NEW YORK STATE
HIV SPECIAL NEEDS PLAN
MODEL MEMBER HANDBOOK

Revised for January 2014

This handbook will tell you how to use your [Insert Plan Name] plan.

Please put this handbook where you can find it when you need it.

Here's Where to Find Information You Want

HIV Special Needs Plan Member Handbook

WELCOME to [Insert Plan Name] HIV Special Needs Plan

We are glad that you chose [Insert Plan Name]. [Insert Plan Name] is a HIV Special Needs Plan (SNP) approved by the New York State Department of Health to serve Medicaid members with HIV/AIDS and their children as well as adults and children who are homeless. We are a special health care plan with providers who have a lot of experience treating persons with HIV/AIDS. People with HIV are living longer, healthier lives, thanks to new and more effective treatments. We want you and your health care team to work together to keep you as healthy as possible.

This handbook will be your guide to the full range of health care services available to you. We want to be sure you get off to a good start as a new member of [Insert Plan Name]. In order to get to know you better, we will get in touch with you in the next two weeks. You can ask us any questions you have, or get help making appointments. If you want to speak with us sooner, just call us at [Insert Member Services Toll-Free Number].

HOW SPECIAL NEEDS PLANS WORK

The Plan, Our Providers, and You

No doubt you have seen or heard about the changes in health care. Many consumers now get their health benefits through managed care which provides a central medical home for your care. Many counties in New York State, including New York City, offer a choice of managed care health plans. In some counties, Medicaid consumers must join a health care plan. Such counties operate a mandatory managed care program.

- As an HIV SNP member, you will have the benefits you had in regular Medicaid plus you get the special care and support you need. You and your health care team will work together to make sure you enjoy the best physical and emotional health possible. You will be able to get special services for healthy living such as nutrition classes and help to stop smoking. If you are HIV positive, we can get you other services that will help you manage your HIV infection.

- **Your children** can also join the plan, whether the child is HIV infected or not. Your partners who do NOT have HIV/AIDS may not join an HIV SNP. Children and adults who are homeless can also join the plan.

- [Insert Plan Name] has a contract with the New York State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs, case managers, and other health care facilities make up our **provider network**. You'll find a list in our provider directory. If you don't have a provider directory, call Member Services at [Insert Member Services Toll-Free Number] to get a copy.

- When you join [Insert Plan Name], one of our providers will take care of you. Most of the

time that person will be your **PCP (Primary Care Provider)**. Only providers who are experienced in treating HIV disease can be Primary Care Providers for members with HIV. 'If you need to have a test, or see another specialist, or go into the hospital, your Primary Care Provider will arrange it. Your Primary Care Provider is available to you every day, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your Primary Care Provider will get back to you as soon as possible. Even though your Primary Care Provider is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page [Insert correct page reference] for details.

- If you are HIV positive, we will send you to providers and hospitals that have lots of experience in treating HIV/AIDS. You will also be able to use the following health provider groups that are in our provider network:

    - Designated AIDS Centers (DACs): Hospitals which have experience treating persons with HIV/AIDS;
    - Maternal/ Pediatric HIV Specialized Care Centers: Providers which give complete care for HIV infected mothers and their children;
    - HIV Primary Care Programs: Primary care with special attention to keeping you healthy;
    - Drug Treatment and Primary Care: Drug treatment providers at the same location as HIV and primary care services; and
    - Specialty Care.

- You may be restricted to certain plan providers if you are:

    - getting care from several doctors for the same problem
    - getting medical care more often than needed
    - using prescription medicine in a way that may be dangerous to your health
    - allowing someone other than yourself to use your plan ID card

Confidentiality

We respect your right to privacy. [Insert Plan Name] recognizes the trust needed between you, your family, your doctors and other care providers. [Insert Plan Name] will never give out your medical history or HIV status without your written approval. The only persons that will have your clinical information will be [Insert Plan Name], your Primary Care Provider, your HIV SNP Care Coordinator or Case Manager, and other providers who give you care. Referrals to such providers will always be discussed with you in advance by your Primary Care Provider and/or HIV SNP Care Coordinator or Case Manager. [Insert Plan Name] staff have been trained in keeping strict member confidentiality.

HOW TO USE THIS HANDBOOK

- This handbook will tell you how your new health care system will work and how you can get

the most from [Insert Plan Name]. This handbook is your guide to health services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time. When you have a question, check this Handbook or call our Member Services unit [Insert Member Services Toll-Free Number]. You can also call the New York Medicaid Choice Helpline at 1- 800-505-5678.

HELP FROM MEMBER SERVICES

There is someone to help you at Member Services
Monday through Friday
8:30 AM - 5 PM
Call 1- [Insert Member Services Toll-Free Number]
If you need help at other times, call us at
1- [Insert the health plan TTY number]

- You can call to get help **any time you have a question.** You may call us to choose or change your Primary Care Provider *(PCP for short)*, to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report that you are pregnant, the birth of a new baby or ask about any change that might affect you or your family's benefits.

Your Family's Care

- If you are HIV positive **and if you are or become pregnant**, you and your baby will need special medical care as early as possible. You could pass HIV to your baby during pregnancy, childbirth, or through breast milk. It is important that you, your doctors and other care providers work together so you can have a healthy baby. You can improve your own health and reduce your baby's chance of being infected with HIV by taking special medicine while you are pregnant. Be sure you call us for early prenatal care and take good care of yourself.

- Almost all the time, your child will become part of [Insert Plan Name] on the day he or she is born. This will happen unless your child is in a group that cannot join managed care. You should call us right away if you become pregnant and let us help you to choose your baby's doctor and meet with the doctor before the baby is born to discuss the baby's care.

- **Your children** can also join the plan, whether the child is HIV infected or not. Your partners who do NOT have HIV/AIDS may only join an HIV SNP if they are homeless.

- We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that are best for you.

- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can speak to you in your language.

