2021

homefirst®

A product of Elderplan

Member Handbook

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Current as of 12/1/2020

Important HomeFirst Names and Telephone Numbers

Member Services: (718) 759-4510

Toll Free Telephone: 1-877-771-1119

TTY/TDD: 711

Executive Director: (718) 759-4022

Care Management Team:

Your Physician:
Your Pharmacy:

Tips To Help With Your Care

Always Remember to...

1. Tell your physician and other health care providers that you are a member of HomeFirst.
2. Call Member Services or your Care Management Team whenever you:
   - Require a service covered by HomeFirst or need help in obtaining a service.
   - Have questions if a service is covered under your long term care benefits
3. Notify HomeFirst within 24 hours if you are admitted to the hospital.
4. Bring your HomeFirst card and your Medicare and Medicaid cards and other health insurance cards when you see your physician or other healthcare providers.

Welcome to HomeFirst

Dear HomeFirst Member:

Welcome to HomeFirst, a product of Elderplan and thank you for selecting us to serve your long term care needs.

This member handbook is your guide to HomeFirst, a managed long term care plan, offering comprehensive long term care services. This member handbook describes who may be eligible for HomeFirst, the benefits of membership, and our policies and procedures. In addition, it will help you understand what is needed to obtain services and how best to work with your Care Management Team, who have experience in long term care.

Please review the handbook carefully. It is very important to become familiar with the policies and procedures outlined in this handbook in order to make the most of your HomeFirst membership. If after reading the handbook you would like more information or if you have any questions, please contact our Member Services Department at (718) 759-4510 or toll free at 1-877-771-1119, Monday through Friday from 8:30 a.m. to 5:00 p.m. For TTY/TDD, call 711. They are there to help you.

We encourage you and your family to take an active role in decisions about your long term care needs. We want you to have an ongoing relationship with your Care Management Team and your primary care physician, who are working together and will help you receive the home, community and facility-based health care services you need.

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

Sincerely,

Felicia Johnson

Executive Director

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About HomeFirst

HomeFirst, a product of Elderplan, is one of the oldest managed long-term care (MLTC) plans in NY. HomeFirst continues a tradition of compassion, dignity and respect that dates back to 1907 when the Four Brooklyn ladies, with the help of charitable support, provided members of the community with quality health care and a safe, comfortable place to live in their time of greatest need.

HomeFirst, a not-for-profit managed long term care (MLTC) plan, brings people and resources together to better plan and deliver accessible, high quality health care services for you.

As a key part of that effort, HomeFirst has developed a respected network of area providers that are able to deliver the services you may require. These providers have all been selected and credentialed by us to ensure you receive quality care.

We encourage our members to take an active role in their own health care and we offer many choices in services and locations to assist in that effort. It's all part of our commitment to you.

Our goal is to help you live independently, in your own home, for as long as possible.

Enrollment in HomeFirst is entirely voluntary. When you enroll in HomeFirst you are required to use providers in the HomeFirst network and obtain authorization from your Care Management Team for services covered by HomeFirst.

What is Managed Long Term Care and How Does it Work?

Managed Long Term Care plans provide, arrange, and coordinate members' long term care services on a capitated basis. At HomeFirst, we offer you a wide selection of covered services through our network providers at no cost to you (see Covered Services on page 21) and can coordinate other services including those covered by Medicare (see page 35).

As a member of HomeFirst you will benefit from:

- Coordination of all your health care services with your physician(s), and health care providers.
- A Care Management Team comprised of a Registered Nurse Assessor, Care Manager, Social Worker, and Care Representative with expertise in caring for individuals with chronic medical needs. Your Care Management Team will collaborate with your physician and other health care professionals to ensure you receive the services you need.
- 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.
  - An on-call nurse, who is available 24 hours a day, 7 days a week for information, emergency consultation services and response in the community, if necessary.

Confidentiality

We Protect the Privacy of your Personal Health Information.

Federal and state laws protect the privacy of your medical records and personal health information. HomeFirst takes your privacy seriously. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How Do We Protect the Privacy of Your Health Information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law. For example, we are required to release health information to government agencies that are checking on quality of care.

You Can See the Information in Your Records and Know How It Has Been Shared with Others.

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

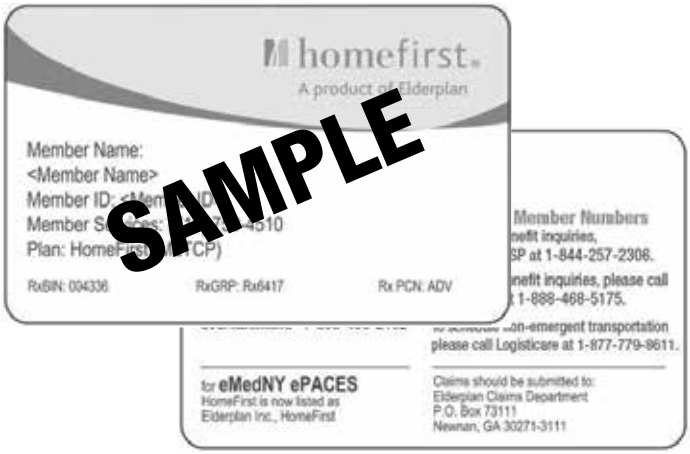
If you have questions or concerns about the privacy of your personal health information, or for a copy of our plan's Notice of Privacy Practices, please call

Member Services
Monday through Friday from
8:30 a.m. to 5:00 p.m.
(718) 759-4510 or toll free at
1-877-771-1119

Your HomeFirst ID Card

Your HomeFirst member ID Card identifies you as a HomeFirst member and should be carried, along with your Medicaid and all other health insurance cards, at all times.

You will need your HomeFirst member ID card to access certain services that are authorized by HomeFirst.



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. Preparing an Advance Directive will ensure that all of 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 whether you have an Advance Directive or not. For more information regarding Advance Directives, please speak with your primary care physician, your Enrollment Representative upon enrollment and/or your Care Management Team. HomeFirst will provide written information about Advance Directives. Forms are available if you wish to complete an Advance Directive. HomeFirst staff is also available to answer questions you may have concerning Advance Directives.

Member Services

HomeFirst wants you to understand your managed long term care plan and receive the best possible care.

Our Member Service Representatives are available to help you in any way regarding your membership. If you have any questions or concerns about benefits, services or procedures, please let us know. We welcome any ideas or suggestions you might have regarding HomeFirst. Your comments help us improve our services to you. Member Services can be reached by telephone:

Member Services
Monday through Friday from
8:30 a.m. to 5:00 p.m.
(718) 759-4510 or toll free at
1-877-771-1119

Cultural Competency and Interpreter Services

HomeFirst shall promote and ensure the delivery of services in a culturally competent manner to all members, including, but not limited to, those with limited English proficiency and diverse cultural and ethnic backgrounds as well as members with diverse faith communities. Cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by member and their communities across all levels of the Contractor's organization.

HomeFirst has employees who speak many languages and we are also able to access interpreter services at no charge to you. HomeFirst shall advise you that you are entitled to receive language interpretation services upon request at no charge to you. We also have written information in the most prevalent languages of our members. Currently written materials are available in English, Russian, Chinese, Bengali, Italian, Haitian Creole and Spanish. If translation is required, please feel free to call Member Services at (718) 759-4510 Monday – Friday from 8:30a.m. to 5:00 p.m. or toll free at 1-877-771-1119 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 wish to speak with a Member Services Representative should first contact a relay operator at 711. They will then facilitate calls between TTY/ TDD users and voice customers.

Services for Visually Impaired Members

HomeFirst has a LARGE print handbook available upon request for those members who are visually impaired. Please contact Member Services to request a copy.
Should you need the handbook or any other HomeFirst documents and forms read to you, HomeFirst will arrange an appointment for this at your convenience.

