

*choice*SM PROGRAM

Choosing Homecare Over Institutionalized Care Environment



Serving the following counties: Brevard, Broward, Citrus, Dade, Hernando, Hillsborough, Indian River, Manatee, Martin, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, and St. Lucie



Neighborly
care network

(a nonprofit organization serving Florida's seniors since 1966)

Member Handbook



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*choice*SM Nursing Home Diversion Plan

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Member Handbook

toll free 1-888-5-choice (1-888-524-6423) | *web* www.Neighborly.org
13945 EVERGREEN AVENUE | CLEARWATER, FL 33762

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Important Information

Your *choice* Program Identification Number: _____

Your Primary Care Physician: _____

Primary Care Physician Phone: _____

Your Pharmacy: _____

Pharmacy Phone: _____

Your Care Manager: _____

Care Manager Phone: _____

Neighborly Customer Service Phone: 1-888-5choice
(1-888-524-6423)

Agency for Health Care Administration
Consumer Hotline: 1-888-419-3456

Florida Elder Abuse Hotline: 1-800-96ABUSE
1-800-962-2873
1-800-453-5145 (TTY)

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Welcome

Thank you for choosing Neighborhood Care Network to be your new *choice* Nursing Home Diversion Plan agency. Neighborhood Care Network has provided care management, personal care, and other services to thousands of elders since 1966.

This handbook describes the *choice* care plan and should help you decide how to best get the help you need. Your care manager will explain the plan in detail during your first meeting. If you have questions, please call your care manager or our customer service line. Both phone numbers are written on the inside cover of this book.

We look forward to helping you manage your care needs. Our goal is to make sure you get the help you need to live safely in your home for many years to come.

Best Wishes,

A handwritten signature in cursive script that reads "Debra Shade". The signature is written in black ink and is positioned above the printed name and title.


Debra Shade, CPA, CRM, MBA
President/CEO

Your Plan

The state of Florida funds Neighborly Care Network's *choice* Nursing Home Diversion Plan. Two state agencies, the Department of Elder Affairs and the Agency for Health Care Administration, have set up the rules for us to follow as we provide you with service. Our goal is to see that you get the help you need to live safely in your home for as long as possible. Key plan benefits include:

Member ID Card

You will receive an identification (ID) card from the *choice* Program. The card will include your name, member number, effective date, member services number, and claims address. When you receive medical services, show your *choice* Program ID card with your Medicare insurance card to medical providers. Your Medicare insurance provides primary coverage, and your *choice* Program benefit provides coverage secondary to Medicare.

	Neighborly care network	<i>choice</i> SM PROGRAM
<hr/> Member Name:		
Member ID #:		
Effective Date:		
<hr/> ALL IN-PATIENT REQUIRES A PRIOR AUTHORIZATION: 1-888-524-6423		
<i>Choosing Homecare Over Institutionalized Care Environment</i>		

For emergencies: Call 911 or go to the nearest emergency room.
 Member Services: 1-888-5-choice (1-888-524-6423)

TO ALL MEDICAL PROVIDERS:

Neighborly Care Network is a secondary Medicaid insurance after Medicare.
 Please send claims and Medicare EOB to:

Claims Address: Neighborly Care Network *choice* Program
 13945 Evergreen Avenue
 Clearwater, FL 33762

Benefits and services are provided secondary to Medicare and are subject to terms of applicable contract, including limitations and exclusions. This card does not prove membership nor guarantee coverage; prior AUTHORIZATION is required.

Your Member ID Card is for your use only. It may not be used by anyone else. Please report lost or stolen cards right away by calling 1-888-5choice (1-888-524-6423).

Care Management

The Care Management team within the *choice* Program is dedicated to helping you. You will be assigned a care manager. He/she will make a care plan based on your health needs, home situation, and support of family and friends. Your care manager will assess your needs and plan with you, your caregiver and doctor to meet those needs. Your care manager will review your services with you often to make sure your needs are met.

All Neighborhood Care Network *choice* Program members receive Care Management services.

