at least one of the following services and care management from AlphaCare for more than 120 days from the effective date of enrollment:**

  - Nursing services in the home;
  - Therapies in the home;
  - Home Health Aide services;
  - Personal Care Services in the home;
  - Adult Day Health care; or
  - Private Duty Nursing
  - Consumer Directed Personal Assistance Services

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

If you are expected to be a hospital inpatient or resident of hospitals or residential facilities operated under the auspices of the State Office of Mental Health, Office for People with Development Disabilities or Office of Alcoholism and Substance Abuse Services facility on the first day of enrollment, you may not begin enrollment unless you disenroll or are 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 must be established through an assessment process and is subject to approval by the New York Medicaid Choice (NYMC) or the Local Department of Social Services (LDSS). The initial assessment for MLTC eligibility must be conducted within thirty (30) days of requesting enrollment or of AlphaCare receiving a referral from the Enrollment Broker or other source. To start the enrollment process an Enrollment representative will contact you within five days of our learning of your possible interest in AlphaCare and will confirm that you meet the eligibility requirements based on age, geographic location of residence and Medicaid eligibility.

An enrollment representative will make an in-home visit for an initial eligibility review. You will be required to present any insurance cards including your Medicaid card and Medicare card if eligible. At this time, a full explanation of AlphaCare's managed long-term care plan will be discussed and you will have the opportunity to ask questions and to discuss your specific needs. An AlphaCare nurse will then obtain your health history and perform a clinical assessment in order to determine your medical eligibility.

If you are interested in enrolling in AlphaCare you will be asked to sign a medical release. A signed medical release is needed for an AlphaCare nurse to follow up with your physician and other health providers to develop your individualized plan of care. Your plan of care will also be completed with your assistance and the help of family and friends, if you wish. AlphaCare will then be able to establish and coordinate the services included in your individualized plan of care.

To conclude the enrollment application process, you will need to sign an Enrollment Agreement. Enrollment in AlphaCare is voluntary and you may choose to withdraw your application or Enrollment Agreement by noon on the 20th day of the month prior to the effective date of enrollment by indicating your wishes orally or in writing. This information will be shared with NYMC/LDSS.

Enrollment will begin the first day of the month. All enrollments are subject to approval by NYMC/LDSS.

Upon enrollment, you will be assigned a Care Manager and issued an AlphaCare membership card. **It is important that you bring this membership card along with your Medicare card, Medicaid cards and any other health insurance cards to all appointments.**

Withdrawal of Enrollment

You may withdraw your application at any time during the enrollment process prior to the effective date of enrollment. If you decide voluntarily not to proceed with the application this will be considered a withdrawal of the application.

Denial of Enrollment

AlphaCare will tell you if you are determined to be ineligible based on age, geographic location of residence, or Medicaid eligibility. If you do not agree with AlphaCare's decision, you may request to pursue an application. The information collected up to this time will then be forwarded to NYMC/LDSS and they will make the final decision about eligibility and whether enrollment can be denied. The following are reasons that your enrollment in AlphaCare would be denied:

- You will be denied enrollment if after the start of the application process it is determined that you have Medicaid only and you are not eligible for nursing home level of care
- You will be denied enrollment if after the start of the application process it is determined that you do not require the long-term care services offered by AlphaCare for more than 120 days from the date ofenrollment
- You will be denied enrollment if at the time of enrollment it is determined that you are not able to return to or remain in your home and community without jeopardy to your health and safety

Before the recommendation for denial of enrollment is processed by NYMC or your LDSS you can withdraw your application.

If AlphaCare determines that you do not meet one or more of the eligibility requirements, you will be notified in writing.

You will only be denied enrollment if NYMC or your LDSS agrees with AlphaCare's determination that you are ineligible.

Coordinating Your Care

Upon enrollment the coordination of your care will begin with an individually assigned Care Manager. They will collaborate with you and others to perform quality care management. Others who might be involved in your care planning include your physicians and others who currently provide care to you, such as physical therapist as well as other care providers. Together, they will work with you and your loved ones to ensure you receive the appropriate level of services. If, at any time the Care Manager notices or you tell the Care Management Team about changes in your health status, he/she will address the problem and confer with your primary care physician.

Care Manager

Each Care Manager is a licensed health care professional whose field of expertise is caring for individuals with chronic medical needs. Your Care Manager will work with you or your representative to develop an initial long-term plan of care designed for you, and will coordinate all of your health care needs. The Care Manager will work cooperatively with your physician, who approves your plan of care, as well as other health care professionals to ensure you receive the services you need. Your Care Management Team will arrange for authorization of covered services. (See page 12)

Entitlement

An Entitlement Specialist will assist you with applying for any entitlements (i.e. Home Energy Assistance Program, Medicaid, and/or Food stamps and other benefits for which you are eligible. The Entitlement Specialist will also assist you in maintaining eligibility through the certification process of all entitlements.

