



2020 Member Handbook

Medicare Advantage with Prescription Drug (MAPD) Plan
Dual Special Needs Plan (D-SNP)
And Medicaid Advantage Plus (MAP) Plan

**Bronx, Kings (Brooklyn), Nassau, New York (Manhattan),
Queens & Westchester**

Coordinated community based long term care services and access to both Medicare and Medicaid benefits, under a single managed care plan.



The Way to Age Well in New York

Medicaid Advantage Plus Handbook

WELCOME TO AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) PROGRAM

Welcome to AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP). The MAP Program is especially designed for people who have Medicare and Medicaid and who need health and long-term care services like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) covers since you are enrolled in the AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP), MAP Program. It also tells you how to request a service, file a complaint or disenroll from AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP). The benefits described in this handbook are in addition to the Medicare benefits described in the AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) Medicare Evidence of Coverage. Keep this handbook with the AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) 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 at the Member Services number below.

There is someone to help you at Member Services:

Monday through Friday

8:00 am to 8:00 pm

Member Services.....	1-866-237-3210
AgeWell New York TTY/TDD.....	1-800-662-1220
Care Manager.....	1-866-237-3210

If you need help at other times, call 1-866-237-3210

ELIGIBILITY FOR ENROLLMENT IN THE MAP PROGRAM

The MAP is a program for people who have both Medicare and Medicaid. You are eligible to join the MAP Program if you are also enrolled in AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) for Medicare coverage and:

1. Are age **18** and older
2. Reside in the plan’s service area: Westchester, Bronx, New York, Brooklyn, Queens, or Nassau counties

3. Have a chronic illness of disability that makes you eligible for services usually provided in a nursing home
4. Are able to return or remain in your home and community, without jeopardy to your health and safety, at the time you join the plan
5. Require care management and are expected to need one or more of the following community based long term care services for more than 120 days from the date that you join our plan:
 - 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, or
 - f. Private Duty Nursing
 - g. Consumer Directed Personal Assistance Services (CDPAS)

An Applicant who is a hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office For People With Developmental Disability (OPWDD) or is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, a Comprehensive Medicaid Case Management Program (CMCM) or OPWDD Day Treatment Program or is receiving services from a hospice may be enrolled with AgeWell New York Advantage Plus (HMO SNP) upon discharge or termination from the inpatient hospital, facility licensed by the OMH, OASAS or OPWDD, other managed care plan, hospice, Home and Community-Based Services waiver program or OPWDD Day Treatment Program.

Joining AgeWell New York Advantage Plus (HMO SNP)

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP), MAP Program. Enrollment in the MAP Program is voluntary.

Enrollment in is voluntary AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP). Your expected coverage date will be stated in your Enrollment Agreement. In general, coverage starts the first day of the month following your signing the Enrollment Agreement. If you are new to needing Medicaid Community-Based Long Term Care Services, you will need to be evaluated by a Registered Nurse from the New York State Conflict-Free Evaluation and Enrollment Center (CFEEC). This nurse will determine whether you are eligible for the community based long term care services provided.

As part of the enrollment process, and following the initial membership assessment telephone call, a Registered Nurse from AgeWell New York will come to your home. During this meeting, the following will occur:

- A comprehensive health assessment must be conducted within thirty (30) days of your request for enrollment.
- Your home environment will be assessed for safety.
- Rules and responsibilities of plan membership will be explained. Assistance will be provided in completing the enrollment process.
- A New York State Licensed Medicare Agent will explain the Medicare benefits and complete a Medicare application to enroll you into AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP)

Denial of Enrollment

AgeWell New York may find a prospective member ineligible to enroll in our MAP program if he/she does not meet the age requirements, is not a resident of the AgeWell New York service areas, or is not eligible for Medicaid. If you do not meet the eligibility criteria, AgeWell New York will recommend denial of your enrollment to NY Medicaid Choice (NYMC), if you do not choose to withdraw your application. Only NYMC may deny enrollment and will notify you of your rights.

You may withdraw your application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment by indicating your wishes verbally or in writing and a written acknowledgment of your withdrawal will be sent to you.

If you are determined to be clinically ineligible for AgeWell New York, you will be advised and you may withdraw your application. Clinical ineligibility means that, based on the assessment completed by the AgeWell New York Registered Nurse, you do not meet one or more of the following criteria:

- You do not meet health and safety criteria; and/or
- You do not require Community-Based Long Term Care Services for more than 120 days.
- You do not require nursing home level of care.