Your care manager is your contact for services. The process begins when he/she meets with you. It continues as follows:

- Medicaid application process
- Needs review
- Care Plan development
- Services arrangement
- Review and rechecking your needs
- Care Plan changes as needed by changes in your health and situation

These services are arranged by your care manager. His/her name and phone number are on the inside of your member packet. Get to know your care manager. Talk with him/her about your needs. Ask questions. We want you to get the best care possible.

Please notify your care manager if you need special communication services. Oral interpretation services and other communication systems are available free of charge.

Coordination of Care

Your care manager will arrange for services provided by the *choice* Program. This is the case whether you are at home, in a hospital or rehabilitation center, or in a nursing home. We want you to contact your care manager whenever your needs change. It is important to contact your care manager when you are admitted to a hospital, you move, or your health needs change.

Contact Your Care Manager When:

- Your address or telephone number changes
- You obtain other health insurance
- You are admitted or discharged to/from a hospital
- You are admitted or discharged to/from a rehabilitation center
- You are enrolled in Hospice

Access and Limitations of Services

Covered services must be authorized by the *choice* Program. Services are limited to those specified in the contract between the *choice* Program and the Department of Elder Affairs. There are two types of services: Medical Services and Home and Community-based services.

Medical Services are covered by the *choice* Program in accordance with Medicaid guidelines. Your primary coverage will continue to be your Medicare insurance.

Home and Community-based Services are provided according to your care plan with the *choice* Program. Your care manager will develop your care plan based on your specific needs, health status, environment, and social supports. Your care manager will talk with you, your caregiver, and other involved persons to choose the right care plan. In accordance with Medicaid guidelines, services in your care plan will be provided in the best place possible.

Medical Services

Your primary health insurance will continue to be your Medicare insurance. The *choice* Program provides medical services that are not covered by Medicare or other insurance. The *choice* Program provides secondary coverage per Medicaid guidelines. This includes but is not limited to the following services:

- Physician Services
- Inpatient Hospitalization
- Outpatient Hospital/Emergency Medical Services
- Lab and X-Rays
- Home Health Nurse
- Medical Equipment and Supplies
- Mental Health Services
- Hospice Services

We do not require that you change your primary care doctor or any other medical specialists you see.

Dental Benefits

The *choice* Program provides dental benefits to include medically necessary emergency dental care. This includes the following:

- Emergency oral examination
- Necessary radiographs
- Extractions
- Incision and drainage of abscess
- Full or partial dentures

Dentures are limited to one set of full or partial dentures a lifetime. Payments can be made to the dental provider or given to you. Please call your care manager for a list of Medicaid dentists.

Hearing Benefits

The *choice* Program provides hearing benefits per Medicaid guidelines. This includes a hearing test and hearing aids within Medicaid guidelines. Payments can be made to the provider or given to you. Please call your care manager for hearing providers.

Vision Benefits

The *choice* Program provides vision benefits per Medicaid guidelines. This includes vision testing, eyeglasses, and eyeglass repair. Payments can be made to the provider directly or given to you. Please call your care manager for help getting a Medicaid vision provider.

Prescription Medication

Most of your prescription medication will be covered by your Medicare Part D plan. Those medications not covered under

Medicare Part D may be covered under Medicaid. The *choice* Program will cover these limited Medicaid covered prescription drugs. Please call your care manager for information about coverage of certain medications.

Prescription Co-Pay Reimbursement

For prescriptions covered by your Medicare Part D plan, the *choice* Program will give you up to \$5 per Medicare Part D co-payment. Give your care manager your pharmacy statement or prescription receipt with the name of the medication, your name and co-payment amount. Give this to him/her within 4 months of the date of service. You will be given up to \$5 for each co-payment. Your pharmacy can bill us directly for these amounts.

Over-the-Counter Medication

The *choice* Program will give you up to \$30 per month for over-the-counter items. This includes over-the-counter medication and vitamins, as well as first aid and other personal care items. Give your receipts to your care manager within 4 months of the date of service.

Home and Community Services

Adult Companion Service: Non-medical care, includes supervision and socialization.

Adult Day Care: An outpatient center that provides social and recreational services in a home-like environment. It includes supervision and help from staff at the center. A meal is provided.

