

WELCOME TO [INSERT PLAN NAME] MEDICAID ADVANTAGE PLUS PROGRAM

Welcome to [Insert Plan Name] Medicaid Advantage Plus (MAP) Program. MAP combines Medicaid and Medicare coverage offered through [Insert Plan Name]. The MAP Program is designed for people who have Medicare and Medicaid and who need health services 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. You must choose one of the doctors from the plan to be your Primary Care Provider (PCP). If you decide later to change your Medicare plan, you will also have to leave [Insert Plan Name] MAP.

This handbook tells you about the added benefits [Insert Plan Name] covers since you are enrolled in the [Insert Plan Name] MAP Program. It also tells you how to request a service, file a complaint or disenroll from [Insert Plan Name] MAP Program. The benefits described in this handbook are in addition to the Medicare benefits described in the [Insert Plan Name] Medicare Evidence of Coverage. Keep this handbook with the [Insert Plan Name] Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

HELP FROM MEMBER SERVICES

You can call us at any time, 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 they can receive information in another language, hearing impaired or vision problems.

ELIGIBILITY FOR ENROLLMENT IN THE MAP PROGRAM

MAP is a program for people who have both Medicare and Medicaid. You are eligible to join the MAP Program if you meet all of the following requirements:

- 1) Are age **18** and older,
- 2) Reside in the plan's service area which is [list plan's service area],
- 3) Have Medicaid,
- 4) Have evidence of Medicare Part A & B coverage,

- 5) Are eligible for nursing home level of care (as of time of enrollment) using the Community Health Assessment (CHA),
- 6) Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety,
- 7) Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the Medicaid Advantage Plus Plan for more than 120 days from the effective 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, **and**
- 8) Must enroll in **[Insert Plan Name]** Medicare Advantage Product.

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in **[Insert Plan Name]** MAP Program. Enrollment in the MAP Program 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 has completed the initial assessment steps, determined that you are eligible for Medicaid Managed Long Term Care, and you have agreed to the plan of care developed for you, you can then choose which Managed Long Term Care plan in which to enroll. Because you also are enrolled in Medicare for this same plan, you have chosen to combine your benefits and enroll in [Insert Plan name].

Plans, please insert here a description of your MAP 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, [Plan Number] (TTY/TDD: [Plan Number]).

SERVICES COVERED BY THE [INSERT PLAN NAME] XXX PROGRAM

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the [Insert Plan Name] Medicare Evidence of Coverage. Sections 2 and 3 of [Insert Plan Name]. The Medicare Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Section 4 of [Insert Plan Name] Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined [Insert Plan Name], and you have Medicaid, [Insert Plan Name] will pay these amounts. You do not have to pay these deductibles and copayments **except for those that apply to** some pharmacy items.

If there is a monthly premium for benefits (see Section 8 of the [Insert Plan Name] Medicare Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

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 the member's 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 the MAP program, 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 enrollee to request medically necessary services from an out-of network provider when the service is included in the [Insert Plan name]'s Benefit Package and is determined by [Insert Plan name] 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)
- Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit *If the member must take some action to access care beyond the 190-day limit, plans must describe the process. If no action is required by the member, no additional text is necessary.*
- Audiology
- DME
- Medical Supplies
- Prosthetics and Orthotics
- Optometry
- Consumer Directed Personal Assistance Services

The following services are also included in the MAP Plan effective January 1, 2023:

- Continuing Day Treatment (CDT)
- Partial Hospitalization (PH)
- Assertive Community Treatment (ACT)
- Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)
- Personalized Recovery Oriented Services (PROS)
- Community Oriented Recovery and Empowerment (CORE) Services
 - Psychosocial Rehabilitation (PSR)
 - Community Psychiatric Supports and Treatment (CPST)
 - Empowerment Services – Peer Supports
 - Family Support and Training (FST)
- Comprehensive Psychiatric Emergency Program (CPEP)
- Mobile Crisis and Telephonic Crisis Services
- Crisis Residential Programs
- Opioid Treatment Centers (OTP)
- OASAS Certified Title 14 Part 820 Residential services
- State Operated Addiction Treatment Center's (ATC)
- Inpatient addiction rehabilitation
- Inpatient Medically Supervised Detox

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 provided you are eligible for institutional Medicaid coverage.