If you do not withdraw your application, your application will be processed as a proposed denial, pending review by NYMC.

Identification (ID) Card

You will receive your AgeWell New York identification (ID) card within 14 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your identification card with you at all times. If your card becomes lost or is stolen, please contact Member Services at, 1-866-237-3210 (TTY/TDD: 1-800-662-1220).

Equality of Access to Enrollment

AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) shall accept Enrollments of Eligible Persons in the order in which they are received without restriction and without regard to the Eligible Person's age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, need for health services or to the Capitation Rate that the AgeWell New York Advantage Plus (HMO SNP) will receive for such Eligible Person.

Network providers will be paid in full directly by AgeWell New York Advantage Plus (HMO SNP) for each service authorized and provided to you with no co-pay or cost to you. If you receive a bill for covered services authorized by AgeWell New York Advantage Plus (HMO SNP) you are not responsible to pay the bill, please contact your Care Manager. You may be responsible for payment of covered services that were not authorized by AgeWell New York Advantage Plus (HMO SNP), or for covered services that are obtained by providers outside of AgeWell New York Advantage Plus (HMO SNP) network.

Transitional care procedures

New enrollees in AgeWell New York Advantage Plus (HMO SNP) 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 AgeWell New York Advantage Plus (HMO SNP) 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.

MONTHLY SPENDDOWN

Medicaid Spenddown/Surplus/Net Allowable Monthly Income (NAMI)

Some members may have a monthly spenddown/surplus to be eligible for Medicaid services. The spenddown amount is determined by the Local Department of Social Services or entity designated by the NYSDOH/Human Resource Administration (HRA). If this applies to you, payments are to be made to AgeWell New York, on a monthly basis. If you have a spenddown amount owed to AgeWell New York and you do not submit payments, you may be disenrolled from AgeWell New York. Spenddown payments can be in the form of check or money order (not cash), and should be sent to the following address:

AgeWell New York
Attn: Finance Department, Member Accounts
1991 Marcus Avenue, Suite M201
Lake Success, NY 11042

If you are a permanently placed member in a nursing home, you are required to contribute your Net Allowable Monthly Income (NAMI) towards the cost of your care. You are required to remit this amount to the nursing home directly.

SERVICES COVERED BY THE AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) 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 AgeWell New York Advantage Plus (HMO SNP) Medicare Evidence of Coverage. Chapters 2 and 3 of the AgeWell New York Advantage Plus (HMO SNP) Medicare Evidence of Coverage explain 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 Chapter 4 of the AgeWell New York Advantage Plus (HMO SNP) Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined AgeWell New York Advantage Plus (HMO SNP), and you have Medicaid, AgeWell New York Advantage Plus (HMO SNP) will pay these amounts. You do not have to pay these deductibles and co-payments except for those that apply to chiropractic care unless you are Qualified Medicare Beneficiary (QMB), and pharmacy items. If there is a monthly premium for benefits (see Chapter 8 of the AgeWell New York

Advantage Plus (HMO SNP) 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 Registered Nurse or a Licensed Social Worker. Your care manager will work with you, your doctor and other health care providers to coordinate and develop a Person Centered Service Plan. Your care manager will also arrange appointments for any services you need and arrange for transportation to those services. Requests for new or additional covered services can be obtained through your care manager by you, designated representative, or your provider. Requests can be made verbally or in writing.

Additional Covered Services

Because you have Medicaid and qualify for the AgeWell New York Advantage Plus (HMO SNP) 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 AgeWell New York Advantage Plus (HMO SNP). New or additional services require the review and authorization of your care manager.

If you cannot find a provider in our plan, a member may request medically necessary services from an out-of network provider when the service is included in the AgeWell New York Advantage Plus (HMO SNP) benefit package. Each request is reviewed individually and determinations are made based on the member's need. Some requests require a medical necessity determination to ensure the requested service is most appropriate for your condition and are medically necessary. The Provider Relation Department will then be contacted to enter into an agreement with the provider.

Covered Services and Authorizations.

The chart below lists the benefits covered by AgeWell New York Advantage Plus (HMO SNP) and indicates whether authorization is required prior to receiving services as well as whether your physician must be involved in arranging the service. Your Care Manager will assist you with arranging these.