Member Services Department

Member Representatives are highly trained professionals to aid you in taking full advantage of the services provided by AlphaCare. You may need to call a coordinator with questions or concerns you have regarding your care and services, including but not limited to issues you may encounter such as an unanticipated disruption of home health aide services, durable medical equipment delivery or equipment already in your home. Member Representatives can also explain any correspondence you may have received from AlphaCare. These coordinators work directly with your Care Manager and providers to schedule your appointments and order the supplies and services that you need and, if necessary, they will make sure that your Care Manager contacts you to explain any medical questions you might have. Member Services can be reached by telephone:

Monday through Friday from 8:30 a.m. to 5:00 p.m.
toll free at 888-770-7811

Selection of Your Primary Care Physician

With AlphaCare you continue to use your own primary care physician. Your Care Manager will work with your primary care physician to coordinate all of your health care needs. If you need

help finding a physician, our referral network can help you locate a highly qualified physician in the community.

Covered Services

The following is a brief list of services that AlphaCare offers. Please call AlphaCare Member services to determine if an authorization is necessary. Services will be authorized by AlphaCare for as long as they are medically necessary. "Medical Necessity" means covered services that are necessary to prevent, diagnose, correct or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with a person's capacity for normal activity, or threaten some significant handicap.

- Care management and coordination - Assists enrollees to access necessary covered services as identified in the care plan, providing referral and coordination of other needed medical, social, educational, psychosocial, financial and other services in support of the care plan.
- Nursing home care - Full-time care delivered in a facility designed for recovery from a hospital, treatment, or assistance with common daily activities. (refer to "Nursing Home Care" on page 19)
- Home health care - Includes coverage for the following services: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.
- Medical social services - Means assessing the need for, arranging for and providing aid for social problems related to maintenance of patient in the home where such service are performed by a qualified social worker in accordance with the patient's care plan.
- Adult day health care - Includes care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.
- Personal care - Means some or total assistance with such activities as personal hygiene, dressing and feeding and nutritional and environmental support functiontasks.
- Durable Medical Equipment - Includes medical/surgical supplies (Compression and support stockings are limited to coverage only for pregnancy or treatment of venous stasis ulcers), prosthetics, orthotics and orthopedic footwear (Prescription footwear and inserts are limited to use in conjunction with a lower limb orthotic brace, as part of a diabetic treatment plan), enteral and parernteral formula (Enteral formula is limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism) and hearing aid batteries.
- Outpatient rehabilitation therapies - Rehabilitation services, including physical therapy, occupational therapy and speech pathology for ambulatory patients provided in settings other than your home. Therapies are limited to 20 visits per calendar year, except for children under age 21 and the developmentally disabled.

- Personal Emergency Response Systems (PERS) - Coverage consists of an electronic device usually connected to patient's phone which enables certain high-risk patients to secure help in the event of an emergency.
- Non-emergency transportation - Transportation services are limited to the provision of passenger-occupied transportation to obtain necessary medical care andservices.
- Podiatry - Service include routine foot care when the Enrollee's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot or when performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections.
- Dental care - Includes, but is not limited to: preventative and other dental care, services and supplies, routine exams, prophylaxis, oral surgery and dental prosthetic and orthotic appliances required to alleviate a serious health condition.
- Optometry/Eyeglasses - Includes the services of an optometrist, such as eye examto detect visual defects and eye disease as required by the patient's condition, and an eyeglass dispenser.
- Audiology (includes hearing aid batteries) - Services covered include: audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations ifindicated.
- Home delivered and congregate meals – Includes meals delivered to themember's home or provided in a group setting as the plan of care indicates.
- Social day care - A structured, comprehensive program which provides functionally impaired individuals with socialization, supervision and monitoring, personal care, and nutrition in protective setting during any part of the day, but for less than a 24-hour period.
- Respiratory therapy - Performance of preventative, maintenance and rehabilitative airway-related techniques and procedure including the application of medical gases, humidity and aerosols; intermittent positive pressure; continuous artificial ventilation; the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.
- Nutritional counseling - Means assessing nutritional needs and food patterns, or planning for the provision of foods and drink appropriate to the individual's physical and medical needs and environmental conditions or providing nutritional education andcounseling to meet normal and therapeutic need.
- Social and environmental supports - Service and items that support the medical needs of the enrollee as identified in his or her care plan, such as home maintenance tasks, homemaker/chore services, housing improvement and respite care.