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 manger 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 enrollees 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 the 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. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or 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 Phone 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 drugs are covered by **[Insert Plan Name]** Medicare Part D as described in section 6 of the **[Insert Plan Name]** Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by **[Insert Plan Name]** Medicare Part D. Medicaid may also cover drugs that we deny.

Certain Mental Health Services, including:

- Health Home (HH) and Health Home Plus (HH+) Care Management services
- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs
- OMH Day Treatment
- OASAS Residential Rehabilitation for Youth
- Certified Community Behavioral Health Clinics (CCBHC)
- OMH Residential Treatment Facility (RTF)
- Crisis Intervention Services for Youth ages 18-20

For MAP enrollees up to the age of 21:

- Children and Family Treatment and Support Services (CFTSS)
- Children's Home and Community Based Services (HCBS)

Certain Intellectual Disability 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

- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs, for members meeting criteria

Family Planning [Add to Plan covered services as appropriate]

Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).

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 member services toll-free phone number].

SERVICE AUTHORIZATION, APPEALS AND COMPLAINTS PROCESSES

You have Medicare and also get assistance from Medicaid. Information in this chapter covers your rights for all of your Medicare and most of your Medicaid benefits. In most cases, you will not use one process for your Medicare benefits and a different process for your Medicaid benefits. You will usually use one process for both. This is sometimes called an “integrated process” because it integrates Medicare and Medicaid processes.

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page [\[insert page number\]](#) for more information on the External Appeals process.

Section 1: Service Authorization Request (also known as Coverage Decision Request)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

When you ask for approval of a treatment or service, it is called a **service authorization request (also known as a coverage decision request)**. To get 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 the plan]* before you get them. You or someone you trust can ask for prior authorization. The following treatments and services must be approved **before** you get them:

[List services requiring preauthorization and the process for getting 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 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 acceptable medical standards.

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

After we get your request, we will review it under either a **standard** or a **fast-track** process. You or your provider can ask for a fast-track review if you or your provider believes that a delay will cause serious harm to your health. If we deny your request for a fast-track review, we will tell you and handle your request under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below. More information on the fast-track process is below.

We will tell you and your provider both by phone and in writing if we approve or deny your request. We will also tell you the reason for the decision. We will explain what options you have if you don't agree with our decision.

Standard Process

Generally, we use the **standard timeframe** for giving you our decision about your request for a medical item or service unless we have agreed to use the fast-track deadlines.

- A standard review for a prior authorization request means we will give you an answer within 3 workdays of when we have all the information we need, but no later than **14 calendar days** after we get your request. If your case is a **concurrent review** where you are asking for a change to a service you are already getting, we will make a decision within 1 workday of when we have all the information we need but will give you an answer no later than 14 calendar days after we get your request.
- **We can take up to 14 more calendar days** if you ask for more time or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will 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.
- If you believe we should **not** take extra days, you can file a **“fast complaint.”** When you file a fast complaint, we will give you an answer to your complaint

within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan.)

If we do not give you our answer within 14 calendar days (or by the end of the extra days if we take them), you can file an appeal.

- **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. Section 2: Level 1 Appeals (also known as Level 1) later in this chapter tells how to make an appeal.

Fast Track Process

If your health requires it, ask us to give you a **“fast service authorization.”**

- A fast review of a prior authorization request means we will give you an answer within 1 workday of when we have all the information we need but no later than **72 hours** from when you made your request to us.
- We can take **up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing what information is needed and why the delay is in your best interest. We will 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.
- If you believe we should not take extra days, **you can file a “fast complaint”** (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.) We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 2: Level 1 Appeals, below for how to make an appeal.

To get a fast service authorization, you must meet two requirements:

1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a fast service authorization if your request is about payment for medical care, you already got.)
2. Using the standard deadlines could cause serious harm to your life or health or hurt your ability to function.

If your provider tells us that your health requires a “fast service authorization,” we will automatically agree to give you a fast service authorization.

If you ask for a fast service authorization on your own, without your provider’s support, we will decide whether your health requires that we give you a fast service authorization.

If we decide that your medical condition does not meet the requirements for a fast service authorization, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your provider asks for the fast service authorization, we will automatically give a fast service authorization.
- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints, see **“Section 5: What To Do If You Have A Complaint About Our Plan”** later in this chapter.)