AgeWell New York Advantage Plus Benefit	Description of Covered Service	Physician Order Required	AgeWell New York Advantage Plus
Personal Care	Some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care must be medically necessary, ordered by the member’s physician and provided by a qualified person as determined by regulation, in accordance with the plan or care.	✓	✓
Consumer Directed Personal Assistance Services (CDPAS)	The New York State Medicaid program permits Medicaid-eligible persons to hire, monitor, and terminate their own home caregivers (personal assistants). Instead of an outside vendor or agency managing their care, CDPAS gives MLTC eligible individuals independence and control. Certain guidelines apply to eligibility for CDPAS	✓	✓

AgeWell New York Advantage Plus Benefit	Description of Covered Service	Physician Order Required	AgeWell New York Advantage Plus
	and individuals who can serve as personal assistants.		
Home Health Care Services Not Covered by Medicare	Includes services such as nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services, which are of a preventative, rehabilitative, health guidance or supportive nature.	✓	✓
Nutrition	(including Nutritional Supplements) – The assessment of nutritional needs or the planning for appropriate meals and nutritional supplements to meet the member’s needs. Supplements include enteral and parenteral formulas.	✓	✓
Medical Social Services	Services and items that support the medical needs of the member		✓
Home Delivered Meals and/or meals in a group setting such as day care	Meals provided in accordance with each individual member’s plan or care. Congregate meals are meals delivered at a group setting such as day care.		✓
Social Day Care	A structured program which provides functionally-impaired members with socialization,		✓

AgeWell New York Advantage Plus Benefit	Description of Covered Service	Physician Order Required	AgeWell New York Advantage Plus
	supervision and monitoring, and nutrition in a protective setting during any part of the day, but for less than a 24 hour period. Additional services may include, but are not limited to personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.		
Non-Emergency Transportation	Transportation by ambulance, ambulette, taxi or livery service or public transportation, at the appropriate level the member's condition requires, for medically necessary trips such as to dialysis or medical appointments.		✓
Private Duty Nursing	Are medically necessary services provided to members at their permanent or temporary place of residence , by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of	✓	✓

AgeWell New York Advantage Plus Benefit	Description of Covered Service	Physician Order Required	AgeWell New York Advantage Plus
	care available from certified home care agencies (CHHAs)		
Dental	Includes services such as preventative, prophylactic, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition.		✓
Social/Environmental Supports	Services and items that support the medical needs of the member and are included in a member's plan of care. These services and items include, but are not limited to, the following; home maintenance tasks, homemaker/chore services, housing improvement and respite care.		✓
Personal Emergency Response System	An electronic device which enables certain high-risk patients to secure help in the event of an emergency.		✓
Adult Day Health Care	Adult day health care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired,	✓	✓

AgeWell New York Advantage Plus Benefit	Description of Covered Service	Physician Order Required	AgeWell New York Advantage Plus
	not homebound, who requires certain preventative, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, and other ancillary services.		
Nursing Home Care not covered by Medicare	Care provided in a nursing home when a member is eligible for institutional Medicaid, and placed permanently in the home.	✓	✓
Outpatient Rehabilitation	Medicaid covered Occupational therapy and Speech Language therapy are limited to twenty (20) visits per calendar year and Physical therapy is limited to forty (40) visits per therapy per calendar year except for children under 21 and the developmentally disabled.	✓	✓
Durable Medical Supplies	Includes medical and surgical equipment and	✓	✓

AgeWell New York Advantage Plus Benefit	Description of Covered Service	Physician Order Required	AgeWell New York Advantage Plus
	supplies, such as orthopedic footwear, hearing aid batteries, diabetic supplies, and incontinent supplies as key examples. Durable medical equipment is devices and equipment, which have been ordered by a practitioner in the treatment of a specific medical condition.		
Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit	All inpatient mental health services, including voluntary or involuntary admissions for mental health services over the Medicare 190-Day Lifetime Limit. AgeWell New York Advantage Plus (HMO SNP) may provide the covered benefit for medically necessary mental health inpatient services through hospitals licensed pursuant to Article 28 of the NYS P.H.L.	✓	✓
Parenteral Formula, Enteral Formula, Nutritional Supplements	Enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through and other means, and to the following conditions: 1) individuals who cannot chew or swallow	✓	✓