- Private Duty Nursing – continuous and skilled nursing care provided in your home by properly licensed registered professional or licensed practical nurses.
- Consumer Directed Personal Care Services – Services can include any of the services provided by a personal care aide (home attendant), home health aide or nurse, with you or your designee assuming responsibility for the hiring, training, supervising and - if need be – terminating the employment of the person providing the service.
- Health care services delivered by Telehealth – Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee. A Telehealth provider is a physician, physician assistant, dentist, nurse practitioner, registered professional nurse (only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring), podiatrist, optometrist, psychologist, social worker, speech language pathologist, audiologist, midwife, certified diabetes educator, certified asthma educator, certified genetic counselor, hospital, home care agency, hospice, or any other provider determined by the Commissioner of Health pursuant to regulation. *Clarification: Assessment as it relates to telehealth refers to the clinical disciplines' assessments. It does not refer to the Uniform Assessment System (UAS).*

Our goal at AlphaCare is to ensure that all of your care is working together to maintain your health and independence. If you need services please call AlphaCare Member Services at **888-770-7811** to request them. We will involve your Care Management Team to make sure that all of your doctors are working together in your best interests. All of your covered services are provided by or contracted through AlphaCare. Check the current provider network in your membership folder or call Member Services for a listing of network providers.

As an AlphaCare member, you must get an authorization before obtaining services for most covered benefits. Member Services or your Care Management Team is available to help you with all authorizations, including referrals to other providers, such as Physical or Occupational Therapists, Podiatrists, or Audiologists, to name a few. To get an authorization simply speak to your Care Management Team or call Member Services. If you receive services without obtaining an authorization you may be responsible for paying for that service.

Finally, you are not required to pay for covered services from network providers when the prior authorization procedure is followed. In the event that you receive a bill directly from a network provider, you must notify AlphaCare. We will contact the network provider to correct their error.

Member Reimbursement

AlphaCare members should never have to pay for a service out of their own pocket. If a provider is asking you to pay them please call AlphaCare Member Services before giving them any payment. AlphaCare network providers should always be seen when you use the following services:

- Transportation
- Medical Supplies and Equipment
- Dental Care, Podiatry or Vision Care

If you accidentally pay for a service, AlphaCare will reimburse you up to the amount that we would normally pay an in-network provider. In most cases we pay our providers rates that are much lower than what they would charge the public, so you may not be reimbursed as much as you paid for the service. This is why it is important that you use AlphaCare providers.

Non-Covered Services

The following services are **NOT** covered by AlphaCare, but are covered by Medicare or Medicaid on a fee-for-service basis:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Hospice
- Laboratory Service
- Physician services including services provided in an office setting, a clinic, a facility, or in the home.
- Radiology and Radioisotope Services
- Emergency Transportation (Emergency or Ambulance transportation to a hospital)
- Rural Health Clinic Services
- Chronic Renal Dialysis
- Mental Health Services
- Alcohol and Substance Abuse Services
- Office of Mental Retardation and Developmental Disabilities Services
- Family Planning Services
- Prescription Drugs

Although these services are not part of AlphaCare's benefit package, your Care Manager will help arrange and coordinate them as needed. If you are currently enrolled in anotherhealth plan that covers all or part of these services, you may wish to keep that coverage in effect to continue receiving these benefits.

Coordination of Covered and Non-covered Services

Enrolling in AlphaCare Does Not Affect Your Medicare Benefits

If you have Medicare, membership in AlphaCare MLTC does not affect your Medicare benefits. You will continue to be covered by Medicare for your physician visits, hospitalizations, lab tests, ambulance, and other Medicare benefits. You do not need AlphaCare's authorization to receive Medicare services.

However, AlphaCare can:

- Refer you to a qualified physician (if you don't have one already).
- Schedule physician appointments and arrange transportation for you.
- Arrange for transportation to laboratory, x-ray, diagnostic tests, dialysis, etc. that are ordered by your physician.
- Arrange for ambulance transportation, if needed.
- Visit you in the hospital (if you are hospitalized), and assist with discharge arrangements.
- Arrange Medicare-covered home care services.

If you are receiving any service covered by AlphaCare (see page 12), and it is determined that it is also covered under Medicare, Medicare will be billed as your primary insurance. If Medicare does not cover the entire cost of the covered service then AlphaCare will be billed for any deductibles or coinsurance.

Any service you receive that is not paid for by AlphaCare (see page 16) will be billed to Medicare as your primary insurance. If Medicare does not cover the entire cost of that service, the remaining balance will be billed to Medicaid fee-for-service. **It is important that you bring your AlphaCare membership card along with your Medicare card, Medicaid cards and any other health insurance cards to all appointments.**

If a covered service you currently receive is a Medicare covered service, you can continue using the provider of your choice. AlphaCare recommends that you use a provider in our network so that you will not have to change providers if Medicare coverage limits are met and AlphaCare becomes responsible for primary payment for the care.

Medicaid Will Pay for Services Not Covered by AlphaCare

For example, mental health, dialysis, substance abuse, alcoholism and detoxification services are available to you through your regular Medicaid. You do not need AlphaCare to authorize these types of services. Your Care Manager can, however, make it easier for you by helping you obtain and coordinate Medicaid covered services with AlphaCare services.