Non-Work Hours On-Call Service

If you need help after work 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. They may also refer you to a hospital, contact your physician or follow up if there is a problem with a provider or service. To contact HomeFirst during nights, weekends or holidays, call:

Member Services
Monday through Friday from
8:30 a.m. to 5:00 p.m.
(718) 759-4510 or toll free at
1-877-771-1119

You are not required to call HomeFirst prior to obtaining emergency care. (See page 13)

Eligibility and Enrollment

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

- You are a minimum of 18 years of age
- You reside in one of the five boroughs of New York City or in Dutchess, Nassau, Orange, Putnam, Rockland, Sullivan, Ulster or Westchester

- You are eligible for full Medicaid as determined by the Local Department of Social Services (LDSS) or Human Resource Administration (HRA)
- You are able to return to or remain at home and community without jeopardy to your health and safety at the time of enrollment unless you are designated as a long term resident of a nursing home
- You are medically eligible for nursing home level of care at of the time of enrollment, if you are either 18-20 years old and dually eligible (Medicare and Medicaid) or if you are 18 years old or greater and only eligible for Medicaid
- You are determined eligible for managed long term care by HomeFirst or entity designated by the Department using the current NYS eligibility tool. You are expected to require at least one of the following Community Based Long Term Care Services (CBLTCS) and care management from HomeFirst for more than 120 continuous days from the effective date of enrollment:
  1. Nursing Services in the Home
  2. Therapies in the Home
  3. Home Health Aide Services
  4. Personal Care Services in the Home
  5. Adult Day Health care
  6. Private Duty Nursing
  7. Consumer Directed Personal Assistance Services

The potential that you may require acute hospital inpatient services or nursing home placement during the 120 continuous days shall not be taken into consideration when determining an applicant's eligibility for enrollment.

If it is determined during the screening process that a person is enrolled in another managed care plan capitated by Medicaid, a Home and Community Based Service Waiver Program, an Office for People with Developmental Disabilities (OPWDD) Day Treatment Program or is receiving services from a Hospice the

individual may be enrolled with HomeFirst upon termination from such other plans or programs.

If the person is expected to be a hospital inpatient or resident of hospitals or residential facilities operated under the auspices of the State Office of Mental Health, Office for People with Development Disabilities or Office of Alcoholism and Substance Abuse Services facility on the first day of enrollment, the person may not begin enrollment unless he/she disenrolls or is discharged from the program/ services currently being received.

Enrollment Process

Eligibility for enrollment in HomeFirst must be established through an assessment process. Enrollment is voluntary and you may choose to disenroll at any time. To start the enrollment process, an Enrollment Representative will contact you within five (5) days of our learning of your possible interest in HomeFirst and will confirm that you meet the eligibility requirements based on age, geographic location of residence, and Medicaid eligibility. We will determine if you require a New York Medicaid CHOICE Conflict-Free Evaluation and Enrollment Center (CFEEC) nursing visit.

Conflict Free Evaluation and Enrollment Center (CFEEC) is the entity that contracts with the New York State Department of Health to provide initial evaluations to determine if you are eligible for Community Based Long Term Care (CBLTC) for a continuous period of more than 120 days. The CFEEC will be responsible for providing conflict-free determinations by completing the Uniform Assessment System (UAS) for you in need of care. CFEEC evaluations are conducted in your home.

You will require a nursing visit if you are new to long term care service and are interested in enrolling for the first time or if you have not been enrolled in a plan for the past 45 days. Our Enrollment Representative will connect you with the New York

Medicaid CHOICE Conflict Free Evaluation and Enrollment Center (CFEEC), or you can call directly to 1-855-222-8350 TTY 1-888-329-1546. Individuals transferring from another Managed Long Term Care plan or Mainstream Medicaid plan and are a Medicare recipient do not require a CFEEC evaluation.

If you are a plan to plan transfer or if your CFEEC evaluation is complete and you are deemed eligible to enroll in managed long term care services, our Enrollment Representative will assist in scheduling an appointment with a Home First Enrollment Nurse with an enrollment representative.

An Enrollment Nurse will make an in- home visit to provide feedback about our plan and propose a care plan for your 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 HomeFirst"s managed long term care plan will be discussed and you will have the opportunity to ask questions and to discuss your specific needs. A HomeFirst nurse will obtain your health history and perform a comprehensive assessment in order to determine your care plan needs.

If you are interested in enrolling in HomeFirst, you will be asked to sign a medical release. A signed medical release is needed for a HomeFirst nurse to follow up with your physician and other health providers to develop your individualized plan of care. Your plan of care will be developed with assistance from you, your informal supports and your physician. HomeFirst will then be able to establish and coordinate the services included in your individualized plan of care. Social Day Care can contribute to your individualized care plan,but cannot be the sole service that you will receive.

If you are choosing to enroll in HomeFirst from a Mainstream Medicaid Managed Care Plan, both you and your physician must complete the required NY Medicaid CHOICE plan transfer form and complete a CFEEC,

if you are a Medicaid only recipient. In this form, both you and your primary care physician must attest that you require one of the following services exclusive to Managed Long Term Care plans: social day care, social and environmental supports, and/ or home delivered meals. Without this signed form, you will not be able to enroll in a Managed Long Term Care plan like HomeFirst.

If you want to transfer to another MLTC Medicaid Plan:

You can try us for 90 days. You may leave Homefirst and join another health plan at any time during that time. If you do not leave in the first 90 days, you must stay in Homefirst for nine more months, unless you have a good reason (good cause). Some examples of Good Cause 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 Homefirst 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 contact 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 1-800-505-5678. 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. Homefirst will 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 Homefirst.

To conclude the enrollment application process, you will need to sign an Enrollment Agreement. A signed *Release of Information* is required to complete your application.

Enrollment will begin the first day of the month. All enrollments are subject to approval by the LDSS or New York Medicaid CHOICE.

Applications for enrollments submitted to LDSS or NY Medicaid CHOICE by noon on the 20th day of the month will be accepted for enrollment on the first of the following month if the application is complete and your Medicaid is active.

If the 20th day of the month falls on a holiday or weekend, the enrollment application will be submitted by noon of the prior work day.

Upon enrollment, you will be assigned a Care Management Team and issued a HomeFirst membership card.

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

Withdrawal of Enrollment

If you decide not to proceed with the application, this will be considered a withdrawal of the application. You may 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 to us verbally or in writing.

If you choose to withdraw your application, and are:

- Dually eligible: you must choose another managed long term

care plan in order to continue to receive long term care services such as personal care. You are no longer able to return to Medicaid Fee for Service services through HRA or LDSS.

- Eligible for Medicaid only: you must choose another managed long term care plan, Medicaid managed care plan or waivered service in order to receive long term care services. You are no longer able to return to Medicaid Fee for Services for long term care through HRA or LDSS

Denial of Enrollment

HomeFirst 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 HomeFirst's decision, you may request to pursue an application. The information collected up to this time will then be forwarded to the Local Department of Social Services (LDSS) or NY Medicaid Choice and they will make the final decision about your eligibility

- You will be denied enrollment if after the start of the application process it is determined you are not eligible for nursing home level of care if you are either 18-20 years old and dually eligible (Medicare and Medicaid) or if you are 18 years old or greater and only eligible for Medicaid.
- You will be denied enrollment if after the start of the application process it is determined that you do not require the community based long term care services offered by HomeFirst for more than 120 continuous days from the date of enrollment.
- 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 **unless you are designated as a long term resident of a nursing home**.

Before the recommendation for denial of enrollment is processed by the LDSS or NY Medicaid Choice you can withdraw your

application by providing your wishes orally or in writing.