Assisted Living: Provided at an Assisted Living Facility and may include personal care, homemaker, companion or chore services. It may also include medication management or social and recreational activities. This does not include the cost of room and board while living at the facility.

Chore Service: Doing heavy chores in the home to maintain a clean, sanitary and safe living environment. This service is usually provided once a year.

Consumable Medical Supplies: Disposable supplies used by you, your caregiver or service staff that are needed for your care.

Environmental Adaptation Services: Changes to your home that are needed for your health, welfare and safety. Without these changes, you would need institutionalization.

Escort Service: An aide will take you to and from a medical appointment.

Family Training: Training and counseling services for your family members. This is to teach and update them about treatment routines and using equipment to stay safe in the home.

Financial Assessment/Risk Reduction Service: Assessment and guidance for your financial matters.

Home Delivered Meals: Hot or frozen nutritionally balanced meals served in the home. This is for members who cannot prepare meals for themselves.

Homemaker Service: An aide will visit your home to provide general household services. These include light housekeeping, meal preparation, and laundry.

Nutritional Assessment/Risk Reduction Services: Assessment of nutritional risk. Guidance is provided based on current dietary intake, medications and health conditions.

Nursing Facility: Nursing facility services are available for members who need such services. They will be in nursing homes contracted with the *choice* Program. You will have patient financial responsibility, as determined by the Department of Children and Families.

Personal Care Service: Help from an aide with activities of daily living. This includes bathing, dressing, eating and walking. It does not include medical service.

Personal Emergency Response System: An electronic device that allows members at high risk to get help in an emergency. This includes installation and monthly monitoring service.

At Home Respite: An aide will visit your home. He/she will provide personal care, homemaker or supervision service to help relieve your caregiver.

In-Facility Respite: Short-term care at a facility to provide caregiver relief. This is usually limited to 1-2 weeks per year.

Occupational, Physical & Speech Therapy

These services are covered in part by Medicare.

Health Promotion:

As a member of the *choice* plan, you will be taught how to stay healthy and safe. In fact, your care plan made just for you will include a section on healthy living. Important health activities include:

- good eating habits
- regular exercise (up to your ability)
- regular visits to your primary care doctor
- regular screening for breast, cervical, prostate, colon, and skin cancers; diabetes; cardiovascular health; and osteoporosis
- medication management, including over-the-counter and prescribed medicines
- attention to mental health and changes your doctor should know about
- flu shots (if your primary doctor recommends this)
- regular dental exams
- regular eye exams

If you want more information on any of these, please call 1-888-5-choice (1-888-524-6423).

Post-Stabilization Services:

Services covered by the *choice* Program may be needed after you leave the hospital or rehab following an emergency medical condition. Your treating doctor will help to determine when you have been stabilized. He/she will suggest services needed in your plan of care. Prior authorization is not needed for post-stabilization services.

Out-of-Network Providers:

You should use participating providers for services covered by the *choice* Program. The *choice* Program is not liable for payment of services obtained from unauthorized providers.

Enrollment

To be eligible for the *choice* Program, you must:

- Be 65 years of age or older
- Be enrolled in Medicare A & B
- Live in the *choice* Program service area
- Meet the clinical eligibility requirements as determined by CARES
- Meet Medicaid financial eligibility requirements as determined by the Department of Children and Families

Your enrollment in the *choice* Program is contingent on these eligibility requirements. You may lose your Medicaid eligibility while you are enrolled in the *choice* Program, for reasons such as missing annual recertification with Medicaid. Should you lose your Medicaid, your membership eligibility with the *choice* Program will change. You will have 60 days to become reinstated with Medicaid. Then you will be automatically reinstated in the *choice* Program.

Neighborhood Care Network does not discriminate against people eligible to enroll on the basis of race, color or national origin. We will not use any policy or practice that has the effect of discriminating on any basis, including but not limited to, race, color or national origin.