Plan of care Development and Monitoring

When you enroll, you, your physician, and your Care Manager will work together to develop a plan of care that meets your needs. Your plan of care will include all of the services you need to maintain and improve your health status. The plan of care includes both AlphaCare covered services and those services covered by Medicaid and Medicare. It is based on our assessment of your health care needs, the recommendation of your physicians and your personal preferences.

As your health care needs change you may require different services, or the same services more or less frequently. Naturally this will require that your plan of care changes. You, along with your Care Manager and your physician will review and approve any changes to your plan of care. This plan will periodically be reviewed with you to ensure that the services you are receiving meet your needs. Generally, a plan of care is authorized in six month intervals. It will be adjusted as your medical needs increase or decrease.

You are the most important member of your health care team so it is important for you to let us know what you need. Please talk with your physician, Care Manager and other AlphaCare staff if you have a need for any service you are not currently receiving or wish to make changes in your plan of care. In addition, your Care Manager will work with you to make certain that your medical conditions are being properly monitored.

Requesting Changes to the Plan of Care

If you would like to change your plan of care (for example, changing the days or times you receive services) or request a service, such as dental care or optometry, you or your physician should call AlphaCare Member Services. Your Care Manager will then consult with your physician about changes you have requested. If your Care Manager and physician agree, your plan of care will be changed accordingly. If we have all the necessary information, AlphaCare will respond to your request for changes to the plan of care as quickly as your condition warrants, but no later than three business days of receipt of yourrequest.

If AlphaCare denies your request for change or your request for service you may appeal the decision. See “Resolving Issues” (page 26) for instructions on how to appeal an adverse determination by AlphaCare.

Services in Your Plan of Care Requiring Prior Authorization or Concurrent Review

To receive covered services (see page 12), you must obtain prior authorization from AlphaCare. You can speak to either your Care Manager or Member Services as described on page 18. Member Services can be reached by calling toll free at **888-770-7811**. The Member Representative will quickly relay the information to your Care Manager.

If you have Medicare and have any questions about authorizations or coordinating benefits please contact Member Services toll free at **888-770-7811**.

Most covered services, with the exception of emergency services, require an authorization from AlphaCare prior to obtaining them. The following paragraphs concern some often used services that require special instructions, such as calling AlphaCare to arrange your transportation or obtaining an authorization for Nursing Home care.

Transportation

AlphaCare covers your transportation needs to and from your physician's office, other providers, health-related services and approved social events. AlphaCare will not provide emergency or ambulance transportation to a hospital. Emergency transportation is covered by Medicaid fee for service or Medicare. If you need transportation please call Member Services toll free at **855-558-1638** or **888- 770-7811**. Call at least 48 hours in advance, unless urgent care is needed.

Medical Equipment, Supplies and Oxygen

AlphaCare will arrange for all of your required medical equipment, medical supplies and oxygen. Your Care Manager will consult with your physician and arrange for delivery and installation. If you already have or need medical equipment that Medicare pays for, AlphaCare will pay your co-pays for that equipment even if they are from a non-network provider.

Nursing Home Care

Your Care Manager will make arrangements and AlphaCare will cover nursing home care for those members who, along with their physician, agree to a nursing home stay. Members must use nursing homes in the AlphaCare provider network. Admission to one of our participating nursing homes is made on an individual basis and follows the Medicaid eligibility rules. AlphaCare must cancel your membership if you require nursing home care and you are not eligible for institutional Medicaid. If you have any questions about nursing home care or your Medicaid or Medicare coverage, please contact Member Services.

Referrals to Providers Outside of AlphaCare's Provider Network

If the network does not have an appropriately trained or experienced provider for the specialty care you require, your Care Manager will assist you in arranging care with the appropriate specialist (such as a specialty dentist) by working with your physician.

When using a provider outside of AlphaCare's network for covered services, you must get an authorization before seeing the provider. Without first obtaining the required authorization, the provider will not be paid for their services and you will be responsible for payment for the services rendered.

If the services you require are not in the AlphaCare benefit package, or if Medicare is the primary payer of a covered service, then prior authorization from AlphaCare is not required. If you have questions regarding what services are covered under Medicare, please contact the Member Services Department toll free at **888-770-7811**.

Service Authorization

What is Service Authorization?

"Service Authorization" refers to AlphaCare's review to determine whether health care services that have been provided, are being provided or are requested for a member are medically necessary. Qualified clinical personnel will determine if a service is medically necessary, and will review covered services for authorization. The service authorization process begins with your initial plan of care when you are enrolled. See page 10 for an explanation of the creation of your initial plan of care.

Service Authorization Review Policy

AlphaCare will ensure that service authorizations for all members are carried out in accordance with all applicable Federal and State regulations and that all decision timeframes are followed. Every AlphaCare member and member designee has the right to request services. AlphaCare staff is available to help you understand the proper timeline for receiving a response to a request and timeframes for processing the request.

These are the types of service authorizations and timeframes:

Expedited Service Authorization
AlphaCare determines or your provider indicates that a delay would seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function. You may request an expedited review of a Prior Authorization or Concurrent Review. If AlphaCare denies your request for an expedited review, the request will be handled as a standard review. If you appeal an action resulting from a concurrent review then it must be handled as expedited.