If our answer is yes to part or all of what you asked for, we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service authorization on your request for a medical item or service, we will give you our answer by the end of that extended period.

If our answer is no to part or all of what you asked for, we will send you a detailed written explanation as to why we said no. If you are not satisfied with our answer, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If you do not hear from us on time, it is the same as if we denied your service authorization request. If this happens, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If we are changing a service you are already getting:

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved that you are now getting, we must tell you at least 15 days before we change the service.
- If we are checking care that you got in the past, we will make a decision about paying for it within 30 days of getting 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 we deny the payment. **You will not have to pay for any care you got that the plan or Medicaid covered even if we later deny payment to the provider.**

You may also have special **Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services** is ending. For more information about these

rights, refer to **Chapter 9** of the **[Insert Medicare Health Plan Name]** Evidence of Coverage.

What To Do If You Want To Appeal A Decision About Your Care

If we say no to your request for coverage for a medical item or service, you decide if you want to make an appeal.

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).
- **[Insert Plan Name]** can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at **[Insert Member Services toll-free phone number]** to get more information on your rights and the options available to you.

At any time in the process, 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.

Section 2: Level 1 Appeals (also known as a Plan Level Appeal)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

There are some treatments and services that you need approval for before you get them or to be able to keep getting them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. We describe this process earlier in Section 1 of this chapter. If we decide to deny a service authorization request or to approve it for an amount that is less than asked for, you will receive a notice called an Integrated Coverage Determination Notice.

If you receive an Integrated Coverage Determination Notice and disagree with our decision, you have the right to make an appeal. Making an appeal means trying to get the medical item or service you want by asking us to review your request again.

You can file a Level 1 Appeal:

When you appeal a decision for the first time, this is called a Level 1 Appeal, or a Plan Appeal. In this appeal, we review the decision we made to see if we properly followed all the rules. Different reviewers handle your appeal than the ones who made the original unfavorable decision. When we complete the review, we will give you our decision. Under certain circumstances, which we discuss below, you can request a fast appeal.

Steps to file a Level 1 Appeal:

- If you are not satisfied with our decision, you have **60 days** from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for asking for an appeal.
- If you are appealing a decision, we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a **“fast appeal.”**
 - The requirements and procedures for getting a “fast appeal” are the same as for getting a “fast track service authorization.” To ask for a fast appeal, follow the instructions for asking for a fast track service authorization. (These instructions are given in Section 1, in the Fast Track Process section.)
 - If your provider tells us that your health requires a “fast appeal,” we will give you a fast appeal.
 - If your case was a **concurrent review** where we were reviewing a service you are already getting, you will automatically get a fast appeal.
- You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you. You can call Member Services at **[Insert Plan Name toll-free number]** if you need help filing a Level 1 Appeal.
 - Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an “Appointment of Representative” form, or write and sign a letter naming your representative.
 - To get an “Appointment of Representative” form, call Member Services and ask for the form. You can also get the form on the Medicare website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> **[plans may also insert: or on our website at <web address or link to form>]**. The form gives the person permission to act for you. You must give us a copy of the signed form, **or**
 - You can write a letter and send it to us. (You or the person named in the letter as your representative can send us the letter.)
- We will not treat you any differently or act badly toward you because you file a Level 1 Appeal.

- You can make the Level 1 Appeal by phone or in writing. *[Optional: After your call, we will send you a form that summarizes your phone appeal. You can make any needed changes to the summary before signing and returning the form to us.]*

Continuing Your Service or Item While Appealing a Decision About Your Care

If we told you we were going to stop, suspend, or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking action.
- If you disagree with the action, you can file a Level 1 Appeal.
- We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.
- **Note:** If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative.

What happens after we get your Level 1 Appeal

- Within 15 days, we will send you a letter to let you know we are working on your Level 1 Appeal. We will let you know if we need additional information to make our decision.
- We will send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records we will use to make the appeal decision. If your Level 1 Appeal is fast tracked, there may be a short time to review this information.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one 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.
- You can also provide information to be used in making the decision in person or in writing. Call us at *[Insert Toll-free Health Plan Number]* if you are not sure what information to give us.
- We will give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you

asked for, we will send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we will **automatically** send your case on to the next level of the appeals process.