- **For people with disabilities:** If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:

    - TTY/TDD machine (Our TTY phone number is [Insert the health plan TTY number]).
    - Information in Large Print
    - Case Management
    - Help in Making or Getting to Appointments
    - Names and Addresses of Providers Who Specialize in Your Disability

YOUR HEALTH PLAN ID CARD

After you enroll, we'll send you a welcome letter. Your [Insert Plan Name] ID card should arrive within 14 days after your enrollment date. Your card has your PCP's (Primary Care Provider's) name and phone number on it. It will also have your client identification number (CIN). If anything is wrong, call us right away. Your ID card does not show that you have HIV or AIDS. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need your Medicaid card to get services that [Insert Plan Name] does not cover. These services include outpatient chemical dependency benefits.

PART I --- First Things You Should Know

HOW TO CHOOSE YOUR PRIMARY CARE PROVIDER (PCP)

- You may have already picked your PCP (Primary Care Provider). **If you have not chosen a PCP for you and your family, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you. Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. If you are HIV positive, an HIV Specialist will be your primary care provider. Member Services can help you choose a PCP.

- With this Handbook, you should have a provider directory. This is a list of all the providers, clinics, hospitals, labs, and others who work with [Insert Plan Name]. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP.

You may want to find a doctor:

- whom you have seen before,
- who understands your health problems,
- who is taking new patients,
- who can speak to you in your language,
- who is easy to get to.

- Women can also choose one of our OB/GYN doctors to deal with women's health issues. **[*OR alternate language* for plans that do not allow separate selection of OB/GYN:]** Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine check ups (twice a year), follow-up care if there is a problem, and regular care during pregnancy.

(If contracting with FQHCs)

- We also contract with several FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose one of our providers. Or you can sign up with a PCP in one of the FQHCs that we work with, listed below. Just call Member Services ([Insert Member Services Toll-Free Number]) for help.

{List available FQHCs here}

ALTERNATE LANGUAGE: If not contracting with FQHCs:

- FQHCs (Federally Qualified Health Centers) give primary and specialty care. Some people want to get their care from FQHCs because the centers have a long history in the neighborhood. Although we do not have a contract with these centers, we offer similar services. For example, besides primary and specialty care, these centers have social support services, case management, and classes to help you stop smoking, control diabetes, or lose weight. We have all these services, too. For information, call [Insert Member Services Toll-Free Number].

- In almost all cases, your doctors will be [Insert Plan Name] providers. There are two instances when you can still **see another doctor that you had before you joined [Insert Plan Name]**. In both cases, however, your doctor must agree to work with our plan. You can continue to see your doctor if:

  - You are more than 3 months pregnant when you join and you are getting prenatal care. In that case, you can keep your doctor until after your delivery through post-partum care.
  - At the time you join, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your doctor for up to 60 days.

- **If you have another long lasting illness** besides your HIV/AIDS, your HIV specialist Primary Care Physician and care coordinator will work with the other specialist to manage your care. [Plans should specify the process]

  - If you need to, you can **change your PCP** in the first 30 days after your first appointment with your PCP. After that, you can change once every six months without cause, or more

often if you have a good reason. You can also change your OB/GYN or a specialist to which your PCP has referred you. [**Note to Plans: Health Plans are allowed to adopt a more liberal policy regarding PCP changes. You may describe such liberalized policy in this section.]**

- If your **provider leaves** [Insert Plan Name], we will tell you within 5 days from when we know about this. If you wish, you may be able to see that provider ***if*** you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor through post-partum care. If you are seeing a doctor regularly for a special medical problem, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with [Insert Plan Name] during this time. If any of these conditions apply to you, check with your PCP or call Member Services at [Insert Member Services Toll-Free Number].

REGULAR AND HIV CARE

- Your health care will include regular check-ups for all your health care needs. If you are HIV positive, your doctor can prescribe medicines that help control HIV and other treatments to keep you well. We provide help in choosing the best combination of drug treatment and advice when you need to change certain drugs. We provide referrals to hospitals or specialists. We want new members to see his or her Primary Care Provider for a first medical visit soon after enrolling in [Insert Plan Name]. This will give you a chance to talk with your Primary Care Provider about your past health issues, the medicines you take, and any questions that you have.

- [Insert Plan Name]
- Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

- You can call [Insert Plan Name] twenty-four (24) hours a day, seven (7) days a week at [Insert Member Services Toll-Free Number], if you have questions about getting services or if for some reason you cannot reach your Primary Care Provider.

- Your care must be **medically necessary** -- the services you get must be needed:

  - to prevent, or diagnose and correct what could cause more suffering, or
  - to deal with a danger to your life, or
  - to deal with a problem that could cause illness, or
  - to deal with something that could limit your normal activities.

- Your PCP will take care of most of your health care needs. You should have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know. As soon as you choose a PCP, call to make a first appointment. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell

him or her. Make a list of your medical background, any problems you have now, and the questions you want to ask your PCP. In most cases, your first visit should be within four weeks of your joining the plan. If you have the need for treatment over the coming weeks, make your first appointment in the first week of joining the plan.

- **If you need care before your first appointment**, call your PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the first appointment to discuss your medical history and ask questions.)

- Use the following list as a guide for the longest time you may have to wait after you ask for an appointment:

  - urgent care: within 24 hours
  - non-urgent sick visits: within 3 days
  - routine, preventive care: within 4 weeks
  - first pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
  - first newborn visit: within 48 hours of hospital discharge
  - first family planning visit: within 2 weeks
  - well child care: 4 weeks
  - follow-up visit after mental health/substance abuse ER or inpatient visit: 5 days
  - non-urgent mental health or substance abuse visit: 2 weeks.
  - adult baseline and routine physicals: within 4 weeks

- **Care and Benefits Coordination** is a unique feature of HIV SNPs, [Insert Plan Name] is responsible for providing and coordinating your Medicaid benefit package services. We are also responsible for coordinating services not directly provided by [Insert Plan Name]. These include such services as:

  - COBRA case management
  - Housing services
  - Supportive Services
  - Community based case management

When you enroll, [Insert Plan Name] staff will work with you to find out what services you may need or want, including case management. [Insert Plan Name] staff will help find a case management provider for you and assist you in making the first contact. Once you have a case manager we will work together with them to coordinate your care and service needs. If you already have a case manager, we will work with them to coordinate your care and service needs.

[Note: Plans should detail their care coordination programs.]