AgeWell New York Advantage Plus Benefit	Description of Covered Service	Physician Order Required	AgeWell New York Advantage Plus
	food and must obtain nutrition through formula nasogastric, jejunostomy, or gastrostomy tube feeding; and 20 individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.		
Audiology	Audiology services include audiometric examination or testing, hearing aid evaluations, conformity evaluation and hearing aid prescriptions or recommendation, if indicated. Hearing aid services are included.	✓	✓
Prosthetic and Orthotic Appliances and Devices	Prosthetic appliances and devices which replace any missing part of the body. Orthotic appliances and devices are used to support a weak or deformed body member, or to restrict or eliminate motion in a diseased or injured part of the body.	✓	✓
Respiratory Therapy	Means the performance of preventive, maintenance and	✓	✓

AgeWell New York Advantage Plus Benefit	Description of Covered Service	Physician Order Required	AgeWell New York Advantage Plus
	rehabilitative airway related techniques and procedures.		
Optometry	Includes the services of an optometrist and ophthalmic dispenser. It includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes, and low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the member's condition.	✓	✓
Podiatry	Services by a Podiatrist that include routine foot care when it is medically necessary for the member, such as serious localized illness or diabetic foot care.	✓	✓

Limitations

- Outpatient Physical therapy is limited to 40 Medicaid visits and Occupational and Speech Language therapy are limited to 20 Medicaid visits per therapy per year except for children under age 21 or if you have been determined developmentally disabled by the Office for People With Developmental Disabilities or if you have a traumatic brain injury.
- Enteral formula and nutritional supplements is 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 manager should be contacted to assist you in arranging services.

Emergency Service

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

If you are hospitalized, a family member or other caregiver should contact AgeWell New York Advantage plus (HMO SNP) 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 cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact AgeWell New York Advantage Plus (HMO SNP) so that we may work with them to plan your care upon discharge from the hospital.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that AgeWell New York Advantage Plus (HMO SNP) does not cover. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call our Toll-Free Member Services number at 1-866-237-3210 (TTY/TDD: 1-800-662-1220) if you have a question about whether a benefit is covered by AgeWell New York Advantage Plus (HMO SNP) or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription drugs are covered by AgeWell New York Advantage Plus (HMO SNP)

Medicare Part D as described in section 6 of the AgeWell New York Advantage Plus (HMO SNP) Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Medicare.

Certain Mental Health Services, including:

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

Certain Mental Retardation 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
- Comprehensive Medicaid Case Management
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management

FAMILY PLANNING

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 AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) PROGRAM

You must pay for services that are not covered by AgeWell New York Advantage Plus (HMO SNP) 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 AgeWell New York Advantage Plus (HMO SNP) or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Services of a Provider that is not part of the plan (unless AgeWell New York Advantage plus (HMO SNP) sends you to that provider)

If you have any questions, call our Toll-Free Member Services number at 1-866-237-3210 (TTY/TDD: 1-800-662-1220).

You have Medicare and 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 27 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:

Your Care Manager must be contacted to obtain requests for new or additional covered services by you or your provider. Requests can be made verbally or in writing. New or additional services require the review and authorization of your Care Manager. Some requests require a medical necessity determination to ensure the requested service is most appropriate for your condition and are medically necessary. In some cases, Service Authorizations will be sent to you and your service provider in writing. You or your doctor may call our Toll-Free Member Services number at 1-866-237-3210 (TTY/TDD: 1-800-662-1220) or send your request in writing to our fax number at 1-866-582-3894 or mail:

**AgeWell New York Advantage Plus (HMO SNP)
Attn. Care Management Department
1991 Marcus Avenue | Suite M201 | Lake Success N.Y. 11042-2057**

We will be 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 your Care Manager 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:

- Personal Care
- Consumer Directed Personal Assistance Services (CDPAS)
- Home Health Care Services
- Nutrition
- Medical Social Services
- Home Delivered Meals and/or meals in a group setting such as day care
- Social Day Care
- Non-Emergency Transportation
- Private Duty Nursing
- Social/Environmental Supports
- Personal Emergency Response System
- Adult Day Care
- Nursing Home Care
- Outpatient Rehabilitation
- Durable Medical Supplies
- Inpatient Mental Health Care
- Parenteral Formula, Enteral Formula, Nutritional Supplements
- Audiology
- Optometry
- Orthotic and Prosthetics
- Podiatry
- Respiratory therapy (For a complete benefit description, see Chapter 4 of AgeWell New York Advantage Plus (HMO SNP) Evidence of Coverage.)
- Cardiac Rehabilitation Services
- Colonoscopy
- Therapeutic Shoes and Inserts
- Inpatient Hospital Care
- Part B Prescription Drugs
- Radiation
- Elective, Non-Emergency Surgery
- Blood -Including Storage and Administration
- Radiological Diagnostics (e.g. MRIs, CT, PET scans)
- Outpatient Mental Health
- Outpatient Substance Abuse Services
- Partial Hospitalization Services
- Pulmonary Rehabilitation Services
- Services to Treat Kidney Disease
- Skilled Nursing Facility Care
- Supervised Exercise Therapy
- Telemonitoring Services