Timeframes for a “Standard” Appeal

- If we are using the standard appeal timeframes, we must give you our answer on a request **within 30 calendar days** after we get your appeal if your appeal is about coverage for services, you have not gotten yet.
- We will give you our decision sooner if your health condition requires us to.
- However, if you ask for more time or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide we need to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will 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.
 - If you believe we should **not** take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
 - For more information about the process for making complaints, including fast complaints, see Section 5: What to Do If You Have A Complaint About Our Plan, below, for more information.
- If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process.
 - An independent outside organization will review it.
 - We talk about this review organization and explain what happens at Level 2 of the appeals process in Section 3: Level 2 Appeals.
- **If our answer is “Yes” to part or all of what you asked for**, we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision.
- **If our answer is no to part or all of what you asked for**, to make sure we followed all the rules when we said no to your appeal, **we are required to send your appeal to the next level of appeal**. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Timeframes for a “Fast” Appeal

- When we are using the fast timeframes, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to do so.
- If you ask for more time or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will 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.
- If we do not give you an answer within 72 hours (or by the end of the extra days we took), we are required to automatically send your request on to Level 2 of the appeals process which is discussed below in Section 3: Level 2 Appeals.

If our answer is “YES” to part or all of what you asked for, we must authorize or provide the coverage we have agreed to provide within 72 hours after we get your appeal.

If our answer is “NO” to part or all of what you asked for, we will automatically send your appeal to an independent review organization for a Level 2 Appeal. You or someone you trust can also file a complaint with the plan if you don’t agree with our decision to take more time to review your action appeal.

- During the Level 2 Appeal, an independent review organization, called the **“Integrated Administrative Hearing Office” or “Hearing Office,”** reviews our decision on your first appeal. This organization decides whether the decision we made should be changed.
- We tell you about this organization and explain what happens at Level 2 of the appeals process later in Section 3: Level 2 Appeals.

At any time in the process, 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.

Section 3: Level 2 Appeals

Information in this section applies to **all** your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

If we say **“No”** to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Hearing Office**

reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- **The Hearing Office is an independent New York State agency.** It is not connected with us. Medicare and Medicaid oversee its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a free copy of your case file.**
- You have a right to give the Hearing Office additional information to support your appeal.
- Reviewers at the Hearing Office will take a careful look at all the information related to your appeal. The Hearing Office will contact you to schedule a hearing.
- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed by waiting for a decision under a standard timeframe, you will automatically get a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you would automatically get a standard appeal at Level 2.
- The review organization must give you an answer to your Level 2 Appeal **within 60 calendar days** of when it gets your appeal. There is a total of 90 days available between the date you request a plan appeal (Level 1) and the date that the Hearing Office decides your Level 2 appeal.
- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page <xx> for information about continuing your benefits during Level 1 Appeals.

The Hearing Office will tell you about its decision in writing and explain the reasons for it.

- If the Hearing Office says “**Yes**” to part or all your request, we must authorize the service or give you the item **within one business day of when we get the Hearing Office’s decision.**
- If the Hearing Office says “**No**” to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical

care should not be approved. (This is called “upholding the decision” or “turning down your appeal.”)

If the Hearing Office says “No” to part or all your appeal, you can choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal).
- If your Level 2 Appeal is turned down, you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you got after your Level 2 Appeal has the details on how to do this.
- The Medicare Appeals Council handles the Level 3 Appeal. After that, you may have the right to ask a federal court to look at your appeal.

At any time in the process, 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.

Section 4: External Appeals for Medicaid Only

You or your doctor can ask for an External Appeal for **Medicaid covered benefits only**. You can ask New York State for an independent **external appeal** if our plan decides to deny coverage for a medical service you and your doctor asked for because it is:

- not medically necessary or
- experimental or investigational or
- not different from care you can get in the plan’s network or
- available from a participating provider who has correct training and experience to meet your needs.

This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. 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. You do not have to pay for an external appeal.

Before you appeal to the State:

- You must file a Level 1 appeal with the plan and get the plan’s Final Adverse Determination; **or**
- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited 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 Level 1 appeal.

You have **4 months** after you get 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 within 4 months of when you made that agreement.

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 Plan's 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' website at www.dfs.ny.gov .
- Contact the health plan at [Insert Plan's Toll-free Number]

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five workdays) may be needed. The reviewer will tell you and the plan the final decision within two days after making the decision.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, 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.