Prior Authorization (New Services)
Prior Authorization is a request by you or your provider on your behalf for a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period.

Decisions concerning prior authorizations will be made as quickly as your condition requires, but in no event later than:

- **Expedited** - three business days from the request for service
- **Standard** - within three business days of receipt of necessary information, but no more than 14 days of receipt of request for services

Concurrent Review (More of the Same Services)
Concurrent Review is a request by you or your provider on your behalf for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Decisions concerning concurrent review will be made as quickly as your condition requires, but in no event later than:

- **Expedited** - within one business day of receipt of necessary information, but no more than three business days of receipt of request for services.
- **Standard** - within one business day of receipt of necessary information, but no more than 14 days of receipt of request for services.
- In the case of a request for Medicaid covered home health care services following an inpatient admission:
  - One business day after receipt of necessary information.
  - 72 hours after receipt of necessary information when the day after the request for services falls on a weekend or holiday.
  - In any event, decisions concerning concurrent review following an inpatient admission will be made no more than three business days after receipt of the request for services.

Extensions

If it is in your best interest, AlphaCare may take up to a 14 calendar day extension. Extensions may be requested by you or your provider on your behalf (written or verbal). AlphaCare may also initiate an extension if it can justify the need for additional information and if the extension is in your best interest.

Denials of Prior Authorization or Concurrent Review

You or your provider may appeal an unfavorable decision - see **Resolving Issues** (page 26).

If AlphaCare's decision is that the item or service is not medically necessary, and you disagree with that decision, you may appeal the decision. Please refer to **How Do I File an Appeal of an Action?** (page 29) for instructions on how to access the appeal process.

Definition of Medical Necessity

Medical Necessity means covered services that are necessary to prevent, diagnose, correct or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with a person's capacity for normal activity, or threaten some significant handicap.

How Do I Designate a Representative To Speak For Me?

You may wish to choose a family member or friend to speak on your behalf. You must inform AlphaCare of the name of your designated representative. You can do this by calling our Member Services Department. We will provide you with a form that you can fill out and sign stating who the representative will be.

Transitional Care

Upon enrollment in AlphaCare, you may continue an ongoing course of treatment for a transitional period of up to 90 days from enrollment with a non-network health care provider if the provider accepts payment at AlphaCare's rate, adheres to AlphaCare's quality assurance standards and other policies, and provides medical information about your care to AlphaCare. If these conditions are met, AlphaCare will agree to pay the non-network provider.

Should your health care provider leave the AlphaCare network, your ongoing course of treatment may be continued for a transitional period of up to 90 days if your provider accepts payment at AlphaCare's rate and adheres to AlphaCare quality assurance standards and other policies, and provides medical information about your care to AlphaCare.

During the transitional period of up to 90 days, AlphaCare will issue a notice of action for any restriction, in addition to reduction, suspension or termination of authorized services.

If you were receiving CBLTC services from a Mainstream Managed Care (MMC) plan, and were disenrolled either due to a change in Medicaid eligibility status or receipt of Medicare, AlphaCare must continue to provide services until a comprehensive assessment is complete and an updated person centered plan of care is established in collaboration with you and your provider(s).

If you feel you have a condition that meets the criteria for transitional care services, please notify AlphaCare Member Services.

Selection of Health Care Providers

We cannot restrict your ability to choose non-covered service providers for your Medicare covered benefits. We feel that it is in your best interest to use our network providers. Since these network providers have a contractual obligation to AlphaCare, we have the ability to monitor their services and hold them to our professional standards. If your Medicare benefits are exhausted and Medicaid becomes the primary payer for a covered service, you will need to switch to one of our network providers.

As an AlphaCare member, you may obtain a referral to a health care provider outside the network in the event AlphaCare does not have a provider with appropriate training or experience to meet your needs. If you require an out of network provider, please contact your Care Manager to assist you in obtaining a referral.

Changing Your Provider

To change your provider of services you only need to inform AlphaCare of your desire to make a change. To do so, you simply need to call Member Services toll free at **888-770-7811**. The change will become effective immediately.

You will be able to choose a primary care dentist from the Liberty Dental network. To choose or change your primary care dentist, please call Liberty Dental at 877-550-4437. Please continue to

call AlphaCare to set up transportation to and from your dental appointments.

Services for Veterans

AlphaCare contracts with a Veterans' Home that operates in our service area. The veterans' home we contract with can be found in our printed Provider Directory you received in the mail or can be requested by calling Member Services at 888-770-7811.

If you want to receive care from a Veterans' Home, you may. Your eligibility is based on clinical need and setting availability. New York State Veterans' Homes are limited to Veterans, non-Veteran spouses, and gold star parents.