If HomeFirst determines that you do not meet one or more of the eligibility requirements, we will recommend denial of enrollment and you will be notified in writing. You will only be denied enrollment if the LDSS or NY Medicaid Choice agrees with HomeFirst's determination that you are ineligible.

Coordinating Your Care

Upon enrollment, each member is assigned to a Care Management Team, which includes clinical and social care managers along with administrative support. This team is responsible for the coordination of your care and providing you with quality person centered service planning and Care Management.

The Person Centered Service Plan must be developed with you and those individuals you select to participate in service planning and delivery, including service providers and your chosen informal supports. You shall receive a Person Centered Service Plan after your initial assessment, or reassessment where applicable, which must be completed within fifteen (15 days) of enrollment/ reassessment, or must document reason for any delay in your record. The completed PCSP must be signed by you and a copy must be provided to you, and a signed copy must be retained by HomeFirst. An attempt to obtain your signature is required. If you refuse, the refusal will be documented in your record.

Together, your Care Management team will work with you, your informal supports and your primary care physician to ensure you receive the appropriate level of services based on your current and unique psychosocial and medical needs, functional level and support systems. Your Care Management Team will coordinate all of your health care needs for covered and non-covered services, and any other services provided by other providers, community resources and informal supports. A Health Care Professional will assist you with applying for any entitlements

and other benefits for which you are eligible, as well as in maintaining eligibility through the certification process of all entitlements.

The Nurse Assessor, as a member of your Care Management Team, will make home visits at least twice a year to complete a comprehensive assessment of your health and to identify any changes or needs you may have. Additional home visits may be scheduled as determined by your Care Management Team. We will work cooperatively with your physician, who is notified of your plan of care, as well as other health care professionals to ensure you receive the services you need.

Member Services Department

Member Services Representatives are available by telephone to assist you with any questions that you may have regarding HomeFirst, including the benefit package or what services are or are not covered. You can contact Member Services at (718) 759-4510 Monday – Friday from 8:30 a.m. to 5:00 p.m. or toll-free at 1-877-771-1119. For TTY/TDD, call 711. The Member Services Team will work with your Care Management Team to schedule your appointments and order the supplies and services that you need. They will also work with your Care Management Team and the service vendors to ensure that you receive the services you need or to resolve any problems you have with your services. Member Services Representatives can answer most questions you have regarding your plan of care. If necessary, they will ensure your Care Management Team contacts you to explain any medical questions you might have.

Selection of Your Primary Care Physician

With HomeFirst, you continue to use your own primary care physician. Your Care Management Team will work with your primary care physician to coordinate all your health care needs. If you need help finding a physician, we can help you locate a physician in the community that meets our quality standards.

Transitional Care

Upon enrollment in HomeFirst, you may continue an ongoing course of treatment, with a non-network health care provider, for a transitional period of up to sixty (60) days from enrollment for any treatment relating to a life- threatening disease or condition or a degenerative or disabling disease or condition. If your provider accepts payment at HomeFirst's rate, adheres to HomeFirst's quality assurance and other policies, and provides medical information about your care to HomeFirst, HomeFirst will be responsible for payment to the non-network provider.

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

If you feel you have a condition that meets the criteria for transitional care services, please notify your Care Management Team.

If you are being disenrolled from another MLTC Plan into HomeFirst, due to an approved service area reduction, closure, acquisition, merger, or other approved arrangement, HomeFirst must continue to provide services under your current existing Person Centered Service Plan for a continuous period of 120 days after enrollment or until the HomeFirst has conducted an assessment and you have agreed to the new Person Centered Service Plan.

Selection of Health Care Providers

We cannot restrict your ability to choose non-network service providers for your Medicare covered benefits. We do however feel that it is in your best interest to use our network providers. Since these network providers have a contractual obligation to HomeFirst, we have the ability

to monitor their services and hold them accountable 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 a HomeFirst member, you may obtain a referral to a health care provider outside the network in the event HomeFirst does not have a provider with appropriate training or experience to meet your needs. In the event that you require an out-of-network provider, please contact your Care Management Team to assist you to obtain an authorization and referral.

Changing Your Provider

To change your provider, you need only to inform HomeFirst of your desire to make a change. To do so, you simply need to call Member Services at (718) 759-4510 Monday – Friday from 8:30a.m. to 5:00 p.m. or toll-free at 1-877-771-1119. For TTY/TDD, call 711. The change will become effective immediately.

You will be able to choose a primary care dentist from our Healthplex Dental Network. To choose or change your primary care dentist, please call Healthplex at 1-888-468-5175, toll-free Monday to Friday, from 8AM to 6PM. For TTY/TDD, call 711. Dentists can be changed once a month, no later than the 15th of the month.

What To Do In a Medical Emergency

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

Emergency Care

You are NOT required to obtain HomeFirst's pre-authorization or prior authorization to get emergency care.

Definition of an Emergency

An emergency1 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 Management Team at HomeFirst.

After An Emergency

Notify your physician and your Care Management Team at HomeFirst within 24 hours of the emergency. You may be in need of long term care services that can only be provided by HomeFirst. Your Care Management Team will work with you and your providers to coordinate the care that you need.

If You Are Hospitalized

If you are hospitalized, a family member or a friend should contact HomeFirst as soon as possible. Your Care Management Team will cancel your home care services and other appointments. If you are in the hospital, be sure to ask your physician or hospital discharge planner to contact HomeFirst.

We will work with the physician, hospital discharge planner and you to plan for your care upon discharge from the hospital.

1 "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 affiliated 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 disfiguration of such person.

Out of Area Care

If You Leave the HomeFirst Service Area

If you are planning to visit friends or family who live outside of our service area (Brooklyn, Manhattan, Queens, Staten Island, the Bronx, Westchester, Nassau, Putnam, Rockland, Orange, Dutchess, or Sullivan county), HomeFirst requests that you inform your Care Management Team and 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 at (718) 759-4510 or toll free at 1-877-771-1119, Monday through Friday, 8:30am to 5:00pm. For TTY/TDD, call 711.

If you are planning to leave the service area for more than (30) thirty consecutive days, it will be difficult for HomeFirst to properly monitor your health needs. When this happens HomeFirst must initiate disenrollment within five (5) work days after the

thirty (30) days have passed. In this case you should call Member Services or your Care Management Team to discuss your options.

Out of Area Emergency Care

If an emergency situation occurs while you are out of the area, you should seek care immediately. You, a family member or friend should contact HomeFirst 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, HomeFirst will accept the medical necessity decision made by the attending physician or other health care professional. HomeFirst will pay for any services that are ordered by the physician that are covered services through HomeFirst.

Covered Services

HomeFirst offers a wide range of home, community and facility-based health care services and Long Term Services and Supports.

Long Term Services and Supports or (LTSS) are health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS is comprised of community-based services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, Personal Care Services, and institutional services including Long Term Placement in Residential Health Care Facilities.

Your provider must get authorization from HomeFirst for services. These services will be authorized by HomeFirst if 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.

Covered Services Provided as Medically Necessary are:

Care Management	A process that assists the member to access necessary covered services as identified in the Person Centered Service Plan (PCSP). Care Management services include referral, assistance in or coordination of services for the member to obtain needed medical, social, educational, psychosocial, financial and other services in support of the PCSP, irrespective of whether the needed services are included in the Benefit Package.

Nursing Home Care	Care provided to members by a licensed facility (please refer to "Nursing Home Care" on page 38)
Home Care **a.** Nursing **b.** Home Health Aide **c.** Physical Therapy (PT) **d.** Occupational Therapy (OT) **e.** Speech Pathology (SP) **f.** Medical Social Services	Includes preventive, therapeutic rehabilitative, health guidance and/or supportive care Prior authorization is required.
Personal Care	Provision of some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks by another person. Personal care must be medically necessary and provided by a qualified person in accordance with the plan of care. Prior authorization is required.
Adult Day Health Care	Care and services provided in a residential health care facility or approved extension site and includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities, dental pharmaceutical, and other ancillary services. Prior authorization is required.