HOW TO GET SPECIALTY CARE AND REFERRALS

- If you need care that your PCP cannot give, he or she will REFER you to other specialists who can. If your PCP refers you to another doctor, we will pay for your care. Most of these

specialists are [Insert Plan Name] providers. Talk with your PCP to be sure you know how referrals work. If you think the specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask our plan to approve *before* you can get them. Your PCP will be able to tell you what they are.

- If you are having trouble getting a referral you think you need, contact Member Services at [Insert Member Services Toll-Free Number].

- Plans must indicate whether there are any limitations on accessing the entire approved provider network, if applicable, other than the standard referral process.

- If we do not have a specialist in our plan who can give you the care you need, we will get you the care you need from a specialist outside our plan. [Insert plan-specific process for Enrollees to request services from a specialist outside the network. Include timeframes for resolving the request for care from out-of-network specialists, process for appeal, required documentation, and phone number for members to contact plan regarding the request. Include information needed to file a UR appeal for a decision that the out-of-network service requested is not materially different from an alternate in-network service.] If your PCP or plan refers you to a provider outside our network, you are not responsible for any of the costs except any co-payments as described in this handbook.

- *You may need to see a specialist for ongoing care of a condition other than for HIV or AIDS.* Your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.

- *If you have a long-term disease or a disabling illness other than HIV or AIDS* that gets worse over time, your PCP will work with a specialist to coordinate your care. You can:

  - receive a referral to a specialty care center that deals with the treatment of your problem.
  - call Member Services for help in getting access to a specialty care center.

If you are HIV positive, even when you meet with a specialist, your Primary Care Provider will still take care of your HIV care.

- You will be able to get into *clinical trials* which allow you to benefit from the latest treatments and other research programs. *Experimental treatments* will be covered on a case by case basis, once regular treatments have been tried.

GET THESE SERVICES FROM OUR PLAN *WITHOUT* A Referral

Women's Services:

You do not need a referral from your PCP to see one of our providers IF

- you are pregnant, or

- you need OB/GYN services, or
- you need family planning services, or
- you want to see a mid-wife, or
- you need to have a breast or pelvic exam.

Family Planning

- You can get the following family planning services: advice for birth control, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, or an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam or a pelvic exam.

- You *do not need a referral* from your PCP to get these services. In fact, you can choose where to get these services. You can *use your [Insert Plan Name] ID card* to see one of our family planning providers. Check the plan's Provider Directory or call Member Services for help in finding a provider. Or, you can *use your Medicaid card* if you want to go to a doctor or clinic outside our plan. Ask your PCP or Member Services [Insert Member Services Toll-Free Number] for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

HIV Testing

If you need HIV testing services, you have three choices:

- You can visit an anonymous HIV testing site or a community organization that offers this service. For information, call the NYS HIV Hotline at 1-800-872-2777 or 1-800-541-AIDS (2437). For Spanish 1-800-233-SIDA (7432) and TDD 1-800-369-AIDS (2437).

- You can get HIV testing any time you have family planning services. You do not need a referral from your PCP (primary care provider). Just make an appointment with any family planning provider. If you want HIV testing and counseling but *not as part of a family planning service*, your PCP can provide or arrange it for you.

- Or, if you'd rather not see one of our Plan's providers, you can use your Medicaid card to see a family planning provider outside The Plan. For help in finding either a Plan provider or a Medicaid provider for family planning services call member services at [Insert Member Services Toll-Free Number].

If you need HIV treatment after the testing service, your PCP will help you get follow-up care. If your test is negative, we can help you learn to stay that way.

Partner Notification

If you are HIV positive, the PartNer Assistance Program (PNAP) can help you find the best way to let your partners know they need to have an HIV test. Your counselor will help you decide which

way of telling your partners is the best and safest for you. If telling your partner will seriously affect the health or safety of you or someone close to you, talk to your PNAP counselor about your choices. To learn more about PNAP, ask your case manager or call 1-800-541-AIDS (2437), or in New York City (212) 693-1419. If your partner is upset or angry call the NYS Domestic Violence Hotline at 1-800-842-6906.

HIV Prevention Services

Many HIV prevention and counseling services are available to you. We will talk with you about any sexual or drug use activities that might put you or others at risk of transmitting HIV or getting sexually transmitted diseases. If your sexual or drug use activities could be harmful to yourself and others, we will help you learn how to protect yourself. Both [Insert Plan Name] staff and referrals to community-based groups will help you with activities to keep you and your loved ones stay healthy. We can also help you get free male and female condoms and clean syringes.

If you are HIV positive, we can help you inform partners of your HIV status (see PartNer Assistance Program above). We can help you talk to your family and friends and help them understand HIV and AIDS. If you need help talking about your HIV status with future partners [Insert Plan Name] staff will assist you. We can even help you talk to your children about HIV and the risks involved.

Eye Care

The covered service includes the needed services of an ophthalmologist, optometrist, and an ophthalmic dispenser and includes an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any twelve (12) month period. You just choose one of our participating providers. New eyeglasses (with Medicaid approved frames) are usually provided once every two years. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses or broken eyeglasses that can't be fixed will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Mental Health / Chemical Dependence (Including Alcohol and Substance Abuse)

We want to help you get the mental health and drug or alcohol abuse services that you may need. You may go for one (1) mental health assessment without a referral in any calendar year period. You must use a [Insert Plan Name] provider, but you do not need an OK from your PCP. If you need more visits, your PCP will help you get a referral.

You may also go for one (1) chemical dependence assessment for all inpatient detoxification, inpatient rehabilitation, or outpatient detoxification services without a referral in any calendar year period. You must use a [Insert Plan Name] provider, but you do not need an OK from your PCP. If you need more visits, your PCP will help you get a referral.

If you want a chemical dependence assessment for any alcohol and/or substance abuse outpatient

treatment services except outpatient detoxification services, you must use your Medicaid Benefit card to go to any provider that takes Medicaid.

Emergencies

You are always covered for emergencies. In New York State, an emergency means a medical or behavioral condition:

- that comes on all of a sudden, and
- has pain or other symptoms.