Disenrollment

Voluntary Disenrollment:

In order to end your membership with the *choice* Program, you must complete a disenrollment form. To get a disenrollment form, contact your care manager, or call or write to:

Neighborly Care Network
choice Program
13945 Evergreen Avenue
Clearwater, FL 33762
1-888-5-choice (1-888-524-6423)

We will send you a disenrollment form within 48 hours of your request. We will assist you with completing the form if needed. You can complete the disenrollment form at any time. However, it is not effective until the State's fiscal agent processes the disenrollment. If voluntary disenrollment is requested before the State's fiscal agent's monthly processing deadline, disenrollment will be effective the first of the next month. If voluntary disenrollment is requested after the fiscal agent's monthly processing deadline, disenrollment will take place the first of the second calendar month following the month the request was received.

Involuntary Disenrollment:

In some cases, the *choice* Program will process disenrollment. This disenrollment can occur without your completing the disenrollment form. This occurs in the following situations:

- Member's death
- Member loses Medicaid eligibility
- Member becomes ineligible for services under the plan
- Member moves outside *choice* Program service area
- Unlawful use of the member's Medicaid ID card
- Incarceration
- Non-cooperation with the Care Plan, subject to Department of Elder Affairs approval
- Disruptive, unruly, abusive or uncooperative behavior. This is to the extent that it interferes with our ability to provide services to you or other members, subject to Department of Elder Affairs approval.

Privacy Practices

You will receive a personal copy of the Privacy Practices.

Member Rights

We want you to know all of your rights as a member of the *choice* plan. They are listed below. If you do not understand one or more of them, please ask your care manager to explain them. You can also call 1-888-5-choice (1-888-524-6423). You have the right to:

- receive proper and skilled care. This means that you should get the service you most need from well-trained people.

- choose the home care service providers you want from our Provider Network.
- get what you need to either:
 - give informed consent before a procedure or treatment, or
 - refuse part or all treatment within the law.

You have the right to understand the risks and possible problems resulting from either choice.

- be treated with dignity and respect by everyone from the Neighborly *choice* plan. All providers within the Network must also treat you with respect. This is true no matter what kind of lifestyle, cultural and/or religious and spiritual beliefs you have.
- your own care plan and a teaching plan based on your needs.
- take part in all aspects of your care. This includes forming your care plan and choosing providers. It also includes a change to your care plan or chosen providers. You have the right to be told about a change before it is made.
- receive a second opinion, at no cost to you, on the course of medical treatment, if so desired.
- tell us if you need interpretation services for foreign languages or if you need hearing impaired (TTY/TDD) communication services. These services are available at no cost.

- ask for a copy of your care plan. If you want one, call your care manager or Member Services.
- tell us if you don't like something. You can suggest changes in service or staff without fear of being treated unfairly.
- look at your personal health information and correct it if you feel that it is wrong.
- have your personal health information kept private. Only people who are legally allowed, or who have a medical need to know, will see it.
- get a copy of a bill that lists all items and details of the charge.
- tell us your likes and dislikes about the plan. You can call 1-888-5-choice (1-888-524-6423).
- call Florida's toll-free Home Health Agency Consumer Hotline if you have a problem or question about Neighborhood Care Network or any home health agency. The number is 1-888-419-3456, ext. 1. Call between 8 a.m. and 5 p.m., Monday through Friday, except state and federal holidays.
- call the Florida Central Abuse Registry if you are being abused or neglected, or if you know someone who is. It is available 24 hours each day at 1-800-96-Abuse (1-800-962-2873).

- call our Member Services at 1-888-5-choice (1-888-524-6423) and ask for any of the following:
 - a report of our service authorization and referral process
 - a report of the process we use to see whether services are medically necessary
 - a report of our quality assurance program
 - a report of our approval process for other providers
 - our policies and procedures about prescribed drugs
 - our policies and procedures about keeping members' medical records private
 - our quality performance indicators, including satisfaction data
 - our policies and procedures about the credentialing of providers
 - a report of our member satisfaction

Member Responsibilities

As a member of the *choice* plan, you must follow the rules listed below. If you do not understand one or more of them, please ask your care manager to explain them. You can also call 1-888-5-choice (1-888-524-6423).