Consumer Directed Personal Assistant Services (CDPAS)	As part of your managed long term care services, you may be eligible to self-direct your care. Consumer Directed Personal Assistant Service (CDPAS) is a specialized program where a member or a person acting on a member's behalf known as a designated representative, self directs and manages the member's personal care and other authorized services. CDPAS members have freedom in choosing their personal aide, home health services and/or skilled nursing services that they are eligible to receive. The member and/or designated representative is responsible for hiring, training, supervising and if necessary, terminating the employment of his/her aide. HomeFirst must ensure that you are notified on initial assessment and at reassessment that CDPAS is an available voluntary benefit, and document in your record that these notifications occurred. To learn more about CDPAS, including eligibility for this program, contract your nurse assessor or care manager. Prior authorization is required.

Durable Medical Equipment (DME)	Devices and equipment, other than prosthetic, orthotics or orthopedic footwear, which have been ordered by a practitioner in the treatment of a specific medical condition. Includes medical equipment and hearing aid batteries. Prior authorization is required.
Medical/Surgical Supplies	Items for medical use other than drugs, prosthetics, orthotics, durable medical equipment or orthopedic footwear. Includes enteral nutritional formula coverage, which is limited to tube feeding and inborn metabolic diseases. In children under age 21, oral formulas remain covered when caloric and dietary nutrients cannot be absorbed or metabolized. Prior authorization is required.
Orthotics and Prosthetics	Includes orthotics, orthopedic footwear and prosthetics. Prior authorization is required.
Personal Emergency Response System (PERS)	PERS is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. Prior authorization is required.

Non-Emergent Transportation	Transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the member's condition. Logisticare is HomeFirst's approved non-emergent transportation vendor. Please contact Logisticare directly to arrange an appointment for ambulance, ambulette, taxi or livery service, or public transportation at 1-877-779-8611. Reservations are requested 3 days in advance of your trip and can be made Monday – Friday from 8:00 AM to 5:00 PM. Member Transportation Inquiries can be made 24 hours a day, 7 days a week. Refer to page 37 for additional information. Prior authorization is required.
Podiatry	Includes routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a medical condition. Prior authorization is required.

Dentistry	Includes but is not limited to preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxsis, oral surgery, dental prosthetic and orthotic appliances to alleviate a service health condition. Healthplex is HomeFirst's group of in network dentists. Please contact Healthplex at 1-888-468-5175, toll-free Monday to Friday, from 8AM to 6PM. For TTY/TDD, call 711. Prior authorization may be required.
Optometry/Eyeglasses	Includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses; medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low vision aids. Eye exams are also covered to detect visual defects and eye disease. Exams which include refraction are limited to every two years unless otherwise justified as medically necessary. Routine vision services do not require an authorization. Medically necessary services may require prior authorization.

Outpatient Rehabilitation Therapy: Physical Therapy, Occupational Therapy, Speech Language Pathology or other Rehabilitative Therapies provided in a setting other than a home	Rehabilitation services provided by a licensed and registered therapist, for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level, provided in a setting other than a home. Effective January 1, 2021, Homefirst will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional. Prior authorization is required.
Nutrition	The assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. Prior authorization is required.

Private Duty Nursing	Medically necessary services provided to members at their permanent or temporary place of residence by properly licensed registered professional or licensed practical nurses (RNs or LPNs) in accordance with physician orders. Private Duty Nursing Services may be continuous and go beyond the scope of care available from a certified home health care agency (CHHA). Prior authorization is required.
Home Delivered or Congregate Meals	Meals provided to members who are unable to plan, shop, or prepare such meals due to illness, disability or advanced age. Meals may be provided at home or in congregate settings (e.g., senior centers). Prior authorization is required.
Social Day Care	Structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Prior authorization is required.
Social and Environmental Supports	Services and items that support your medical needs that include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care. Prior authorization is required.

Respiratory Therapy	Respiratory therapy is used to treat chronic and acute respiratory illnesses. These services must be provided by a qualified respiratory therapist. Treatment would include the performance of preventive, maintenance and rehabilitative airway-related techniques and procedures 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. Your physician would provide medical order to treat your specified conditions. Prior authorization is required.
Audiology/Hearing Aids	Includes audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription, fitting, dispensation and repair. Prior authorization is required.

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 a member. Telehealth does not include delivery of health care services by means of audio-only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring. Prior authorization is required.
Veterans Home Benefits	Each veteran, spouse of a veteran, or Gold Star parent member in need of long term placement is eligible for Veterans home placement and will be notified by HomeFirst of availability in the network. If HomeFirst does not operate in an area with an accessible veteran's home, or does not have one in its network, you will be directed to the enrollment broker. Prior authorization is required.

All covered services are provided by or contracted through HomeFirst Check the current provider network in your membership folder or call Member Services for a listing of network providers. Your provider must get authorization from HomeFirst for certain covered services. HomeFirst will make every effort to authorize services as quickly as your condition requires.

Upon enrollment, you will receive a HomeFirst membership card. It is important to carry it at all times.

As a HomeFirst member, you are not liable 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 HomeFirst. We will contact the network provider to correct their error.

HomeFirst members can self-refer for the following services at Article 28 Clinics.

- Vision Services: Optometry services and are affiliated with College of Optometry of the State University of New York
- Dental Services: operated by academic medical centers

For in network dental providers, please contact Healthplex Dental Network at 1-888-468-5175, toll-free Monday to Friday, from 8AM to 6PM. For TTY/ TDD, call 711. Additional details are listed on page 21 of this handbook.

For in network optometry providers, please contact member services at (718) 759-4510 or toll free at 1-877-771-1119, Monday through Friday, 8:30 am to 5:00 pm. For TTY/TDD, call 711.

Non-Covered Services

The following services are not covered by HomeFirst, but are covered by Medicare or Medicaid on a fee for service basis:

Inpatient Hospital Services	Inpatient hospital services include care, treatment, and nursing services that require an admission to the hospital.
Outpatient Hospital Services	Are services which are provided by a hospital providing diagnosis, treatment or prevention services for patients not requiring an overnight hospital stay.
Laboratory Services	Include medically necessary tests and procedures ordered by a qualified medical professional.
Physician Services, including services provided in an Office Setting, a Clinic, a Facility, or in the Home.	Physician services include the services of physician's assistants, and social workers provided in the office, home and facilities.
Radiology and Radioisotope Services	Diagnostic radiology, ultrasound, nuclear medicine, radiation oncology, and magnetic resonance imaging (MRI) services performed upon the order of a qualified practitioner.
Emergency Transportation (Emergency or Ambulance Transportation to a Hospital)	Emergency Transportation (Emergency or Ambulance Transportation to a Hospital)
Rural Health Clinic Services	Program servicing Medicare and Medicaid beneficiaries in rural areas to increase the utilization of non-physician practitioners (i.e. Nurse Practitioners and Physician Assistants).

Chronic Renal Dialysis	Services and treatment of chronic renal disease.
Mental Health Services	Include both inpatient and outpatient care and treatment of mental health patient services including medication and psychiatric hospital admissions.
Alcohol and Substance Abuse Services	Treatment and prevention of alcohol and drug addictions.
Office for People with Developmental Disabilities (OPWDD)	Long term therapy serving primarily persons with developmental disabilities: day treatment services and home and community based program services for the developmentally disabled.
Family Planning Services	Confidential services to prevent and/or reduce the incidence of unintentional pregnancies.
Prescription and Non-Prescription Drugs, Compounded Prescriptions	Include drugs and medical supplies ordered by a qualified practitioner.
Hospice	Hospice programs provide patients and families with supportive and end of life care to meet the special needs experienced during the final stages of illness.