This would make a person with an average knowledge of health be afraid that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.

Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop or a bad burn
- broken bones
- trouble breathing / convulsions / loss of consciousness
- when you feel you might hurt yourself or others
- if you are pregnant and have signs like pain, bleeding, fever, or vomiting

Examples of **non-emergencies** are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles.

If you have an emergency, here's what to do:

- *If you believe you have an **emergency***, call 911 or go to the emergency room. You do not need [Insert Plan Name] or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

- ***If you're not sure*, call your PCP or** [Insert Plan Name]**.**

  Tell the person you speak with what is happening. Your PCP or [Insert Plan Name] representative will:

  - tell you what to do at home, or
  - tell you to come to the PCP's office, or
  - tell you to go to the nearest emergency room.

- *If you are **out of the area*** when you have an emergency:

  - Go to the nearest emergency room.
  - Call [Insert Plan Name] as soon as you can (within 48 hours if you can).

Remember

You do not need prior approval for emergency services.

Use the emergency room **only** if you have a **TRUE EMERGENCY.**

The Emergency Room should NOT be used for problems like flu, sore throats, or ear infections.

If you have questions, call your PCP or our plan at [Insert Member Services Toll-Free Number].

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care.

- This could be a child with an earache who wakes up in the middle of the night and won't stop crying.
- It could be a sprained ankle, or a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. If you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at [Insert Member Services Toll-Free Number]. Tell the person who answers what is happening. They will tell you what to do.

Care Outside of the United States

If you travel outside of the United States, you can get urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

WE WANT TO KEEP YOU HEALTHY

Besides the regular check ups and the shots you and your family need, here are some other services we provide and ways to keep you in good health: (***list of plan services***)

- Classes for You and Your Family
- HIV Treatment Education
- Peer Support
- Exercise Programs
- Grief / Loss Support
- Stop Smoking Classes
- Stress Management/Reduction
- Drug Use Support Groups

- Staying on Schedule with Your Medicine
- HIV/AIDS Support Groups
- Harm Reduction/Needle Exchange
- Alternative Therapies
- Pre-natal and Baby Care
- Pre-natal care and nutrition
- Breast feeding and baby care
- Dental/Oral Health
- HIV Prevention
- Managing Asthma
- Cholesterol Control
- Healthy Eating
- Diabetes Counseling
- Domestic Violence Services
- Mental Health Services
- Weight control
- Skin Care
- Prevention for Positives
- Referral to CBOs
- Sexually Transmitted Disease (STD) Testing & Protecting Yourself from STDs
- HIV Specific Legal Services (such as Permanency Planning)
- Diabetes counseling and self-management training
- Asthma counseling and self-management training

Call Member Services at [Insert Member Services Toll-Free Number] to find out more and get a list of upcoming classes.

Handbook -- Part 2

YOUR BENEFITS AND PLAN PROCEDURES

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

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BENEFITS

Special Needs Plans provide a number of services you get in addition to those you get with regular Medicaid. We will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing; and specific self referral services, including those you can get from within the plan and some that you can choose to go to any Medicaid provider of the service.

SERVICES COVERED BY OUR PLAN

You must get these services from the providers who are in our plan. All services must be medically necessary and provided or referred by your PCP (primary care provider). Please call our member services department at <insert Member Services Toll-Free Number> if you have any questions or need help with any of the services below.

Regular and HIV Medical Care

- office visits with your PCP
- access to HIV Primary Care Programs
- referrals to specialists
- access to combination therapies
- eye / hearing exams
- help staying on schedule with medicines
- coordination of care and benefits

Preventive Care

- HIV education and risk reduction
- referral to CBOs for supportive care
- well-baby care
- well-child care
- regular check-ups
- shots for children from birth through childhood
- access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21 years
- access to free needles and syringes
- smoking cessation counseling. Enrollees are eligible for 6 sessions in a calendar year.

Maternity Care

- access to special HIV Centers for mothers and children (If you are HIV positive.)
- pregnancy care
- doctors/mid-wife and hospital services
- access to antiretroviral therapy for mother and baby
- newborn nursery care

Home Health Care (must be medically needed and arranged by [Insert Plan Name])

- one medically necessary post partum home health visit, additional visits as medically necessary for high-risk women
- at least 2 visits to high-risk infants (newborns)
- other home health care visits as needed and ordered by your PCP/specialist

Personal Care/Home Attendant/Consumer Directed Personal Assistance Services (CDPAS) (must be medically needed and arranged by [Insert Plan Name])

- Personal Care/Home Attendant - Provide some or total assistance with personal hygiene, dressing and feeding and assist in preparing meals and housekeeping.
- CDPAS – Provide some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping as well as home health aide and nursing tasks. This is provided by an aide chosen and directed by you. If you want more information contact [insert plan name and toll free number]

Personal Emergency Response System (PERS) – This is a piece of equipment you wear to get help if you have an emergency. In order to qualify and receive this service you must be receiving personal care/home attendant services.

Adult Day Healthcare Services

- Must be recommended by your Primary Care Provider (PCP).
- Provides some or all of the following; health education, nutrition, interdisciplinary care planning, nursing and social services, assistance and supervision with the activities of daily living, restorative rehabilitative and maintenance therapy, planned therapeutic or recreational activities, pharmaceutical services as well as, referrals for necessary dental services and sub-specialty care.

AIDS Adult Day Health Care Services

- Must be recommended by your Primary Care Provider (PCP).
- Provides general medical and nursing care, substance abuse supportive services, mental health supportive services, individual and group nutritional services as well as, structured socialization, recreational and wellness/health promotion activities.

Directly Observed Therapy for Tuberculosis Disease

- Provides observation and dispensing of medication, assessment of any adverse reactions to medications and case follow up.

Hospice (must be medically needed and arranged by <insert plan name>

- Hospice care provides non-curative medical and support services for members certified by a physician to be terminally ill with a life expectancy of one (1) year or less. Hospice may be provided in your home or in an inpatient setting.
- Hospice programs provide patients and their families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses experienced during the final stages of illness, and during dying and bereavement.
- For children under age twenty-one (21) who are receiving hospice services, medically necessary curative services are covered, in addition to palliative care.

