WELCOME TO METROPLUS ULTRACARE (HMO-DSNP) MEDICAID ADVANTAGE PLUS (MAP) PROGRAM

Welcome to MetroPlus UltraCare (HMO-DSNP), ("UltraCare") our Medicaid Advantage Plus ("MAP") Plan. UltraCare is especially designed for people who have Medicare (Parts A & B) and FULL Medicaid and who need health and community based 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 UltraCare covers since you are enrolled in the UltraCare Plan. It also tells you how to request a service, file a complaint or disenroll from UltraCare. The benefits described in this handbook are in addition to the Medicare benefits described in the *UltraCare Evidence of Coverage* (EOC). Keep this handbook with the EOC. You need both to learn what services are covered, and how to get services.

HELP FROM YOUR 24/7 MEMBER SERVICES HELP LINE

You can call us at any time, 24 hours a day seven days a week, at the 24/7 Member Services Help Line number below.

There is someone to help you at the 24/7 Member Services Help Line
7 Days a Week
24 Hours a Day
Call 1-866-986-0356 (TTY: 711)

To get this material in other formats, or ask for language translation services, call the 24/7 Member Services Help Line.

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ELIGIBILITY FOR ENROLLMENT IN THE MEDICAID ADVANTAGE PLUS (MAP) PROGRAM

UltraCare's MAP is a program for people who have both Medicare and Full Medicaid. You are eligible to join the UltraCare MAP if you are also enrolled in Medicare Advantage (Part C) coverage and:

1) Are age **18** and older
2) Reside in the plan's service area, which is the Bronx, Brooklyn, Manhattan, Queens, and Staten Island
3) Have FULL 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 Uniform Assessment System (UAS)
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 Care Services (CBLTCS) covered by UltraCare 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

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in UltraCare. Enrollment in the UltraCare MAP is voluntary.

How Do I Enroll?

Enrolling in UltraCare is easy. Our staff can help you each step of the way, as outlined below.

You or your family/caregiver or another person who helps you get medical services may contact UltraCare by phone. Our staff is available during normal business hours, from 8:00 AM to 8:00 PM to talk to you about the Medicare + Medicaid/MAP program and get the process started. Just call us to let us know that you are interested in learning more about the program. Please call 1-866-986-0356 (TTY: 711).

An UltraCare representative will talk to you and explain the program and benefits. He/she will determine that you are Medicare eligible (have Part A & B); meet the Plan's

age requirements; reside in our service area; have or are interested in Medicaid benefits and/or need long-term care services and supports for more than 120 consecutive days.

If you are interested in enrolling, he/she will connect you to a licensed sales representative who will discuss the UltraCare benefits with you over the telephone or will schedule an in-home appointment with you. During the appointment, the sales representative will provide you with detailed information about the UltraCare benefit package, the provider network, Part D pharmacy benefits, and address any questions you may have.

When you agree to enroll the sales representative will assist you with completing the Medicare enrollment application.

If you are new to long-term care services and supports and interested in enrolling in **MetroPlus UltraCare (HMO-DSNP),** a sales representative will refer you to the Conflict-Free Evaluation and Enrollment Center (CFEEC) at 1-855-222-8350, TTY: 1-888-329-1546. You may call anytime Monday – Friday, from 8:30 AM to 8:00 PM or Saturday, from 10:00 AM to 6:00 PM. Counselors speak all languages. The phone call and help are free. Or, you can visit *nymedicaidchoice.com* to complete an evaluation to find out if you are eligible to enroll.

CFEEC is the entity that contracts with the Department of Health to provide initial evaluations to determine if an applicant is eligible for Community Based Long-Term Care for a continuous period of more than 120 days. CFEEC will be responsible for providing conflict-free determinations by completing the Uniform Assessment System (UAS) for applicants in need of care. CFEEC evaluations are conducted in your home -- including hospital or nursing home -- by a registered nurse. Once the nurse decides you meet basic eligibility requirements, he or she will tell you about your choices concerning long-term care plans you may join.

If you are transferring from another Managed Long-Term Care (MLTC) Plan, a conflict-free evaluation will not be needed. A conflict-free evaluation is needed only if you are new to long-term care services and enrolling for the first time, or if you have not been enrolled in a plan for 45 days or if your CFEEC evaluation has expired.