Although these services are not part of HomeFirst's benefit package, your Care Management Team will help arrange and coordinate them as needed. 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.

Coordination of Covered and Non-Covered Services

Enrolling in HomeFirst Does Not Affect Your Medicare Benefits

If you have Medicare, membership in HomeFirst 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 HomeFirst's authorization to receive Medicare services.

However, HomeFirst can:

- Provide you with a list of qualified physicians (if you don't have one already).
- Schedule physician appointments.
- Assist with your discharge arrangements if you are hospitalized.
- Arrange Medicare-covered home care services.

If you are receiving any service covered by HomeFirst (see page 21), and it is determined that it is also covered under Medicare, your provider will bill Medicare as your primary insurance. If Medicare does not cover the entire cost of the covered service, then HomeFirst will be billed for any deductibles or coinsurance.

Any service you receive that is a non-covered HomeFirst service (see page 32) 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.

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

If a covered service you currently receive is a Medicare covered service, you can continue using the provider of your choice. HomeFirst 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 HomeFirst becomes responsible for primary payment for the care.

Medicaid Will Pay for Services Not Covered by HomeFirst

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

How to Obtain Covered Services

Plan of Care Development and Monitoring

When you enroll, you, your physician, and your Care Management Team 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 HomeFirst 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. Your Care Management Team and your physician will review and approve any changes to your plan of care. They will periodically evaluate it with you to ensure that the services you are receiving meet your needs.

Generally, a plan of care is assessed and authorized at six-month intervals or more frequently if necessary. It will be adjusted as your medical needs increase or decrease.

You are an 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 and Care Management Team if you have a need for any service that you are not currently receiving or wish to change in your plan of care. In addition, your Care Management Team 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 Member Services to inform your Care Management Team. Your Care Management Team will then consult with your physician about changes you have requested. If your Care Management Team and physician agree, your plan of care will be changed accordingly. If we have all the necessary information, HomeFirst will respond to your request for changes in your plan of care as quickly as your condition warrants, but no later than fourteen (14) calendar days for standard requests and seventy-two (72) hours for expedited. If HomeFirst denies your request for change or your request for service, you may appeal the decision. See "Complaint and Appeal Process" (page 45) for instructions on how to appeal an adverse determination by HomeFirst.

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

To receive covered services (see page 21), you or your provider must obtain prior authorization from HomeFirst. You can speak to either your Care Management Team or Member Services as described on page 6. Member Services can be reached by calling (718) 759-4510 or call toll free at 1-877-771-1119 Monday through Friday, 8:30am to 5:00pm. For TTY/TDD, call 711. The Member Services Representative will gladly relay the information to your Care Management Team.

If you have Medicare and have any questions about authorizations or coordinating benefits, please contact Member Services at (718) 759-4510 or by calling toll free at 1-877-771-1119. For TTY/TDD, call 711.

All covered services, with the exception of emergency services, requires an authorization from HomeFirst prior to obtaining them. The following paragraphs concern some often used services that require special instructions, such as calling Logisticare at 1-877-779-8611 to arrange your transportation or obtaining an authorization for Nursing Home care.

Transportation

HomeFirst covers your transportation needs to and from your physician's office, other providers, health-related services and approved events.

HomeFirst will not provide emergency or ambulance transportation to a hospital.

Emergency transportation is covered by fee for service Medicaid or Medicare.

If you need transportation, please call Logisticare at the following numbers:

- Reservations: 1-877-779-8611. Reservations are requested 3 days in advance of your trip and can be made Monday – Friday from 8:00 AM to 5:00 PM. Member Transportation Inquiries can be made 24 hrs a day, 7 days a week

- Ride Assist 1-877-779-8612 (this line is open for assistance to members who have scheduled trip(s) or need to cancel their trip(s) 24 hours a day/7 days a week/365 days a year)
- Hearing impaired (TTY) 1-866-288-3133 for both Reservations and Ride Assistance

If public transportation is available and you are well enough to travel to your medical appointments or other services included in the plan of care, Logisticare will reimburse you. You need to obtain authorization from Logisticare to be reimbursed for public transportation.

Medical Equipment, Supplies and Oxygen

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

Nursing Home Care

Admission to one of our participating nursing homes is made on an individual basis and follows the Medicaid eligibility rules. Your Care Management Team will make arrangements and HomeFirst 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 HomeFirst provider network.

If you have any questions about nursing home care or your Medicaid or Medicare coverage, please call your Care Management Team.

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 you move from a

nursing home back into your home or residence in the community. You may qualify for MFP if you:

- Have lived in a nursing home for three months are 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 you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Mangers and Discharge Planners. They can help you by:

- Giving you information about service and supports in the community
- Finding services offered in the community to help you be independent
- Visiting or calling you after you move to make sure that you have what you 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.

Referrals to Providers Outside of HomeFirst's Provider Network

If the network does not have an appropriately trained or experienced provider for the specialty care you require, your Care Management Team 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 HomeFirst'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.

If the services you require are not in the HomeFirst benefit package, or if Medicare is the primary payer of

a covered service, prior authorization from HomeFirst is not required. If you have questions regarding what services are covered under Medicare, please contact Member Services Department at (718) 759-4510 or toll free at 1-877-771-1119, Monday to Friday, 8:30 am to 5:00 pm. For TTY/TDD, call 711.

Service Authorization and Actions

Service Authorization Requests are requests by a member, or a provider on the member's behalf, for the provision of a service or for a referral to a non- covered service. Qualified clinical personnel will determine if a service is medically necessary and appropriate based on a comprehensive assessment of your current condition. The service authorization process begins with your initial plan of care when you are enrolled. See page 27 for an explanation of the creation of your initial plan of care.

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

We will make decisions about your care following these rules:

Prior Authorization

All covered services, with the exception of emergency services, require an authorization from HomeFirst prior to obtaining them. You or your provider on your behalf must get authorization from HomeFirst for covered services. For a list of covered services, please see page 21.

When you ask for approval of a treatment or service, it is called a service authorization request. To get a service authorization, you or your provider on your behalf must contact provider services at 1-877-771-1119.

You or your doctor may call our toll free Member Services number 1-877-771-1119 or send your request in writing to the following address:

HomeFirst
6323 Seventh Avenue
Brooklyn, NY 11220

Services will be authorized in a certain amount and for a specified period of time. This is called an authorization period.

You will also need to get prior authorization if you are getting one of these services now but need to get more of the care during an authorization period. This includes a request for Medicaid covered home health care services following an inpatient hospital stay. This is called concurrent review.

What Happens After We Get Your Service Authorization Request?

The health plan has a review team to be sure you get the services that you qualify to receive. 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.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an action. These decisions will be made by qualified health care professionals. 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 expedited process. You or your doctor can ask for an expedited review if it is believed that a delay will cause serious harm to your health. If your request for an expedited 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 mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals you will have if you don't agree with our decision (see Action Appeals section on page 48).

Timeframes for Prior Authorization Requests

- **Standard review:** We will make a decision about your request within three (3) work days of when we have all the information we need, but you will hear from us no later than fourteen (14) calendar days after we receive your request. We will tell you by the fourteenth (14th) calendar day if we need more information.
- **Expedited review:** We will make a decision about your request within seventy-two (72) hours from the receipt of your request and tell you if we need more information.

Timeframes for Concurrent Review Requests

- **Standard review:** We will make a decision within one (1) work day of when we have all the information we need, but you will hear from us no later than fourteen (14) calendar days after we received your request.
- **Expedited review:** We will make a decision as expeditiously as possible, but no later than seventy-two (72) hours from the receipt of the request. In the case of a request for Medicaid covered home health care service following an inpatient admission, one (1) work day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, seventy-two (72) hours after receipt of necessary information.