Concurrent Review

You can also ask your Care Manager 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 requested. These decisions will be made by a qualified health care professional. If we decide that the requested service 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 a **standard** or **fast track** process. You or your provider can ask for a fast track review if you or your provider believe 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 of 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 work days 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 work day 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 of 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 you 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 work day of when we have all the information we need but no later than **72 hours** from when you made your requests 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 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 of all of what you asked for, we must give you our answer within 72 hours after we get your request. If we extended the time needed to make our service authorization to 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 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 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 AgeWell New York Advantage Plus (HMO SNP) 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 decided to make an appeal, it means you are going on to Level 1 of the appeals process (see below).
- AgeWell New York can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at 1-866-237-3210 (TTY/TDD: 1-800-662-1220) 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, 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 1-866-237-3210 (TTY/TDD: 1-800-662-1220) 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> or on our website at <https://agewellnewyork.com/for-members/appoint-a-representative/>. 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.

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 decide 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 1-866-237-3210 (TTY/TDD: 1-800-662-1220) 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** of 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 of 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 will automatically get a standard appeal at Level 2.
- The review organization must give you an answer to your Level 2 Appeal **within 90 calendar days** 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 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 23 for information about continuing your benefits during Level 1 Appeals.

The Hearing Office will tell you 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 of 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.
- The decision you get from the Medicare Appeals Council related to **Medicaid** benefits will be **final**.

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 1-866-327-3210 (TTY/TDD: 1-800-662-1220) 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 1-866-237-3210 (TTY/TDD: 1-800-662-1220)

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five work days) 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 1-866-237-3210 (TTY/TDD: 1-800-662-1220) 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. 1-866-237-3210 (TTY/TDD: 1-800-662-1220), 7 days a week from 8:00 am to 8:00 pm. Note: From April 1 to September 30, we may use alternate technologies on Weekends and Federal Holidays. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.
- 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.
- If you choose to write your complaint, it should be mailed to:

AgeWell New York
Attn: Appeals and Grievances Department
1991 Marcus Avenue, Suite M201, Lake Success, NY 11042

- **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 work days 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 work days. 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 work days from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 work 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 1-866-712-7197.

DISENROLLMENT FROM AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP), 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, 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 Disenroll

You can ask to leave the AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP), MAP PROGRAM at any time for any reason.

To request disenrollment, call 1-866-237-3210. 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 Care (CBLTC) services, like personal care, you must join another MLTC plan or Home and Community Based Waiver program, in order to receive CBLTC services.

You Will Have to Leave AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP), MAP Program if you:

- No longer are in AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) for your Medicare coverage
- No Longer Medicaid eligible

- Need nursing home care, but are not eligible for institutional Medicaid
- Are out of the plan's service area for more than 30 consecutive days
- Permanently move out of the AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) service area
- No longer require a nursing home level of care as determined using the Uniform Assessment System (UAS) or other tool designated by SDOH.
- 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.

We Can Ask You to Leave the Plan

We will ask that you leave AGEWELL NEW YORK ADVANTAGE PLUS (HMO SNP) if

- You or family member or caregiver behaves in a way that prevents the plan from providing the care you need
- You knowingly provide false information or behave in a deceptive or fraudulent way.
- You fail to complete or submit any consent form or other document that is needed to obtain services for you
- Fail to pay or make arrangements to pay money owed to the plan (spenddown/surplus)

Before being involuntarily disenrolled, AgeWell New York 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 community based long term care services, 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

Re-Enrollment Provisions

If you voluntarily disenroll, you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled from AgeWell New York and you wish to re-enroll, AgeWell New York will review the reasons for your involuntary disenrollment to determine eligibility for re-enrollment.

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 enrollees move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP if they:

- 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 enrollees in the nursing home and talk with them about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help enrollees by:

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

Rights and Responsibilities

Staff of AgeWell New York 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.