Section 5: What To Do If You Have A Complaint About Our Plan

Information in this section applies to **all** of your Medicare and Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

We hope our plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services *you get from us*, call Member Services at [Insert Member Services Toll-free Number] or write to

Member Services. **The formal name for “making a complaint” is “filing a grievance.”**

You can ask someone you trust to file the complaint for you. If you need our help because of a hearing or vision impairment or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint:

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. **[Insert phone number, TTY, and days and hours of operation.]**
- If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **[Insert description of the procedures and instructions about what members need to do if they want to use the process for making a complaint.]**
- **Whether you call or write, you should contact Member Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

What happens next?

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **We answer most complaints in 30 calendar days.**
- If you are making a complaint because we denied your request for a “fast service authorization” or a “fast appeal,” **we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**
- If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- However, if you have already asked us for a service authorization or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples of when you can make a complaint:
 - If you asked us to give you a “fast service authorization” or a “fast appeal” and we said we will not.

- If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made.
- When a service authorization we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines.
- When we do not give you a decision on time and we do not forward your case to the Hearing Office by the required deadline.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Complaint Appeals

If you disagree with a decision we made about your complaint about your Medicaid benefits, 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 workdays after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you.
- You must make the complaint appeal in writing.
 - If you make an appeal by phone, you must follow it up in writing.
 - After your call, we will send you a form that summarizes your phone appeal.
 - 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 workdays. The letter will tell you:

- Who is working on your complaint appeal.
- How to contact this person.
- If we need more information.

One or more qualified people will review your complaint appeal. These reviewers are at a higher level than the reviewers who made the first decision about your complaint.

If your complaint appeal involves clinical matters, one or more qualified health professionals will review your case. At least one of them will be a clinical peer reviewer who was not involved in making the first decision about your complaint.

We will let you know our decision within 30 workdays from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 workdays 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 1-866 712-7197.

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 MAP plan like **[Insert Plan Name]**. This support includes unbiased health plan choice counseling and general program related information.

Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)

Web: www.icannys.org | Email: ican@cssny.org

DISENROLLMENT FROM [Insert Plan Name] MAP PROGRAM

Enrollees shall not be disenrolled from the Medicaid Advantage Plus Product based on any of the following reasons:

- High utilization of covered medical services, an existing condition or a change in the Enrollee's health, *or*
- diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs unless the behavior results in the Enrollee becoming ineligible for Medicaid Advantage Plus.

You Can Choose to Voluntary Disenroll

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

To request disenrollment, call **[Plan number]**. 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 Community Based Long Term Services and Supports (CBLTSS), like personal care, you must join another MLTC plan or Home and Community Based Waiver program, in order to receive CBLTSS services.

You Will Have to Leave [Insert Plan Name], MAP Program if:

- You no longer are in [Insert Plan Name] for your Medicare coverage,
- You no longer are Medicaid eligible,
- You need nursing home care, but are not eligible for institutional Medicaid,
- You are out of the plan's service area for more than 30 consecutive days,
- You permanently move out of [Insert Plan Name] service area,
- You are no longer eligible for nursing home level of care as determined using the Community Health Assessment (CHA), unless the termination of the services provided by the plan could reasonably be expected to result in you being eligible for nursing home level of care within the succeeding six-month period,
- At the point of any reassessment while living in the community, you are determined to no longer demonstrate a functional or clinical need for Community Based Long Term Services and Supports (CBLTSS),
- Your sole service is identified as Social Day Care,
- You join a Home and Community Based Services Waiver program, or are enrolled in a program or become a resident in a facility that is under the auspices of the Offices for People with Developmental Disabilities, or Alcoholism and Substance Abuse Services; or
- You are a resident of a State-operated psychiatric facility

We May Ask You to Leave the [Insert Plan Name], MAP Program 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.
- You knowingly provide fraudulent information on an enrollment form, or you permit abuse of an enrollment card in the MAP Program;
- You fail to complete and submit any necessary consent or release; or
- You fail to pay or make arrangements to pay the amount of money, as determined by the Local District of Social Services (LDSS), 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 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 the disenrollment is processed. If you continue to need CBLTSS, you will be required to choose another plan or you will be auto assigned to another plan to provide you with coverage for needed services.

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 enrollees. 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; and, 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 [Inset 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; and policies and procedures used by [Insert Plan Name] to determine eligibility of a provider.