If we need more information to make either a standard or expedited decision about your service request, the timeframes above can be extended up to fourteen (14) calendar days. We will:

- Write and tell you what information is needed. If your request is in an expedited 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 fourteen (14) calendar days from the end of original timeframe.

If you are not satisfied with our answer, you have the right to file an action appeal with us. If your internal appeal is decided and the decision is not in your favor, you can request a fair hearing with the New York State Office of Temporary and Disability Assistance (OTDA). See the Action Appeal section on page 48 for additional 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 1-877-771-1119 or in writing to:

HomeFirst
6323 Seventh Avenue
Brooklyn, NY 11220

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.

Other Decisions About Your Care

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called a retrospective review. We will tell you if we take these other actions.

Timeframes for Notice of Other Actions

- In most cases, if we make a decision to restrict, reduce, suspend or terminate a service we have already approved

and you are now getting within an authorization period, we must tell you at least ten (10) calendar days before we change the service except when:

a. the period of advance notice is shortened to five (5) calendar days in cases of confirmed member fraud; or

b. we may mail notice not later than date of the Action for the following:

   i. the death of member;

   ii. a signed written statement from you requesting service termination or giving information requiring termination or reduction of services (where you understand that this must be the result of supplying the information);

   iii. the member's admission to an institution where the member is ineligible for further services;

   iv. the member's address is unknown and mail directed to the member is returned stating that there is no forwarding address;

   v. the member has been accepted for Medicaid services by another jurisdiction; or the member's physician prescribes a change in the level of medical care.

- If we are checking care that has been given in the past, we will make a decision about paying for it within thirty (30) calendar days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

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

HomeFirst of the name of your designated representative. You can do this by calling your Care Management Team or our Member Services Department. We will provide you with a form that you can fill out and sign stating who the representative will be.

Complaint and Appeal Process

Elderplan HomeFirst will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have. There will be no change in your services or the way you are treated by HomeFirst 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 or to appeal a plan action, please call: 1-877-771-1119 or write to:

HomeFirst
6323 Seventh Avenue
Brooklyn, NY 11220
Attn: Appeals and Grievances 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 Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services.

For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who

receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint.

We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

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

For all other types of complaints, we will notify you of our decision within forty-five (45) days of receipt of necessary information, but the process must be completed within sixty (60) days of the receipt of the complaint.

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

How Do I Appeal a Complaint Decision?

If you are not satisfied with the decision we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal in writing. It must be filed within sixty (60) work days of receipt of our initial decision about your complaint. 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 complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within thirty (30) work days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint

appeal process. For expedited complaint appeals, we will make our appeal decision within two (2) work days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When HomeFirst denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See "How do I File an Appeal of an Action" section below on page 48 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 ten (10) days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

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

- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.
- If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How Do I File an Appeal of an Action?

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

How Do I Contact my Plan to File an Appeal?

We can be reached by calling 1-877-771-1119 or write to:

HomeFirst
6323 Seventh Avenue
Brooklyn, NY 11220
Attn: Appeals and Grievances 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 include a copy of your case file which includes medical records and other documents used to make

the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

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

Your services will continue until you withdraw the appeal, or until ten (10) days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See "State Fair Hearing" section below page 51) Although you may request a continuation of services while your appeal is under review, if the appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

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

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

You will also have the chance to look at any of your records that are part of the appeal review.

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

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires.
In some cases, you may request an "expedited" appeal. (See "Expedited Appeal Process" 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 seventy-two (72) hours.

In no event will the time for issuing our decision be more than seventy-two (72) hours after we receive your appeal. (The review period can be increased up to fourteen (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 two (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 one hundred twenty (120) calendar days after the date on the Final Adverse Determination Notice.

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

State Fair Hearings

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

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

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

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

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

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

- Online Request Form: **http://otda.ny.gov/oah/FHReq.asp**
- Mail a Printable Request Form:

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

- Fax a Printable Request Form: (518) 473-6735
- Request by Telephone:
  Standard Fair Hearing line: 1-800-342-3334
  Emergency Fair Hearing line: 1-800-205-0110
  TTY line – 711 (request that the operator call 1-877-502-6155)

Request in Person:

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

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 (4) months from the date we denied your appeal.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov
- Write the Department of Financial Services at:

New York City - Main Office
New York State Department
of Financial Services
One State Street
New York, NY 10004-1511

Additional DFS Contact Information:

You can also contact the New York State Department of Financial Services at:
NYS Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12210
1-800-342-3736

Contact the health plan at 1-877-891-6447 (TTY 711) if you need help filing an appeal.

Your external appeal will be decided within thirty (30) days. More time (up to five (5) work 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 (2) work 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 seventy-two (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."

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."

Participant Ombudsman

At this time, the Participant Ombudsman is the Independent Consumer Advocacy Network (ICAN), an independent network of consumer advocacy organizations. ICAN is available to answer long-term care member's questions regarding member rights, Medicare, Medicaid and Long Term Care Services. ICAN can also assist members with resolution of any issues related to access to care and with filing appeals and complaints.

ICAN Contact Information:

ICAN may be reached toll-free at 1-844-614-8800, TTY 711, or online at icannys.org.

DOH Contact Information

If you are not able to resolve your needs within the plan, you can also contact New York State Department of Health and file a complaint at any time at:
NYS Department of Health
Bureau of Managed Long Term Care
Suite 1620, One Commerce Plaza
99 Washington Avenue
Albany, NY 12210
1-866-712-7197

HomeFirst Member Bill of Rights

- 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, age, 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, place of origin or with regard to the rate the health plan will receive;
- 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 HomeFirst's network.

- You have the right to complain to the New York State Department of Health (see contact information on the previous page), the NYC Human Resources Administration or Local Department of Social Services; 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 appoint someone to speak for you about your care and treatment;
- You have the right to make advance directives and plans about your care.
- You have the right to seek assistance from the Participant Ombudsman program.

These rights are based on requirements found in PHL 4408, 10 NYCRR 98 1.14, 42 CFR 438.100 and Article 49 of NYS PHL.

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

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

Your Responsibilities

As with membership in any health care plan, you have certain rights and responsibilities when you join HomeFirst. You'll find a copy of the **Member Bill of Rights** on page 55 of this handbook. As a member, you also have some responsibilities.

These include:

- Receive all of your covered services from the HomeFirst Provider Network.
- Obtain authorization from HomeFirst prior to receiving services subject to Review (refer to page 35).
- Pay HomeFirst any Medicaid surplus that you may have as determined by the New York State Department of Health or the NYC Human Resources Administration.
- Call HomeFirst whenever you have a question regarding your membership or if you need assistance, (718) 759-4510, or toll-free at 1-877-771-1119.
- Tell HomeFirst when you plan to be out of town so we can help you arrange your services.
- Tell HomeFirst when you believe there is a need to change your plan of care.

We want HomeFirst to be the very best Managed Long Term Care plan 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 HomeFirst. Since New York State Medicaid pays HomeFirst, the New York State Department of Health will also be evaluating HomeFirst 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 HomeFirst provides, please call 1-877-771-1119 or write to:

HomeFirst
6323 Seventh Avenue
Brooklyn, NY 11220
Attn: Member Services

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

Membership Disenrollment

Voluntary Disenrollment

Should you choose to leave HomeFirst, please call the Member Services Department or your Care Management Team and tell them you wish to disenroll from HomeFirst. Your Care Management Team will work with you and NY Medicaid Choice to ensure you transition safely from our plan to the plan of your choice if you desire to continue to receive long term care services.

When you choose to end your membership, a disenrollment form will be provided to you. If you do not wish to fill it out and request to submit your request to disenroll orally, a HomeFirst representative can fill it out for you.