If you have any questions about this benefit, you can call Member Services Department at [Insert plan's toll-free number].

Dental Care

[Insert Plan Name] believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with [Name of Dental Vendor], an expert in providing high quality dental services. or We offer dental care through contracts with individual dentists who are experts in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. *You do not need a referral from your PCP to see a dentist!*

How to Access Dental Services:

[Describe the process the member uses to access dental services. State whether the member will be assigned a primary care dentist (PCD) with the option of selecting an alternate network dentist (include the timeframe, if any, for changing PCD) OR state whether the member may see any dentist in the provider's network.]

- If you need to find a dentist or change your dentist, please call [Name of Dental Vendor] at [Insert 800 number] or please call [Name of Plan and (800 number)]. Customer Services Representatives are there to help you. Many speak your language or have a contract with Language Line Services.

Note: **State which one of the following 2 bullets applies.**

- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card. or;
- You will receive a separate Dental ID card with the name of your assigned dentist. Show your Dental ID card to access dental benefits.

You can also go to a dental clinic that is run by an academic dental center without a referral. Plans should either list academic dental centers within a (30) thirty mile radius or include toll free member services number for members to call.

Orthodontic Care

[Insert Plan Name] will cover braces for children up to age 21 who have a severe problem with their teeth; such as, can't chew food due to severely crooked teeth, cleft palette or cleft lip.

Vision Care

- services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider
- eye exams, generally every two years, unless medically needed more often
- glasses (new pair of Medicaid approved frames every two years, or more often if medically needed)
- low vision exam and vision aids ordered by your doctor
- specialist referrals for eye diseases or defects

Pharmacy

- Prescription drugs
- Over-the-counter medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Emergency Contraception (6 per calendar year)
- Medical and surgical supplies

A co-payment may be required for some people, for some medications and pharmacy items. The following consumers/services are exempt from co-payments:

- Consumers younger than 21 years old.
- Consumers who are pregnant. Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.
- Family Planning drugs and supplies like birth control pills, male or female condoms, syringes and needles.
- Consumers in a Comprehensive Medicaid Care Management (CMCM) or Service Coordination Program.
- Consumers in an OMH or OPWDD Home and Community Based Services (HCBS) Waiver Program.
- Consumers in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Generic co-pays (if waiving copay)

Prescription Item	**Co-payment amount**	**Co-payment details**
Brand-name prescription drugs	$3.00/$1.00	1 co-pay charge for each new prescription and each refill No co-payment for drugs to treat mental illness (psychotropic) and tuberculosis.
Generic prescription drugs	$1.00 (Delete if waiving co-pay)	
Over-the-counter medications (e,g,for smoking cessation and diabetes)	$0.50	

There is a co-payment for each new Prescription *and* each refill.

If you are required to pay a co-pay, you are responsible for a maximum of $200 per calendar year. If you transferred plans during the calendar year, keep your receipts as proof of your co-payments or you may request proof of paid co-payments from your pharmacy. You will need to give a copy to your new plan.

Certain medications may require that your doctor get prior authorization from us before writing your prescription. Your doctor can work with [plan name] to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.

You have a choice in where you fill your prescriptions. You can go to any Pharmacy that participates with our plan or you can fill your prescriptions by using a mail order pharmacy. For more information on your options, please contact member services at [member service number or insert specific instructions] .

Hospital Care

- access to Designated AIDS Centers
- inpatient care
- outpatient care
- lab, x-ray, other tests

Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.

- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the Emergency Room, in an inpatient hospital room, or in another setting. This is called **Post Stabilization Services.**

- For more about emergency services, see page 12.

Mental Health / Chemical Dependence (Including Alcohol and Substance Abuse)

- access to drug treatment and primary care at the same location
- all inpatient mental health and chemical dependence services (including alcohol and substance abuse
- most outpatient mental health services (contact [Insert Plan Name] for specifics)
- Inpatient detoxification services are covered by the plan as an inpatient hospital benefit.
- Uninfected children and homeless adults who are not HIV positive who receive SSI or who are certified blind or disabled can get mental health and chemical dependence (including alcohol and substance abuse) services from any Medicaid provider by using their Medicaid card. Detoxification services, however, are covered by the plan as a benefit.

Specialty Care
Includes the services of other practitioners, including

- occupational, physical and speech therapists– Limited to twenty (20) visits per therapy per calendar year, except for children under age 21 or if you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities, or if you have a traumatic brain injury.
- audiologist
- midwives
- cardiac rehabilitation
- other non-HIV specialty care [plans highlight key specialty services]

Residential Health Care Facility Care (Nursing Home)

- when ordered by your physician and authorized by [Insert Plan Name];
- when the stay in the nursing home is not determined permanent by your LDSS;
- covered nursing home services include medical supervision, 24-hour nursing care, assistance with activities of daily living, physical therapy, occupational therapy, and speech-language pathology.

Other Covered Services

[plans should add only where they apply]

Durable Medical Equipment (DME) / Hearing Aids / Prosthetics / Orthotics
Court Ordered Services
Social Support Services (help in getting community services)
FQHC or similar services

Services of a Podiatrist for children under 21 years old

Benefits You Can Get From Our Plan *OR* With Your Medicaid Card

For some services, you can choose where to get the care. You can get these services by using your [Insert Plan Name] membership card. You can also go to providers who will take your Medicaid Benefit card. *You do not need a referral from your PCP to get these services.* Call Member Services if you have questions at [Insert Member Services Toll-Free Number].

Family Planning
You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can visit one of our family planning providers as well. Either way, you do not need a referral from your PCP.

HIV Testing
You can get this service any time from our plan doctors if you talk to your PCP first. Your PCP can provide or arrange HIV testing. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit. You can also go to anonymous testing clinics offered by the state and local health departments. To get more information about these sites, call the New York State HIV Hotline at 1-800-872-2777 or 1-800-

541-AIDS (2437) For Spanish 1-800-233-SIDA (7432) and TDD at 1-800-369-AIDS (2437).

TB Diagnosis and Treatment
You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

Benefits Using Your MEDICAID CARD Only

There are some services [Insert Plan Name] does not provide. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit card.

