

## **WELCOME TO [INSERT PLAN NAME] MANAGED LONG TERM CARE PLAN**

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

This handbook tells you about the added benefits [Insert Plan Name] covers since you are enrolled in the plan. It also tells you how to request a service, file a complaint, or disenroll from [Insert Plan Name]. Please keep this handbook as a reference, it includes important information regarding [Insert Plan Name] and the advantages of our plan. You need this handbook to learn what services are covered and how to get these services.

### **HELP FROM MEMBER SERVICES**

You can call us at anytime, 24 hours a day seven days a week, at the Member Services number below.

There is someone to help you at Member Services:

Monday through Friday

Insert Plan Member Services Hours

Call [Insert Plan Member Services Toll-free Number; Also Include the TTY number.]

If you need help at other times, call us at

[Insert an off-hours Number if different from the regular number.]

**Please indicate how members can receive information in another language, hearing impaired or vision problems**

### **ELIGIBILITY FOR ENROLLMENT IN THE MLTC PLAN**

The MLTC plan is for people who have Medicaid. You are eligible to join the MLTC plan if you:

- 1) Are age **[18 or 21]** and older,
- 2) Reside in the plan's service area which is **list service area**,
- 3) Have Medicaid,
- 4) Have Medicaid only **or are aged 18-20 with both Medicaid and Medicare and are eligible for nursing home level of care, [the highlighted section can be removed if plan's age begins at 21]**
- 5) Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, **and**
- 6) Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the MLTC Plan for a continuous period of more than 120 days from the date of enrollment:
  - a. Nursing services in the home
  - b. Therapies in the home

- c. Home health aide services
- d. Personal care services in the home
- e. Adult day health care,
- f. Private duty nursing; or
- g. Consumer Directed Personal Assistance Services

The coverage explained in this Handbook becomes effective on the date of your enrollment in [Insert Plan Name]-MLTC plan. Enrollment in the MLTC plan is voluntary.

## **NEW YORK INDEPENDENT ASSESSOR - INITIAL ASSESSMENT PROCESS**

**Effective May 16, 2022**, the Conflict Free Evaluation and Enrollment Center (CFEEC) is now known as the New York Independent Assessor (NYIA). The NYIA will manage the initial assessment process. NYIA will start the expedited initial assessments at a later date. The initial assessment process includes completing the:

- **Community Health Assessment (CHA):** The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a Managed Long Term Care plan.
- **Clinical appointment and Practitioner Order (PO):** The PO documents your clinical appointment and indicates that you:
  - have a need for help with daily activities, **and**
  - that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

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

[Insert Plan Name] will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIA Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care, and any other medical documentation. If more information is needed, someone on the panel may examine you or discuss your needs with you. The IRP will make a recommendation to [Insert Plan name] about whether the plan of care meets your needs.

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

**Plans, please insert here a description of your plan's: enrollment process, withdrawal of the enrollment application, denial of enrollment process, and development of an initial plan of care.**

## **Plan Member (ID)Card**

You will receive your [Insert Plan Name] identification (ID) card within XX days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your ID card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Member Services at [Insert Plan Number]

## **SERVICES COVERED BY THE [INSERT PLAN NAME] MLTC PLAN**

### **Care Management Services**

As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a health care professional – usually a nurse or a social worker. Your care manager will work with you and your doctor to decide the services you need and develop a care plan. Your care manager will also arrange appointments for any services you need and arrange for transportation to those services. [Insert plan specific procedures for the member to request care management and any plan specific care management features including credentials of the care manager, home visits, development of your Plan of Care (POC), etc. Please include the process and procedures for obtaining after hours care.]

### **Additional Covered Services**

Because you have Medicaid and qualify for MLTC, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in [Insert Plan Name] network. If you cannot find a provider in our plan, [insert procedures for member to request medically necessary services from an out of network provider when the service is included in the Contractor's Benefit Package and is determined by the Contractor as solely covered by Medicaid and is not available from an in-network provider].

[Please define and describe the process to access each of the services below, indicating if prior approval or referral is needed]

- **Outpatient Rehabilitation**
- **Personal Care** (such as assistance with bathing, eating, dressing, toileting and walking)
- **Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical and speech therapies
- **Nutrition**
- **Medical Social Services**
- **Home Delivered Meals and/or meals in a group setting such as a day care**
- **Social Day Care**
- **Non-Emergency Transportation**
- **Private Duty Nursing**

- **Dental**
- **Social/Environmental Supports** (such as chore services, home modifications or respite)
- **Personal Emergency Response System**
- **Adult Day Health Care**
- **Nursing Home Care not covered by Medicare (*provided you are eligible for institutional Medicaid*)**
- **Audiology**
- **DME**
- **Medical Supplies**
- **Prosthetics and Orthotics**
- **Optometry**
- **Consumer Directed Personal Assistance Services**
- **Podiatry**
- **Respiratory Therapy**

### **Limitations**

Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions:

1. tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; **and**
2. individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.

Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

Nursing Home Care is covered for individuals who are considered a permanent placement for at least three months. Following that time period, your Nursing Home Care may be covered through regular Medicaid, and you will be disenrolled from **(Insert plan name)**.

### **Getting Care outside the Service Area**

You must inform your care manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your care manager should be contacted to assist you in arranging services.

### **Emergency Service**

Emergency Service means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial 911. As noted above, prior authorization is not needed for emergency service. However, you should notify **(Insert Plan Name)** within 24 hours of the emergency. You may be in need of long term care services that can only be provided through **(Insert Plan Name)**.

If you are hospitalized, a family member or other caregiver should contact [Insert Plan Name] within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact [Insert Plan Name] so that we may work with them to plan your care upon discharge from the hospital.

## **TRANSITIONAL CARE PROCEDURES**

New members in [Insert Plan Name] may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider if the provider accepts payment at the plan rate, adheres to [Insert Plan Name] quality assurance and other policies, and provides medical information about the care to your plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

## **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/Open Doors if you:

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

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

- Giving you information about services 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](mailto:mfp@health.ny.gov). You can also visit MFP/Open Doors on the web at [www.health.ny.gov/mfp](http://www.health.ny.gov/mfp) or [www.ilny.org](http://www.ilny.org).

## **MEDICAID SERVICES NOT COVERED BY OUR PLAN**

There are some Medicaid services that [Insert Plan Name] does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at [Insert Plan Member Services Telephone Number] if you have a question about whether a benefit is covered by [Insert Plan Name] or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

### **Pharmacy**

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

### **Certain Mental Health Services, including:**

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

### **Certain Intellectual and Developmental Disabilities Services, including:**

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

### **Other Medicaid Services including:**

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

## **SERVICES NOT COVERED BY [INSERT PLAN NAME] OR MEDICAID**

You must pay for services that are not covered by [Insert Plan Name] or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by [Insert Plan Name] or Medicaid are:

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

If you have any questions, call Member Services at [Insert Plan Member Services Telephone Number].

## **SERVICE AUTHORIZATIONS, ACTIONS AND ACTION APPEALS**

When you ask for approval of a treatment or service, it is called a **service authorization request**. To submit a service authorization request, you must

[Insert instructions for submitting a service authorization request: e.g., You or your provider may call our toll-free Member Services number at <Member Services Number> or send your request in writing to <plan address>.]

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

### **Prior Authorization**

Some covered services require **prior authorization** (approval in advance) from [Insert name of organization or group or department that gives prior authorization on behalf of Plan] before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

[List services requiring preauthorization and the process for obtaining prior authorization.]

### **Concurrent Review**

You can also ask [Insert name of organization or group or department that gives prior authorization on behalf of the plan] to get more of a service than you are getting now. This is called **concurrent review**.

### **Retrospective Review**

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

### ***What happens after we get your service authorization request?***

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

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

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

#### ***Timeframes for prior authorization requests***

- **Standard review:** We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14<sup>th</sup> day if we need more information.
- **Fast track review:** We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

#### ***Timeframes for concurrent review requests***

- **Standard review:** We will make a decision within 1 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- **Fast track review:** We will make a decision within 1 workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 workday if we need more information.

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

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



You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling [Insert appropriate toll-free health plan number] or writing.

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

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

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

### ***What is an Action?***

When (insert plan name) 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?* below for more information.)

### **Timing of Notice of Action**

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

### **Contents of the Notice of Action**

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- 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 involved issues of medical necessity or whether the treatment or service in question was experimental or investigational; **and**
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

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

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

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

### ***How do I File an Appeal of an Action?***

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

### ***How do I Contact my Plan to file an Appeal?***

We can be reached by calling [Insert Plan Member Services Telephone Number]. or writing to [Insert Plan address]. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

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

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

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

Unless your appeal is fast tracked, we will review your appeal of the action taken by us as a standard appeal. We will send you a written decision as quickly as your health

condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. We will also send you your records that are part of the appeal review.

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

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

### **Fast Track Appeal Process**

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

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

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

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

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

## State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under ***“How Long Will It Take the Plan to Decide My Appeal of an Action?”*** above, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice.