If you want to receive care from a veteran's home, and AlphaCare does not have a Veteran's home in our service area, we must pay for you to access veterans' home services that are out of our network until you can transfer to another plan that has a Veteran's home in their network.

Money Follows the Person (MFP)/Open Doors

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

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

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

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

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

Out of Area Care

If You Are Leaving the AlphaCare Service Area

If you are planning to visit friends or family who live outside of our service area (Brooklyn, Bronx, Manhattan, Queens or Westchester County), AlphaCare requests that you inform your Care Manager or Member Services as soon as possible before you go. We will help you arrange for medically necessary care that you need while you are away. You can contact Member Services toll free at **888-770-7811**.

If you are planning to leave the service area for more than 30 consecutive days, it will be difficult for AlphaCare to properly monitor your health needs. When this happens AlphaCare must initiate disenrollment within five business days. In this case, you should call Member Services to discuss your options. If you are currently enrolled in another health plan that covers all or part of these services, you may wish to keep that coverage in effect to continue receiving these benefits.

Out of Area Emergency Care

If an emergency situation occurs while you're out of the area you should seek care immediately. You, a family member or friend should contact AlphaCare within 24 hours, if possible. We need to have this information to make any appropriate plan of care changes that may be necessary.

Out of Area Urgent Care

An urgent care need is an illness or medical problem that needs attention by your physician, or other health care provider before your next routine office visit.

If you require urgent care when you are out of the service area, AlphaCare will accept the medical necessity decision made by the attending physician or other health care professional. AlphaCare will pay for any services that are ordered by the physician and are covered services through AlphaCare.

Resolving Issues

AlphaCare will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance 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 AlphaCare staff or a health care provider because you file a grievance or an appeal. We will maintain your privacy. We will give you any help you may need to file a grievance 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 grievance or to appeal a plan action, please call the AlphaCare Grievance & Appeals Department toll-free at **888-770-7811** or write to:

AlphaCare
335 Adams Street, 26th Floor
Brooklyn, NY 11201
Attn: Grievance and Appeals Department

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

The Grievance and Appeal Process

AlphaCare will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance 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 AlphaCare staff or a health care provider because you file a grievance or an appeal. We will maintain your privacy. We will give you any help you may need to file a grievance 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 grievance or to appeal a plan action, please call: **888-770-7811** or write to:
AlphaCare
335 Adams Street, 26th Floor
Brooklyn, NY 11201
Attn: Grievance and Appeals Department

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Grievance?

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

The Grievance Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessaryinformation
2. For all other types of grievances, 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 grievance. 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 grievance and our decision about your grievance.

How do I Appeal a Grievance Decision?

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

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

What is an Action?

When AlphaCare 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; reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal.
(See **How do I File an Appeal of an Action?** on page 29 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 reduce, suspend or terminate a service that is authorized, our letter will be received by the member at least 10 days before we intend to change the service.

Contents of the Notice of Action

- Any notice we send to you about an action will:
- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;

- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, which 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 a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing
- It will say that you do not have to file an appeal before asking for a Fair Hearing;
- It will explain how to ask for a Fair Hearing; and
- If we are reducing, suspending, or terminating an authorized service and you want your services to continue while your appeal is decided, you must ask for a Fair Hearing 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 AlphaCare orally or in writing. When AlphaCare 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 business days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

To file an appeal of a plan action, please call: **888-770-7811** or write to:

AlphaCare
335 Adams Street, 26th Floor
Brooklyn, NY 11201
Attn: Grievance and Appeals Department

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

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

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you must request a Fair Hearing to continue to receive these

services while your appeal is decided. We must continue your service if you ask for a Fair Hearing 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 Fair Hearing, and to ask for aide to continue, see Fair Hearing Section below.

Although you may request continuation of services, if the Fair Hearing 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 AlphaCare to Decide My Appeal of an Action?

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

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

If we reverse our decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires.

In some cases you may request an “expedited” appeal. (See **Expedited Appeal Process** below).

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

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

If AlphaCare 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 60 calendar days after the date on the Initial Determination Notice. This deadline applies even if you are waiting for us to make a decision on your Internal Appeal.

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

You may also request a Fair Hearing form New York State. The Fair Hearing decision can overrule our original decision, whether or not you asked us for an appeal. Your must request a Fair Hearing within 60 calendar days of the date we sent you the notice about our original decision. You can pursue a Plan appeal and a Fair Hearing at the same time, or you can wait until the Plan decides. We may not act in any manner so as to restrict your right to a fair hearing or influence your decision to pursue a fair hearing, your appeal and then ask for a Fair Hearing. In either case, the same 60 calendar day deadline applies.

The State Fair Hearing process is the only process that allows your services to continue while you are waiting for your case to be decided. If we send you a notice about restricting, reducing, suspending, or terminating services you are authorized to receive, and you want your services to continue, you must request a Fair Hearing. Filing and internal or external appeal will not guarantee that your services will continue.