Outpatient Chemical Dependency
You can go to any Medicaid provider or clinic that provides outpatient chemical dependency.

Family Planning [Include here if family planning is not covered by the plan.]
You can go to any Medicaid doctor or clinic that provides family planning.

Transportation [.
[] Emergency and non emergency transportation will be covered by regular Medicaid. To get non-emergency transportation, you or your provider must call LogistiCare at 1-877-564-5922 . If possible, you or your provider should call LogistiCare at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing. Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

How you get emergency transportation will not change. If you have an emergency and need an ambulance, you must call 911.

Mental Health
- Intensive psychiatric rehab treatment
- Day treatment
- Intensive case management
- Partial hospital care
- Rehab services to those in community homes or in family-based treatment
- Clinic services for children with a diagnosis of Serious Emotional Disturbance (SED) at mental health clinics certified by the State Office of Mental Health.
- Continuing day treatment
- All covered mental health services for your uninfected children who receive SSI or who are certified blind or disabled are available by using the Medicaid benefit card.
- All covered mental health services for uninfected homeless adults who receive SSI or who are certified blind or disabled are available by using the Medicaid benefit card.

Mental Retardation and Developmental Disabilities
- Long-term therapies
- Day treatment

- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

Alcohol and Substance Abuse Services

- Methadone treatment
- Out-patient substance abuse treatment
- Out-patient alcohol rehabilitation
- Outpatient alcohol clinic services
- Outpatient chemical dependence services for youth programs
- Chemical dependence (including alcohol and substance abuse) services ordered by the LDSS
- All covered alcohol and substance abuse services (except detox) are available for uninfected children who receive SSI or who are certified blind or disabled by using their Medicaid benefit card.
- All covered alcohol and substance abuse services (except detox) are available for uninfected homeless adults who receive SSI or who are certified blind or disabled by using their Medicaid benefit card.
- Detox services are available using your PLAN ID card.

Other Medicaid Services

- Pre-school and school services programs (early intervention)
- Early start programs
-
-

Services NOT Covered

*These services are **not available** from [Insert Plan Name] **or** Medicaid*. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Services of a Podiatrist (for those 21 years and older unless you are a diabetic)
- Personal and comfort items
- Infertility treatments
- Services from a provider that is not part of [Insert Plan Name], unless it is a provider you are allowed to see as described elsewhere in this handbook, or [Insert Plan Name] or your PCP sends you to that provider.

You may have to pay for any service that your PCP does not approve. Also, if you agree to be a "private pay" or "self-pay" patient before you get a service, you will have to pay for the service.

This includes:

- non-covered services (listed above),
- unauthorized services,
- services provided by providers not part of [Insert Plan Name]

If you have any questions, call Member Services at [Insert Member Services Toll-Free Number].

Service Authorization and Actions

Prior Authorization:

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization.** 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.

Asking for approval of a treatment or service is called a **service authorization request.** To get approval for these treatments or services you need to:

Insert instructions for submitting a service authorization request: e.g. You or your doctor may call our toll-free Member Services number at [Insert Member Services Number] or send your request in writing to [Insert Plan Address].

You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more care. This includes a request for home health care while you are in the hospital or after you have just left the hospital. 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 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 medically acceptable 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 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 or may be 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 either a **standard** or a **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 case will be handled under the standard review process. If you are in the hospital or have just left the hospital and we receive a request for home health care, we will handle the request as a fast track review. 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 or fair hearings you will have if you don't agree with our decision.

Timeframes for prior authorization requests:

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

- **Fast track review**: We will make a decision and you will hear from us within 3 work days. We will tell you by the third work day if we need more information.

Timeframes for concurrent review requests:

- **Standard review**: We will make a decision within 1 work day 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. We will tell you by the 14th day if we need more information.

- **Fast track review**: We will make a decision within 1 work day of when we have all the information we need.

  However, if you are in the hospital or have just left the hospital, and you ask for home health care on a Friday or day before a holiday, we will make a decision no later than 72 hours of when we have all the information we need.

  In all cases, you will hear from us no later than 3 work days after we received your request. We will tell you by the third work day if we need more information.

If we need more information to make either a standard or fast track decision about your service request, we will:

- Write and tell you what information is needed. If your request is 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 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 to [Insert appropriate address].

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 the 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 1-800-206-8125.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

Other Decisions About Your Care:

Sometimes we will do a concurrent review of 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 **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 reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.

- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 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 Medicaid even if we later deny payment to the provider.

How Our Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services ([Insert Member Services Toll-Free Number]) if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a **salary.** The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many -- or even none at all. This is called **capitation**.
- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an **incentive** fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by the Plan.
- Providers may also be paid by **fee-for-service.** This means they get a Plan-agreed-upon fee for each service they provide.

You Can Help With Plan Policies

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at [Insert Member Services Toll-Free Number] to find out how you can help. [Plans describe Consumer Advisory Boards and other options.]

Information From Member Services

Here is information you can get by calling Member Services at [Insert Member Services Toll-Free Number].

- A list of names, addresses, and titles of [Insert Plan Name]'s Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the Department of Financial Services about consumer complaints about [Insert Plan Name].
- How we keep your medical records and member information private.
- In writing, we will tell you how our plan checks on the quality of care to our members
- We will tell you which hospitals our health providers work with.
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by our plan.
- In writing, we will tell you the qualifications needed and how health care providers can apply to be part of our plan.
- If you ask us, we will tell you (1) if our contracts or subcontracts include physician incentive arrangements that affect the use of referral services; and, if so, (2) the types of arrangements we use; and (3) if stop loss protection is provided for physicians and physician groups.
- Information about how our company is organized and how it works.

Keep Us Informed

Call Member Services whenever these changes happen in your life:

- You change your name, address or telephone number
- You have a change in Medicaid eligibility
- You are pregnant
- You give birth
- There is a change in insurance for you or your children
- When you enroll in a new case management program or receive case management services in another community based organization

If you no longer get Medicaid, check with your local Department of Social Services. You ***may*** be able to enroll your children in Child Health Plus, or enroll yourself in the AIDS Drug Assistance Program.