- You must tell us as much as you know about your past and present medical history. You must tell us about a sudden change in your condition. You must tell us your knowledge of the service plan.
- You must follow treatments and activities suggested by:
 - your doctor
 - your care manager

- any other health care person who helps create your plan of care
- If you do not use the treatment or do not follow your doctor's orders, you are responsible for what happens.
- You must obey what the agency says and anything they add to the rules later on.
- You must be respectful of our employees. Your caregiver, your legal agent, and other friends must also be respectful of our staff. This includes people you talk with on the phone. It includes people who provide service to you at home or in another setting.
- You must tell your care manager, as soon as possible, if you cannot go to a planned visit. Except in an emergency, let us know at least 24 hours before the planned visit.
- You must tell us any problems you have with the service provided by any agency or person within our network. You may do this by talking with your care manager or by calling Member Services.
- You must give us the right financial and insurance information.
- You must pay for your health care as soon as possible.
- When you are in any health care place within our network, you must behave according to their rules.

Complaints and Grievances

You, your family and your legal agent have the right to ask questions about your care, services or benefits. You have the right to tell us your concerns. You can also help us fix them. You should call us as soon as you can when such questions or concerns come up. Besides helping you, this will help us to learn more about how to improve our services for all *choice* plan members.

Your services will continue during an appeal of a suspended authorization, but you may be financially responsible for these services in the event of an adverse ruling.

What to do if you have a complaint:

Call, write, or tell us in person. Your complaint tells us that you are not happy with the *choice* plan care or benefits.

If you have a concern about your care or benefits, please call Member Services. The number is 1-888-5-choice (1-888-524-6423). We answer that phone line 24 hours a day, 7 days a week. We will try to decide what to do about your problem within five (5) working days.

What to do if you want to file a formal grievance:

This must be written and signed. Someone from Member Services can help you write it. You may also fill out a formal form for this purpose. If you want to use a form, call Member Services and ask for one. We will send it within three (3) working

IMPORTANT: Your initial grievance must be filed within one year after the date the grievance event occurred.

days. They can also help you fill out the form if needed. Another provider may also send a formal grievance for you. Please send all complaints and grievances to:

Neighborly Care Network *choice* Plan
Attention: Grievance Coordinator
13945 Evergreen Avenue
Clearwater, FL 33762
Phone: 1-888-5-choice (1-888-524-6423)

If we have not handled things the way that you want, you can request a Medicaid fair hearing. You can do this at any time during the process. You can reach them at the address below:

Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard
Building 5, Room 203
Tallahassee, FL 32399-0700

Regardless of your contact with Medicaid representatives, Neighborly Care Network will review your complaint.

What happens after you file a formal grievance:

We will write to you within five (5) working days. We will tell you when Member Services plans to review it. We will also review information from other providers and other *choice* plan staff. You will have a chance to meet with the person at our offices, or at a place that is convenient for you. You will meet with them before a decision is made.

We will take care of your grievance within 60 days from the date we receive it. If we need to know more from another

agency or provider, it may take longer. In that case, we will decide within no more than 90 days from the date we receive it. Within either 60 days or 90 days, as described above, we will write to you about our decision.

How to handle an unresolved grievance:

You may not be happy with the first decision. You then have the right to appeal and to ask for an internal review panel. It will be made up of people who did not take part in the first review. They will also be skilled in judging your problem. The Plan will

A request for review by an internal review panel must be made within 30 days of the postmark date on the decision letter.

resolve each appeal as expeditiously as the member's health requires, but not to exceed forty-five (45) days. You can also meet with the Committee members in person to discuss your concerns and problems.

IMPORTANT: This request must be made within 30 days of the date the Post Office stamped the decision letter.

The internal review panel will have the right to make Neighborly obey the final decision.

If you need a faster grievance review:

You, your caregiver or your legal agent may request a faster review. You might want this when you believe that putting it off could seriously threaten your life or health status. You may ask for this verbally or in writing. Make your request to the Neighborly Care Network Member Services Department.