Completed forms should be submitted to:

HomeFirst
6323 Seventh Avenue
Brooklyn, NY 11220
Attn: Member Services

Your Care Management Team will discuss your decision with you and help you plan for your care following disenrollment. The date on which your disenrollment from HomeFirst is effective will be the first day of the month following the month in which the disenrollment is processed through eMedNY.

HomeFirst will forward your request for disenrollment to the LDSS or NY Medicaid Choice for processing. You will also receive an acknowledgement letter from HomeFirst, confirming your desire to disenroll from the plan.

The disenrollment date will be the last day of the month after LDSS or NY Medicaid Choice has processed the disenrollment and if further services have been arranged if required. Oral requests for disenrollment require the same amount of time to process as written requests. If a request is submitted after the twentieth (20th) of the month, you will be disenrolled by the first day of the next following month.

Should your discharge plans include a request for future services, the effective date of disenrollment is determined by the LDSS or NY Medicaid Choice, once your request is approved.

For transfers that you make between HomeFirst and another plan, HomeFirst will provide your care through the last day of the month and your new managed long term care plan will begin your care on the first day of the next month.

If you require long term care services and wish to leave HomeFirst, you must choose another plan with NY Medicaid Choice in order to continue to receive your services. You are no longer able to return to Medicaid Fee for Service through HRA or LDSS to receive your services.

Involuntary Disenrollment

If HomeFirst believes it is necessary to disenroll a member involuntarily, we must obtain the approval of the LDSS or NY Medicaid Choice. An eligible member will not be involuntarily disenrolled on the basis of health status. Members that are involuntarily disenrolled may have to be transferred to another plan to continue to receive personal care and long term care services. All members will be notified of their fair hearing rights by the LDSS or HRA.

HomeFirst must Initiate Involuntary Disenrollment within five (5) work days:

- If you no longer reside in the HomeFirst service area.
- If you are absent from the service area for more than thirty (30) consecutive days.
- If you are hospitalized or you enter an Office of Mental Health, Office for People with Developmental Disabilities or the Office of Alcohol and Substance Abuse Services residential program for forty-five (45) consecutive days or longer.
- If you are no longer eligible to receive Medicaid benefits.
- If you provide HomeFirst with false information, otherwise deceive HomeFirst, or engage in fraudulent conduct with respect

to any substantive aspect of his/her plan membership.

- 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 are assessed as no longer demonstrating a functional or clinical need for the authorization and delivery of any community-based long term care service on a monthly basis or, for non-dual eligible Members, in addition no longer meet the nursing home level of care as determined by the NYS designated reassessment tool Department of Health. A member whose sole service is identified as Social Day care must be disenrolled from the plan.
- An Enrollee who no longer requires and receives at least one CBLTCS in each calendar month must be disenrolled. HomeFirst will provide the LDSS or entity designated by the Department the results of its assessment and recommendations regarding disenrollment within five (5) work days of the assessment making such determination.
- If you are incarcerated.

HomeFirst may initiate involuntary disenrollment:

- If you or a member of your family or an informal caregiver engages in conduct or behavior that seriously impairs HomeFirsts ability to furnish services to either you or other members. HomeFirst must make and document reasonable efforts to resolve the problems presented by the individual. HomeFirst 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 fail to pay for or make arrangements satisfactory to Homefirst to pay the amount owed as a Medicaid surplus to HomeFirst within thirty (30) days after it becomes due, provided

that during that thirty (30) day period HomeFirst makes reasonable efforts to collect the amount. The Medicaid surplus amount is determined by HRA and/or your LDSS.

- If you are involuntarily disenrolled, HomeFirst will assist you to transfer to another managed long term care plan, Medicaid Managed Care plan (if eligible for Medicaid only) or alternate services.

HomeFirst Funding and Payment

When you enroll, HomeFirst receives a single monthly payment from Medicaid to provide all of the covered services listed on page 21. No premiums, co-payments, or deductibles will be charged to the member.

Payment of Network Providers by HomeFirst

All Network Providers are under contract with HomeFirst and are paid by HomeFirst 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 HomeFirst regardless of the amount of service needed by a member. This payment type is known as capitation.

HomeFirst's providers should never charge you a co-pay. If you receive a bill directly from a provider, do not pay it and call the Member Services Department at (718) 759-4510 or toll free at 877-771-1119, Monday to Friday, 8:30am to 5:00pm, and they will resolve the situation for you. For TTY/ TDD, call 711.

Surplus (Medicaid Surplus/ Spend Down or NAMI)

Surplus amounts, also referred to as "Spend down", or Net Available Monthly Income known as "NAMI," is the amount of income, Local Department of Social Services (LDSS), or the NYC Human Resource Administration (HRA) or entity designated by the Department may determine an individual is

required to pay on a monthly basis to meet Medicaid financial eligibility requirements to continue Medicaid coverage. Should LDSS, HRA or entity designated by the Department determine you owe a monthly surplus obligation, HomeFirst is required to bill you for the surplus charges that are determined. HomeFirst will be notified by LDSS, HRA or entity designated by the Department if the amount of your surplus obligation changes, so adjustments can be made accordingly. If necessary, your Care Management Team can discuss this process in detail with you.

Termination for Non-Payment

HomeFirst may initiate Involuntary Disenrollment if a member fails to pay any amount owed as a Medicaid surplus within thirty (30) days after such amount becomes due. HomeFirst 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 59 for a full explanation of "Involuntary Disenrollment").

Information HomeFirst Will Provide Upon Request

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

HomeFirst
6323 Seventh Avenue
Brooklyn, NY 11220

Simply indicate what documents you are requesting and we will mail them to you within ten (10) work days.

- A listing of names, work addresses, and official positions of board members, officers, controlling persons and owners or partners of HomeFirst.
- The policy & procedures to protect member's confidentiality of medical records and other information.
- A written description of HomeFirst'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 HomeFirst.
- Information on the structure and operation of HomeFirst.
- A copy of the most recent annual certified financial statement of HomeFirst, including a balance sheet and summary of receipts and disbursements prepared by a Certified Public Accountant (CPA).

HomeFirst Notice of Privacy Practices

EFFECTIVE DATE: 9/1/2020

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

This notice summarizes the privacy practices of HomeFirst (the "Plan"), its workforce, medical staff, and other health professionals. We may share protected health information ("PHI" or "Health Information") about you with each other for purposes described in this notice, including for the Plan's administrative activities.

The Plan is committed to safeguarding the privacy of our members' PHI. PHI is information which: (1) identifies you (or can reasonably be used to identify you); and (2) relates to your physical or mental health or condition, the provision of health care to you or the payment for that care.

Our Obligations

- We are required by law to maintain the privacy and security of your PHI.
- 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.

How We May Use and Disclose Health Information

The following categories describe different ways that we may use and disclose Health Information. Not every use or disclosure permitted in a category is listed below, but the categories provide examples of the uses and disclosures permitted by law.

Payment. We may use and disclose Health Information process and pay claims submitted to us by your or by physicians, hospitals and other health care providers for services provided to you. For example, other payment purposes may include the use of Health Information to determine eligibility for benefits, coordination of benefits, collection of premiums, and medical necessity. We may also share your information with another health plan that provides or has provided coverage to you for payment purposes or for detecting or preventing health care fraud and abuse.

Health Care Operations. We may use and disclose Health Information for health care operations, which are administrative activities involved in operating the Plan. For example, we may use Health Information to operate and manage our business activities related to providing and managing your health care coverage or resolving grievances.

Treatment. We may disclose your Health Information with your health care provider (pharmacies, physicians, hospitals, etc.) to help them provide care to you. For example, if you are in the hospital, we may disclose information sent to us by your physician.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose Health Information to contact you as a reminder that you have an appointment/visit with us or your health care provider. We also may use and disclose Health Information to tell you about treatment options, alternatives, health-related benefits, or services that may be of interest to you.