DISENROLLMENT AND TRANSFERS

1. If YOU Want to Leave the Plan

When your county requires you to join a Medicaid health plan (a mandatory county): You can try us out for 90 days. You may leave [Insert Plan Name] and join another health plan at any time during that time. If you do not leave in the first 90 days, however, you must stay in [Insert Plan Name] for nine more months, *unless* you want to join another HIV SNP or you have a good reason (good cause).

Some examples of good cause include:

- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.
- You, the plan, and the LDSS all agree that disenrollment is best for you.
- You are or become exempt or excluded from managed care.
- We do not offer a Medicaid managed care service that you can get from another health plan in your area.
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk.
- We have not been able to provide services to you as we are required to under our contract with the State.
- We do not contract with FQHCs (Federally Qualified Health Centers) and you want to get your care from a FQHC. [Include this statement if plan does not contract with FQHCs.]
- You are an SSI adult with serious mental illness or SSI child who has serious emotional problems and wish to receive related treatment through Medicaid fee-for-service.

To disenroll or change plans:

[NOTE: Plans should include either ONE or BOTH of the following bullets containing language for plans that operate in counties with and/or without the enrollment broker.]

- Call the Managed Care staff at your local Department of Social Services.

- If you live in [List counties served by the enrollment broker], call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans or disenroll.

You may be able to disenroll or transfer to another plan over the phone. If you have to be in managed care, you will have to choose another health plan.

In any case, it may take between two and six weeks to process, depending on when your request is received. You will get a notice that the change will take place by a certain date. [Insert Plan Name] will provide the care you need until then.

You can ask for faster action if you believe the timing of the regular process will cause added

damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services or New York Medicaid Choice.

2. You Could Become Ineligible for Medicaid Managed Care and Special Needs Plans

- You or your child may have to leave [Insert Plan Name] if you or the child:

  - moves out of the County, the service area, or New York City
  - changes to another managed care plan,
  - joins an HMO or other insurance plan through work,
  - goes to prison,
  - becomes a permanent resident of a nursing home, or
  - if the Special Needs Plan is unable to verify HIV status or if you are HIV negative and no longer qualify as homeless.

- Your child may have to leave [Insert Plan Name] if he or she:

  - joins a Physically Handicapped Children's Program,
  - is placed in foster care by an agency that has a contract to provide that service for the local Department of Social Services including all children in foster care in New York City, or
  - is placed in foster care by the local Department of Social Services in an area that is not served by your child's current plan, or
  - if you are no longer enrolled in the Special Needs Plan and your child is not HIV positive.

3. We Can Ask You to Leave [Insert Plan Name] if you often:

- Refuse to work with your PCP in regard to your care
- Don't keep appointments,
- Go to the emergency room for non-emergency care,
- Don't follow [Insert Plan Name]'s rules,
- Do not fill out forms honestly or do not give true information (commit fraud),
- Act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems

You can also lose your [Insert Plan Name] membership, if you cause abuse or harm to plan members, providers or staff.

4. If you lose Medicaid Coverage: The HIV Uninsured Care Programs may be able to help you.

If you are HIV positive and lose Medicaid coverage, you may be eligible for the New York State Department of Health, HIV Uninsured Care Programs (aka ADAP). The programs provide limited

coverage for the care and treatment of HIV. If you have private health insurance, you also may be able to get help paying for your insurance premiums. Call 1-800-542-AIDS (2437) for more information.

5. No matter what reason you disenroll, we will prepare a discharge plan for you to help you get services you need.

Action Appeals

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**.

If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 business days after hearing from us to file an action appeal. [Insert timeframe if different, but can be no less that 60 business days or more than 90 calendar days.]

- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services [Insert Member Services Toll-Free Number] if you need help filing an action appeal.

- We will not treat you any differently or act badly toward you if you file an action appeal.

- The action appeal can be made by phone or in writing. If you make an action appeal by phone it must be followed up in writing. [Optional: After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you should sign and return the form to us. You can make any necessary changes before sending the form back to us.]

To file an action appeal, write to:

[Insert address]

To file an action appeal by phone, call:

[Insert toll-free phone number]

Your action appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your action appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your appeal will be reviewed under the standard process; **or**

- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**

- If your request was denied when you asked for home health care after you were in the hospital.

- Fast track action appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your action appeal:

- Within 15 days, we will send you a letter to let you know we are working on your appeal.

- Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.

- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

- Before and during the appeal you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.

- You can also provide information to be used in making the decision in person or in writing. Call PLAN at 1-800-xxx-xxxx if you are not sure what information to give us.
  - [insert if required by health plan for UR appeal]If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us:
    1. a written statement that the service you asked for is different from the service we have in our network; and
    2. two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you, and will not cause you more harm than the service we have in our network.

- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained to you. You or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Action Appeals:

- **Standard appeals**: If we have all the information we need we will tell you our decision **within thirty days** from your appeal. A written notice of our decision will be sent within 2 working days from when we make the decision.

- **Fast track appeals**: If we have all the information we need, fast track appeal decisions will be made in 2 working days from your appeal. We will tell you in 3 working days after giving us your appeal if we need more information. We will tell you our decision by phone and send a written notice later.

If we need more information for either a standard or fast track decision about your action appeal we will:

- Write to you and tell you what information is needed. If your request is 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 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 you decide your case. This can be done by calling [Insert appropriate toll-free 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 action appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If your original denial was because we said:

- the service was not medically necessary; or
- the service was experimental or investigational; or
- the out-of-network service was not different from a service that is available in our network; and

we do not tell you our decision about your action appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care:

In some cases you may be able to continue the services while you wait for your action appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for a fair hearing:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your fair hearing results in another denial, you may have to pay for the cost of any continued

benefits that you received. The decision you receive from the fair hearing officer will be final.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because:

- the service was not medically necessary; or
- the service was experimental or investigational ; or
- the out-of-network service was not different from a service that is available in our network;

you can ask New York State for an independent **external appeal**. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial or treatment for a rare disease. You do not have to pay for an external appeal.