To make sure that your services continue pending the appeal, generally you must request the Fair Hearing AND make it clear you want your services to continue. Some forms may automatically do this for you, but not all of them, so please read the form carefully. IN all cases, you must make your request within 10 days of the date on the notice, or by the intended effective date o our action (whichever is later).

Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; 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 of 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 decide din 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

- 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 9877) 502-6155
- Online Request form: https://errswebnet.otda.ny.gov/errswebnet/erequestforms.aspx
- Mail a Printable Request Form:

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

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

New York City
14 Boerum Place, 1st Floor
Brooklyn, New York 11201

Albany
40 North Pearl Street, 15th Floor
Albany, New York 12243

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

State External Appeals

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

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

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

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

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an

external appeal, the decision of the Fair Hearing officer will be the one that counts.

Complaints to the State Department of Health

If at any time, you are dissatisfied with how AlphaCare has handled your grievance or appeal or any other problem you feel AlphaCare has not handled in an appropriate manner, youcan contact the New York State Department of Health at the following location:

New York State Department of Health
Bureau of Managed Long Term Care
Corning Tower, Room 1911
Empire State Plaza
Albany, New York 12237
1-866-712-7197

AlphaCare Member Bill of Rights

As with membership in any health care plan, you have certain rights and responsibilities when you join AlphaCare. You'll find a list of the **Your Responsibilities** on the next page.

- You have the right to receive medically necessary care;
- You have the right to timely access to care and services;
- You have the right to privacy about your medical record and when you get treatment;
- You have the right to get information on available treatment options and alternatives presented in a manner and language you understand;
- You have the right to get information in a language you understand - you can get oral translation services free of charge;
- You have the right to get information necessary to give informed consent before the start of treatment;
- You have the right to be treated with respect and dignity;
- You have the right to get a copy of your medical records and ask that the records be amended or corrected;
- You have the right to take part in decisions about your health care, including your right to refuse treatment;
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- You have the right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- You have the right to be informed of where, when and how to obtain the services you need from your managed long term plan of care, including how you can receive benefits from out-of-network providers if the services are not available in AlphaCare's network.
- You have the right to complain to the New York State Department of Health or the NYC Human Resources Administration; and, the right to use the New York State Fair Hearing System; and, in some instances to request a NYS External Appeal;
- You have the right to receive information about AlphaCare and managed long term care in a manner which does not disclose you as participating in the MLTC Plan, provided that inclusion of AlphaCare's name is not considered a violation of this provision.
- You have the Right to seek assistance from the Participant Ombudsman program.
- You have the right to appoint someone to speak for you about your care and treatment; and
- You have the right to make advance directives and plans about your care.

These rights are based on requirements found in PHL 4408, 10 NYCRR 98-1.14, and 42 CFR 438.100

Your Responsibilities

As a member, you also have some responsibilities. These include:

- Receive all of your covered services from the AlphaCare Provider Network.
- Obtain authorization from AlphaCare prior to receiving services subject to Service Authorization Review (refer to page 18).
- Pay AlphaCare any Medicaid surplus that you may have as determined by the NYC Human Resources Administration.
- Call AlphaCare whenever you have a question regarding your membership or if you need assistance toll-free at **888-770-7811**.
- Tell AlphaCare when you plan to be out of town so we can help you arrange your services.
- Have a representative contact AlphaCare in the event that you have been admitted to the hospital.
- Tell AlphaCare when you believe there is a need to change your plan of care.

We want AlphaCare to be the very best managed long-term plan of care available. To achieve this goal, we may send you a short survey or call you on the telephone to ask how you feel about the services and care provided by AlphaCare. Since New York State Medicaid pays AlphaCare, the New York State Department of Health will also be evaluating AlphaCare and our services to see how well we are meeting your needs.

We encourage you to participate in the policy development of the organization. If at any time you believe that you have a suggestion for improving the services AlphaCare provides, please call or write to:

AlphaCare
335 Adams Street, 26th Floor
Brooklyn, NY 11201
Attn: Member Services

We value member opinions and would appreciate any comments that you have.

Membership Disenrollment

Voluntary Disenrollment

If you choose to end your membership, please call the Member Services Department and tell them you wish to leave AlphaCare. A disenrollment form will be provided to you. If you do not wish to fill it out, an AlphaCare representative can fill it out for you. Simply submit the form to:

AlphaCare
335 Adams Street, 26th Floor
Brooklyn, NY 11201
Attn: Enrollment Manager

Your Care Manager will then meet with you to discuss your decision and help you plan for your care following disenrollment. If you need to continue to receive long term care services such as personal care you will need to transfer to another Managed Long Term Care plan or a managed care plan to continue to receives these services. The date on which your disenrollment from AlphaCare will take effect and the discharge plan selected to best meet your future care needs is determined by the New York Medicaid Choice (NYMC) or your Local Department of Social Services (LDSS). AlphaCare will forward your request for disenrollment to NYMC or LDSS.