As a Member, you have the right to:

- Receive medically necessary care;
- Timely access to care and services;
- Confidentiality of your medical records and privacy when you get treatment;
- Get information on your diagnosis and on available treatment options and alternatives, presented in a manner and language you understand from a health care professional;
- Get information in a language you understand; you can get oral translation services free of charge;

- Get information from a health care professional necessary for you to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get a copy of your medical records and ask that the records be amended or corrected;
- Take part in decisions about your health care, including the right to refuse treatment, and to be informed about the medical consequences of those decisions;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status, or religion or any other basis prescribed by law;
- Be told where, when and how to get the services you need from your plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network;
- 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;
- Someone to speak for you about your care and treatment.
- Have the right to seek assistance from the Participant Ombudsman program, ICAN.
- Have the right to receive information about AgeWell New York and managed long term care in a manner which does not disclose you as participating in the MLTC Plan, provided that including AgeWell New York's name is not considered a violation of this right.

As a Member, you are responsible for:

- Receiving covered services through AgeWell New York;
- Using AgeWell New York 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 AgeWell New York 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 AgeWell New York staff (with your input);
- Cooperating with and being respectful with the AgeWell New York staff and not discriminating against AgeWell New York staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status;
- Notifying AgeWell New York within two business days of receiving non-covered or non-pre-approved services;
- Notifying your AgeWell New York health care team in advance whenever you will not be home to receive services or care that has been arranged for you;
- Informing AgeWell New York 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.

Information Available on Request

- Information regarding the structure and operation of AgeWell New York;
- Specific clinical review criteria relating to a particular health condition and other information that AgeWell New York 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 AgeWell New York certified financial statement; and policies and procedures used by AgeWell New York to determine eligibility of a provider

NOTICE OF NON-DISCRIMINATION

AgeWell New York Advantage Plus complies with Federal civil rights laws. **AgeWell New York Advantage Plus** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AgeWell New York Advantage Plus provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call **AgeWell New York Advantage Plus** at 1-866-237-3210. For TTY/TDD services, call 1-800-662-1220.

If you believe that **AgeWell New York Advantage Plus** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **AgeWell New York Advantage Plus** by:

Mail: 1991 Marcus Avenue, Suite M201, Lake Success, New York 11042
Phone: 1-866-237-3210 (for TTY/TDD services, call 1-800-662-1220)
Fax: 1-855-895-0778
In person: 1991 Marcus Avenue, Suite M201, Lake Success, New York 11042
Email: civilrightsunit@agewellnewyork.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web: Office for Civil Rights Complaint Portal at
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>
Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-237-3210 TTY/TDD: 1-800-662-1220.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-237-3210 TTY/TDD: 1-800-662-1220.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-237-3210 TTY/TDD: 1-800-662-1220.	Chinese
جملاب كذا رفاوتت تيوغلا ةدعاسملا تامدخ نإف، ةمغلا ركذا ثدحتت تنك اذا: تظو حلم 1-866-237-3210 مكبللو مصللا فتاه مقر (TTY/TDD 1-800-662-1220	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다1-866-237-3210 TTY/TDD: 1-800-662-1220 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-237-3210 (телетайп: TTY/TDD: 1-800-662-1220).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-237-3210 TTY/TDD 1-800-662-1220.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-237-3210 TTY/TDD1-800-662-1220.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-237-3210 TTY/TDD: 1-800-662-1220.	French Creole
אפצאל. רופט 1-866-237-3210 TTY/TDD1-800-662-1220 .אפצאל רופט אפצאל רופט 1-866-237-3210 TTY/TDD1-800-662-1220 .אפצאל רופט	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-237-3210 TTY/TDD 1-800-662-1220	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-237-3210 TTY/TDD 1-800-662-1220.	Tagalog
লক্ষ্য কখনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেব্বা উপলক্ষ আছ। েফান কখন s1-866-237-3210 TTY/TDD: 1-800-662-1220.	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-237-3210 TTY/TDD:1-800-662-1220.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-237-3210 TTY/TDD: 1-800-662-1220.	Greek
1-866-237-3210 1-800-662-1220 1-866-237-3210 1-800-662-1220	Urdu



agewellnewyork.com
866-237-3210
TTY/TDD 800-662-1220

7 days a week 8:00 am – 8:00 pm. Note: From April 1 to September 30 we may use alternative technologies on Weekends and Federal Holidays