Before you ask for an external appeal:

- You must file an action appeal with the plan and get the plan's final adverse determination; **or**
- If you have not gotten the service, and you ask for a fast track action appeal with the plan, you may ask for an expedited external appeal at the same time. Your doctor will have to say an expedited external appeal is necessary; **or**
- You and the plan may agree to skip the plan's appeals process and go directly to external appeal; **or**.
- You can prove the plan did not follow the rules correctly when processing your action appeal.

You have 4 months after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within4 months of when you made that agreement.

If you had a fast track action appeal and are not satisfied with the plan's decision you can choose to file a standard action appeal with the plan **or** ask for an external appeal. If you choose to file a standard action appeal with the plan, and the plan upholds its decision, you will receive a new final adverse determination and have another chance to ask for an external appeal.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the New York State Department of Financial Services within 4 months from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the appeal process.

You will lose you right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at [Insert Member Services Toll-Free Number] if you need help filing an appeal. You and your doctors will have to give information about your medical

problem. The external appeal application says what information will be needed.

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' web site www.dfa.ny.gov.
- Contact the health plan at [Insert appropriate health plan toll-free number]

Your external appeal will be decided in 30 days. More time (up to five work days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- your doctor says that a delay will cause serious harm to your health: or
- you are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.
You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for 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.

Fair Hearings

In some cases you may ask for a fair hearing from New York State.

- You are not happy with a decision your local department of social services or the State Department of Health made about your staying or leaving [Insert Plan Name].
- You are not happy with a decision that we made about medical care you were getting. You feel the decision limits your Medicaid benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Medicaid benefits.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with [Insert Plan Name]. If [Insert Plan Name] agrees with your doctor, you may ask for a State fair hearing.
- The decision you receive from the fair hearing officer will be final.

If the services you are now getting are scheduled to end, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. However, if you choose to ask for services to be continued and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

You can use one of the following ways to request a Fair Hearing:

1. By phone, call toll-free 800-342-3334
2. By fax, 518-473-6735
3. By internet, www.otda.state.ny.us/oah/forms.asp

By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Manage Care Unit
P.O. Box 22023
Albany, New York 12201-2023

Remember, you can complain anytime to the New York State Department of Health by calling 1-800-206-8125. In some cases, you may be able to keep getting your care the same way while you wait for your Fair Hearing. Call Member Services at XXX-XXX-XXXX if you have questions.

Complaint Process

Complaints:

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services you can file a complaint with the plan. Problems that are not solved right away over the phone and any complaint that comes in the mail will be handled according to our complaint procedure described below.

You can ask someone you trust (such as a legal representative, a family member, or friend) to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services or help filing the forms, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to: NYS Department of Health, Division of Health Plan Contracting and Oversight, Bureau of Managed Care Certification and Surveillance, ESP Corning Tower Room 2019, Albany, NY 12237. You may also contact your local Department of Social Services with your complaint at anytime. You may also call the New York State Department of Financial Services at 1-800-342-3736 if your complaint involves a billing problem.

How to File a Complaint with the Plan:

To file a complaint by phone, call Member Services at [Insert Member Services Toll-Free Number and the appropriate hours of operation]. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you. You can write to us with your complaint or call the Member Services number and request a complaint form. It should be mailed to [Insert appropriate address].

What Happens Next:

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint,
- how to contact this person, and
- if we need more information.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters your case will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will call you with our decision in 24 hours of when we have all the information we need to answer complaint, but you will hear from us in no more than 7 days from the day we get your complaint, We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 working days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your complaint because we don't have enough information, we will send you a letter and let you know.

Complaint Appeals:

If you disagree with a decision we made about your complaint, you or someone you trust can file a **complaint appeal** with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 business days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be in writing. If you make an appeal by phone, it must be followed up in writing. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

After we get your complaint appeal we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint appeal,
- how to contact that person, and
- if we need more information.

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

After we get all the information we need you will know our decision in 30 working days. If a delay would risk your health you will get our decision in 2 working days of when we have all the information we need to decide the appeal.

We will give you the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of [Insert Plan Name], you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from [Insert Plan Name].
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use [Insert Plan Name] complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Your Responsibilities

As a member of [Insert Plan Name], you agree to:

- Work with your care team to protect and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

Advance Directives

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and change these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Health Care Proxy - With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

CPR and DNR - You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

**(Note: This page intentionally left blank
To allow space for local adaptations.)**

Important Phone Numbers

Your PCP..... --- ----

[Insert Plan Name]

Member Services..... --- ----

Other Units....(e.g., Nurse Hotline, Utilization Review, etc)

Your nearest Emergency Room..... --- ----

New York State Department of Health (Complaints)..... 1-800-206-8125

County Social Services..... --- ----

Information on NYS Medicaid Managed Care

Local Department of Social Services…….

[For plans that serve the enrollment broker counties, insert:

New York Medicaid Choice …… 1-800-505-5678]

NYS HIV/AIDS Hotline..... 1-800-541-AIDS (2437)

Spanish..... 1-800-233-SIDA (7432)

TDD..... 1-800-369-AIDS (2437)

New York City HIV/AIDS Hotline (English & Spanish)..... 1-800-TALK-HIV (8255-448)

HIV Uninsured Care Programs 1-800-542-AIDS (2437)

TDD..... Relay, then 1-518-459-0121

Child Health Plus 1 855-693-6765

-Free or low cost health insurance for children

PartNer Assistance Program..... 1-800-541-AIDS (2437)

-In New York City (CNAP)..... 1- (212) 693-1419

Social Security Administration..... 1-(800)-772-1213

AIDS Clinical Trials Information Service (ACTIS) 1-(800)-874-2572

NYS Domestic Violence Hotline..... 1-800-942-6906

Spanish..... 1-800-942-6908

Hearing Impaired..... 1-800-810-7444

Americans with Disabilities Act (ADA) Information Line...1-800-514-0301

TDD..... 1-800-514-0383

Local Pharmacy ..... --- ----

Other Health Providers: --- ----

Important Web Sites

[Insert Plan Name]

NYS Department of Health

NYS DOH HIV/AIDS Information

NYS HIV Uninsured Care Programs
http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm

HIV Testing Resource Directory

NYC DOHMH

NYC DOHMH HIV/AIDS Information