Give us all information we need to make a decision as fast as possible. Also, ask your primary care doctor, or other providers involved in the request, to send us the needed information from their records. They can send it by phone, fax, or in some other quick way. We will help you get this if needed.

Your service will go on during our review. Pending a decision, you will get service without additional cost or liability to you. It will go on until you are formally told, in writing, about our decision. This notice will occur within 72 hours [3 days] from the time we get your request.

Requesting a Medicaid Fair Hearing:

The Department of Children and Families decides your Medicaid acceptance. You can request a hearing if you think that their action, intended action or failure to act would keep you (or your family) from receiving Financial Help, Medical Help, Social Services, or Food Stamp Program Benefits. You can also ask for a fair hearing if their action, intended action or failure to act causes an "unreasonable" delay in your getting such help or service. You may request a Medicaid Fair Hearing within 90 days of the date of the notice of action.

If you receive any denials from Neighborhood Care Network, you can also request a review/hearing through the Medicaid Fair Hearing Process. Services will continue upon appeal of a suspended authorization; however, in case of an adverse ruling, the enrollee may be responsible for paying for those services.

If you want to ask for one of these hearings, contact:

Department of Children and Families
Office of Public Assistance Appeals Hearings
1317 Winewood Boulevard
Building 5, Room 203
Tallahassee, Florida 32399
1-850-488-1429 (This is not a statewide toll-free number.)

Advance Directives

Who has the right to make your health care decisions?

You do, if you can make and communicate your health care decisions. This includes the right to have or not have medical or surgical treatment. It includes planning and directing the type of health care you get later on if you can no longer express your wishes. You can do this by making an Advance Directive.

What is an Advance Directive?

We cannot plan when or how we will die. However, we can make sure that our wishes are carried out at the end-of-life. You can do this with a written or verbal statement. This statement is witnessed before serious illness or injury. It explains how you want medical decisions to be made.

Two forms of this are:

Living Will: This generally states the kind of medical care you

want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. Florida law provides a suggested form for this. You may use it or some other form.

Health Care Surrogate Designation: This is a signed, dated, and witnessed paper. It names another person who can make medical decisions for you if you become unable to make them for yourself. This may be a spouse, child, sibling or close friend. You can include instructions about any treatment you want or do not want. Florida law provides a suggested form for this. You may use it or some other form. Also, you may wish to name a second person in case your first choice is not available.

You want to be sure your wishes will be understood and followed. So you may wish to speak to a lawyer or doctor to make sure you have filled out the forms clearly.

What is a Durable Power of Attorney?

This is a document that can hand over the authority to make health, financial and/or legal decisions on your behalf. It goes into effect when you cannot speak for yourself.

This person may also serve as your health care surrogate designee. If this is your choice, the documents must spell out that health care decisions are included under their authority. This is generally called a durable power of attorney for health care.

What is the difference between a Living Will and a Health Care Surrogate Designation?

A living will goes into effect only when you are near death or in a vegetative state. You have no awareness of what is going on. It deals only with the use or non-use of things that will lengthen your life.

A health care surrogate designation also goes into effect when you can no longer make health care decisions. However, you do not have to be close to death or in a vegetative state. It allows another person to speak for you and make health care decisions that are not limited to artificial life support. The type of decisions this person can make depends upon how much authority you give when you fill out the form.

Should I have both?

It is best to have both. You may combine them into a single document. It would describe treatment choices in many situations. It would name someone to make decisions for you if you cannot make or express them yourself. If you have two separate documents, you should make sure they agree with each other. If they do not, a health care provider will follow the instructions of a health care surrogate, rather than instructions in the living will.

What if I change my mind?

You can cancel or replace either of these at any time. The different ways you can do this are explained on the forms you fill out when you make a living will or appoint a health care surrogate.

Does my health care provider have to follow my Advance Directives?

Some health care providers and doctors may have policies or beliefs that keep them from carrying out your wishes. It is important to discuss them with these people. This will also tell you if they will carry them out. If they will not, you may want to choose another health care provider.

For additional information concerning Advance Directives and Florida-specific guidelines and laws, call Florida's Home Health Agency Hotline. The number is (1-888-419-3456).