The disenrollment date will be the last day of the month after New York Medicaid Choice has processed the disenrollment and arranged any further services. Oral requests for disenrollment require the same amount of time to process as written requests. If a request is submitted after the 15th of the month, you will not be disenrolled by the first day of the following month.

Membership Cancellation (Involuntary Disenrollment)

If AlphaCare believes it is necessary to disenroll a member involuntarily, we must obtain the approval of NYMC or LDSS. An eligible member will not be involuntarily disenrolled on the basis of health status. If you are being Involuntary Disenrolled you will need to choose another Managed Long Term Care Plan to continue to receive your long term care services such as personal care. If you do not choose a new plan then you will be auto assigned to a new plan.

See page 36 **“Involuntary Disenrollment”** for a listing of reasons for which an involuntary disenrollment may be requested. All members will be notified of their appeal rights by NYMC or LDSS.

Involuntary Disenrollment

AlphaCare Must Initiate Involuntary Disenrollment within Five Business Days:

- If you no longer reside in the service area.
- If you are absent from the service area for more than 30 consecutive days.
- If you are hospitalized or you enter an Office of Mental Health, Office for People with Development Disabilities or the Office of Alcoholism and Substance Abuse Services residential program for 45 consecutive days or longer.
- If you are no longer eligible to receive Medicaid benefits.
- If you clinically require nursing home care, but you are not eligible for such care under the Medicaid Program's institutional eligibility rules.
- If you no longer require community-based long term care services or, if you have Medicaid only and no longer meet the nursing home level of care as determined by the assessment tool prescribed by the Department of Health.
- You are incarcerated.
- If you or a family member engages in behavior that seriously impairs the Plan's inability to furnish your special needs.

AlphaCare May Initiate Involuntary Disenrollment:

- If you or a member of your family or an informal caregiver engages in conduct or behavior that seriously impairs AlphaCare's ability to furnish services to either you or other members. AlphaCare must make and document reasonable efforts to resolve the problems presented by the individual. AlphaCare may not request disenrollment because of an adverse change in your health or because you need more services, or because of diminished mental capacity or uncooperative or disruptive behavior resulting from your special needs.
- If you knowingly fail to complete or submit any necessary consent or release.
- If you provide AlphaCare with false information, otherwise deceives AlphaCare, or engage in fraudulent conduct with respect to any substantive aspect of your membership.

AlphaCare Funding and Payment

When you enroll, AlphaCare receives a single monthly payment from Medicaid to provide all of the covered services listed on page 12. No premiums, co-payments, or deductibles willbe charged to the member.

Payment of Network Providers by AlphaCare

All Network Providers are under contract with AlphaCare and are paid by AlphaCare for the covered services they provide. All fees charged by the provider are pre-negotiated rates that are renewable on a yearly basis. Certain types of providers, such as vision and dental providers are paid a set fee per member by AlphaCare regardless of the amount of service needed by a member. This payment type is known as capitation.

AlphaCare's providers should never charge you a co-pay. If you receive a bill directly from a provider, call the Member Services Department toll free at **888-770-7811**, and they will resolve the situation for you.

Surplus (Medicaid Surplus/Spend Down)

HRA or LDSS might determine that you are required to pay a surplus for continued Medicaid coverage. A surplus is the amount of income you will be required to pay on a monthly basis to meet Medicaid eligibility requirements to continue your Medicaid coverage. AlphaCare is required to bill you for surplus charges determined by HRA or LDSS. AlphaCare will be notified by HRA or LDSS if the amount of your surplus changes, so adjustments can be made accordingly. If necessary, an Entitlement Specialist can discuss this process in detail with you.

Termination for Non-Payment

AlphaCare may initiate Involuntary Disenrollment if a Member fails to pay any amount owed as a Medicaid surplus within 30 days after such amount becomes due. AlphaCare will make reasonable efforts to collect the surplus, including written demand for payment and advising the Member of his/her prospective disenrollment. (Refer to page 36 for a full explanation of **Involuntary Disenrollment**).

Information AlphaCare Will Provide Upon Request

If you would like any of the following information, you or your designated representative can write to:

AlphaCare
335 Adams Street, 26th Floor
Brooklyn, NY 11201
Attn: Member Services Department

- Simply indicate what documents you are requesting and we will mail them to you within 10 business days.
- A listing of names, business addresses, and official positions of board members, officers, controlling persons and owners or partners of AlphaCare.
- The policy & procedures to protect member confidentiality of medical records and other information.
- A written description of AlphaCare's quality assurance plan.
- Information regarding service authorization for a particular disease or condition for the purpose of assisting the member or potential member in evaluating covered services.
- Written application procedures and minimum qualifications for health care providers to be considered by AlphaCare.
- Information on the structure and operation of AlphaCare.
- A copy of the most recent annual certified financial statement of AlphaCare, including a balance sheet and summary of receipts and disbursements prepared by a Certified Public Accountant (CPA).

ALPHACARE
888-770-7811
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