If we are reducing, suspending or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

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

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

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

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

- Online Request Form: [Request Hearing | Fair Hearings | OTDA \(ny.gov\)](#)
- 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, 1<sup>st</sup> Floor
    - Brooklyn, New York 11201
  
  - Albany**
    - 40 North Pearl Street, 15th Floor
    - Albany, New York 12243

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

### **State External Appeals**

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

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

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

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

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

### **COMPLAINTS AND COMPLAINT APPEALS**

**[Insert Plan Name]** 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 **[Insert Plan Name]** staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint, please call: [Insert Plan Member Services Telephone Number] or write to: [Insert Plan Address]. 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, didn't show up, or you do not like the quality of care or services you have received from us, you can file a complaint with us.

### **The Complaint Process**

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process must be completed within 7 days of the receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

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

### ***How do I Appeal a Complaint Decision?***

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

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

decision of your complaint appeal. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

### **Participant Ombudsman**

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

- Phone: 1-844-614-8800 (TTY Relay Service: 711)
- Web: [www.icannys.org](http://www.icannys.org) | Email: [ican@cssny.org](mailto:ican@cssny.org)

### **DISENROLLMENT FROM **[Insert Plan Name]** MLTC PLAN**

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

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

### **Voluntary Disenrollment**

You can ask to leave the **[Insert Plan Name]** at any time for any reason

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

### **Transfers**

You can try our plan for 90 days. You may leave **(Insert Plan Name)** and transfer and join another plan at any time during that time. If you do not leave in the first 90 days, you must stay in (Insert Plan name) for nine more months, unless you have good reason (good cause.)

- 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 **[Insert Plan Name]** is best for you.

- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the State

If you qualify, you can change to another type of managed long term care plan like Medicaid Advantage Plus (MAP) or Programs of All-Inclusive Care for the Elderly (PACE) at any time without good cause

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

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. [Insert Plan Name] 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 [Insert Plan Name].

### **Involuntary Disenrollment**

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

### **You Will Have to Leave [Insert Plan Name] if you are:**

- No longer are Medicaid eligible.
- Permanently move out of [Insert Plan Name] service area.
- Out of the plan's service area for more than 30 consecutive days.
- Needing nursing home care but are not eligible for institutional Medicaid.
- Hospitalized or enter an Office of Mental Health, Office for People with Developmental Disability or Office of Alcoholism and Substance Abuse Services residential program for forty-five (45) consecutive days or longer.
- Assessed as no longer having a functional or clinical need for (CBLTSS) on a monthly basis.
- Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- Receiving Social Day Care as your only service.
- No longer require, and receive, at least one CBLTSS in each calendar month.
- At the point of any reassessment, while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- Incarcerated.



- Providing the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

**We Can Ask You to Leave [Insert Plan Name] if you:**

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

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

**CULTURAL AND LINGUISTIC COMPETENCY**

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

**MEMBER RIGHTS AND RESPONSIBILITIES**

[Insert Plan Name] will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

**Member 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 the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the Right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services.
- You have the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to seek assistance from the Participant Ombudsman program.

### **Member Responsibilities**

- Receiving covered services through **[Insert Plan Name]**.

- Using [Insert Plan Name] network providers for covered services to the extent network providers are available.
- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies; Being seen by your physician, if a change in your health status occurs.
- Sharing complete and accurate health information with your health care providers.
- Informing [Insert Plan Name] staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions.
- Following the plan of care recommended by the [Insert Plan Name] staff (with your input).
- Cooperating with and being respectful with the [Insert Plan Name] staff and not discriminating against [Insert Plan Name] staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status.
- Notifying [Insert Plan Name] within two business days of receiving non-covered or non-pre-approved services.
- Notifying your [Insert Plan Name] health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- Informing [Insert Plan Name] before permanently moving out of the service area, or of any lengthy absence from the service area.
- Your actions if you refuse treatment or do not follow the instructions of your caregiver.
- Meeting your financial obligations.

### **Advance Directives**

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf.

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact

your Care Manager for assistance in completing these documents. If you already have an advanced directive, please share a copy with your care manager.

### **Information Available on Request**

- Information regarding the structure and operation of [Insert Plan Name].
- Specific clinical review criteria relating to a particular health condition and other information that [Insert Plan Name] considers when authorizing services.
- Policies and procedures on protected health information.
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.
- Provider credentialing policies.
- A recent copy of the [Insert Plan Name] certified financial statement; policies and procedures used by [Insert Plan Name] to determine eligibility of a provider.