By providing us with certain information, you expressly agree that the Plan and its business associates can use certain information (such as your home/work/cellular telephone number and your email), to contact you about various matters, such as follow up appointments, collection of amounts owed and other operational matters. You agree you may be contacted through the information you have provided and by use of pre-recorded/artificial voice messages and use of an automatic/predictive dialing system.

Individuals Involved in Your Care or Payment for Your Care. We may disclose Health Information to a person, such as a family member or friend, who is involved in your medical care or helps pay for your care. We also may notify such individuals about your location or general condition, or disclose such information to an entity assisting in a disaster relief effort. In these cases, we will only share the Health Information that is directly relevant to the person's involvement in your health care or payment related to your health care.

Personal Representatives. We may disclose your Health Information to your personal representative, if any. A personal representative has legal authority to act on your behalf in making decisions related to your health care or care payment. For example, we may disclose your Health Information to a durable power of attorney or legal guardian.

Research. Under certain circumstances, as an organization that performs research, we may use and disclose Health Information for research purposes. For example, a research project may involve comparing the health and recovery of all members who received one medication or treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. This process evaluates a proposed research project and its use of Health Information to balance the benefits of research with the need for privacy of Health Information. We also may permit researchers to

look at records to help them identify members who may be included in their research project or for other similar purposes.

Fundraising Activities. We may use or disclose your demographic information (e.g., name, address, telephone numbers and other contact information), the dates of health care provided to you, your health care status, the department and physician(s) who provided you services, and your treatment outcome information in contacting you in an effort to raise funds in support of the Plan and other non-profit entities with whom we are conducting a joint fundraising project. We may also disclose your Health Information to a related foundation or to our business associates so that they may contact you to raise funds for us. If we do use or disclose your Health Information for fundraising purposes, you will be informed of your rights to opt-out of receiving further fundraising communications.

Special Circumstances

In addition to the above, we may use and disclose Health Information in the following special circumstances. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent or lessen a serious threat to your health or safety, or the health or safety of the public or another person. Any disclosure, however, will be to someone who we believe may be able to help prevent the threat.

Business Associates. We may disclose Health Information to the business associates that we engage to provide services on our behalf if the information is needed for such services. For example, we may use another company to perform billing services on our behalf. Our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them.

Organ and Tissue Donation. If you are an organ donor, we may release Health Information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may disclose Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; track certain products and monitor their use and effectiveness; if authorized by law, notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and conduct medical surveillance of our facilities in certain limited circumstances concerning workplace illness or injury. We also may

release Health Information to an appropriate government authority if we believe a member has been the victim of abuse, neglect or domestic violence; however, we will only release this information if the member agrees or when we are required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure of our facilities and providers. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Legal Actions. We may disclose Health Information in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in a legal action, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official as follows: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about evidence of criminal conduct on our premises; and (6) in emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. In some circumstances this may be necessary, for example, to determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates or Individuals in Custody. In the case of inmates of a correctional institution or that are under the custody of a law enforcement official, we may release Health Information to the appropriate correctional institution or law enforcement official. This release would be made only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Additional Restrictions on Use and Disclosure: Some kinds of Health Information including, but not limited to, information related to alcohol and drug abuse, mental health treatment, genetic, and confidential HIV related information require written authorization prior to disclosure and are subject to separate special privacy protections under the laws of the State of New York or other federal laws, so that portions of this notice may not apply.

In the case of genetic information, we will not use or share your genetic information for underwriting purposes.

If a use or sharing of Health Information described above in this Notice is prohibited or otherwise limited by other laws that apply to us, our policy is to meet the requirements of the more stringent law.

Uses and Disclosure Requiring Written Authorization

In situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization:

1) for marketing purposes that are unrelated to your benefit plan,

2) before disclosing any psychotherapy notes,

3) related to the sale of your Health Information, and

4) for other reasons as required by law. For example, state law further requires us to ask for your written authorization before using or disclosing information relating to HIV/AIDS, substance abuse, or mental health information.

You have the right to revoke any such authorizations, except in limited circumstance such as if we have taken action in reliance on your authorization.

Your Rights

You have the following rights, subject to certain limitations, regarding Health Information that we maintain about you – all requests must be made IN WRITING:

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information that we use or disclose for treatment, payment, or health care operations. You have the right to request a limit on the Health Information that we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, and we may say "no" if it would affect your care. If we agree to your request, we will comply with your request unless we need to use the information in certain emergency treatment situations.

Right to Request Confidential Communications. If you clearly state that the disclosure of all or part of your Health Information could endanger you, you have the right to request that we communicate with you in a certain manner or at a certain location other than through our usual means of communication. For example, you can ask that we contact you only by sending mail to a P.O. Box rather than your home address or you may wish to receive calls at an alternate phone number. Your request must be in writing and specify how or where you wish to be contacted.

Right to Inspect and Copy. You have the right to inspect and receive a copy of your Health Information that we have in our records that is used to make decisions about your enrollment, care or payment for your care, including information kept in an electronic health record. If you want to review or receive a copy of these records, you must make the request in writing. We may charge you a reasonable fee for the cost of copying and mailing the records. We may deny your access to certain information. If we do so, we will give you the reason in writing. We will also explain how you may appeal the decision.

Please note that there may be a charge for paper or electronic copies of your records.

Right to Amend. If you feel that Health Information that we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained by or for us. You must tell us the reason for your request.

We may deny your request for an amendment to your record. We may do this if your request is not in writing or does not include a reason to support the request. We also may deny your request if you ask us to amend information that:

- we did not create;
- is not part of the records used to make decisions about you;
- is not part of the information which you are permitted to inspect and to receive a copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of Health Information that we made for a six-year period. The accounting will only include disclosures that were not made for treatment, payment, health care operations, to you, pursuant to authorization, or for "special circumstances" as outlined in this notice. You are entitled to one Accounting of Disclosures at no charge. Subsequent requests within a twelve-month period may be subject to a fee.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electron¬ically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at any time from the Plan's website: https://elderplan.org/

How to Exercise Your Rights

To exercise any of your rights described in this notice, other than to obtain a paper copy of this notice, you must contact the Plan.

HomeFirst
Attention: Regulatory Compliance
6323 Seventh Avenue
Brooklyn, NY 11220
1-800-353-3765
TTY: 711

Breach Notification

We will keep your Health Information private and secure as required by law. If there is a breach (as defined by law) of any of your Health Information, then we will notify you within 60 days following the discovery of the breach, unless a delay in notification is requested by law enforcement.

Electronic Health Information Exchange

The Plan may participate in various systems of electronic exchange of Health Information with other healthcare providers, health information exchange networks and health plans. Your Health Information maintained by the Plan may be accessed by other providers, health information exchange networks and health plans for the purposes of treatment, payment, or health care operations. In addition, the Plan may access your Health Information maintained by other providers, health information exchange networks and health plans for treatment, payment or health care operation purposes but only with your consent.

Changes to this Notice

We reserve the right to change this notice and to make the revised or changed notice effective for Health Information that we already have as well as any information we receive in the future. The new notice will be available upon request, on our website, and we will mail a copy to you. The notice will contain the effective date on the first page, in the top left-hand corner.

Complaints and Questions

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with us, contact our Privacy Office at the address listed below. All complaints must be made in writing.

HomeFirst
Attention: Regulatory Compliance
6323 Seventh Avenue
Brooklyn, NY 11220

You may also 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 if you exercise your right to file a complaint.

If you have any questions about this notice, please contact 1-855-395-9169 (TTY: 711)

elderplan
homefirst®
a member of MJHS Health System

6323 Seventh Avenue
Brooklyn, NY 11220

1-877-771-1119

Monday – Friday
8:30 a.m. – 5:00 p.m

www.homefirst.org