Once New York Medicaid Choice (NYMC) and MetroPlus UltraCare have determined that you are eligible to enroll, your Medicare application will be submitted to CMS. If the Centers for Medicare & Medicaid Services (CMS) confirms your enrollment into UltraCare, the application and corresponding MAP enrollment agreement will be submitted to NYMC. All enrollment applications must be signed no later than the 15th of the month in order for the application to be reviewed and submitted to NYMC by noon on the 20th of the month, to ensure an effective date of the first day of the following month. If your enrollment application is received after the 20th day of the month the enrollment will take effect the first day of the second month. The effective date of

enrollment will be given to you at the time of enrollment. If the effective date changes, UltraCare will tell you the revised effective date. UltraCare members will receive a confirmation of enrollment letter which will indicate your effective date of enrollment.

You will receive your UltraCare member identification card within 10 calendar days of your enrollment effective date after your application is verified and approved by the CMS. If we receive and process your enrollment request after the 20th day of the month, you may not receive your ID card before your effective date. You can use your confirmation of enrollment letter as proof of coverage if you have a doctor's appointment or need prescription drugs, and do not have your ID card. You can also call UltraCare's 24/7 Member Services Help Line at 1-866-986-0356, TTY: 711 and we will verify your eligibility with your provider.

If CMS rejects the enrollment request, after the enrollment has been submitted to NYMC, MetroPlus UltraCare (HMO-DSNP) will notify NYMC within five (5) days of receiving the rejection and you will receive a denial of enrollment letter.

Canceling and/or Withdrawing an Application
If you decide you do not want to join UltraCare you can withdraw your enrollment request prior to the effective date. In that case, we must receive your verbal or written request by the 20th of the month preceding the effective date. UltraCare will notify NYMC of your withdrawal and we will mail you a confirmation of cancellation notice.

If you need long-term care services, you may need to contact New York Medicaid Choice at 1-888-401-6582 or TTY: 1-888-329-1541.

SERVICES COVERED BY METROPLUS ULTRACARE

Your Medicare coverage does not change when you join UltraCare. Your Care Manager will help to coordinate your access to Medicare-covered services, such as inpatient hospital services, outpatient hospital services, physician visits, laboratory services, and pharmacy services.

Which Medicare Services Are Covered by MetroPlus UltraCare?
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 *UltraCare Evidence of Coverage* (EOC), Chapter 4, Medical Benefits Chart.

Deductibles and Copayments on Medicare-Covered Services
Sections 2 and 3 of the UltraCare EOC explain the rules for using Plan providers and getting care in a medical emergency or when urgent care is needed.

Some services have deductibles and copayments. These amounts are shown in the Medical Benefits Chart in Section 4 of the EOC under the column, “What you must pay when you get these covered services.” **Because you have joined UltraCare, and you have FULL Medicaid benefits, UltraCare will pay these amounts**. You do not have to pay these deductibles and co-payments **except for those that apply to chiropractic care and some pharmacy items.**

If there is a monthly premium for benefits (see Section 8 of the EOC), you will not have to pay that premium, since you have FULL Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid (or MAP). The sections below explain what is covered.

Which Medicaid/MLTC Services are Covered by MetroPlus UltraCare?
Because you have Medicaid and qualify for the Medicaid Advantage Plus (MAP) program, our Plan will arrange and pay for the extra health and social services described below.

You may get these services if 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 will need a referral, Prior Authorization or a written order from your Primary Care Provider (PCP) to get these services.

You must get these services from the providers who are in the UltraCare network. If you cannot find a provider in our Plan, we will get you the care you need from a provider outside the network. Before you can see the out-of-network specialist, your PCP must ask for a Prior Authorization. To get the Prior Authorization, your PCP must give us some information. Once we get all the information we need, we will decide within 14 calendar days from the date of your request, if you can see the out-of-network specialist.

You or your doctor can ask for a fast-track review if your PCP feels that a delay will cause serious harm to your health. In that case, we will decide and get back to you within 72 hours. You can contact our 24/7 Member Services Help Line for more information about your request.

You must get the following services from providers who are in UltraCare's Provider Network. All services must be provided or referred by your PCP. Please call our 24/7 Member Services Help Line at 1-866-986-0356 or TTY: 711, if you have any questions or need help getting any of these services.

The following services are covered by UltraCare:

Service(s)	What Do I Get?	Coverage Rules
Care Management Services by a Registered Nurse or Social Worker Your care manager will assist you with getting the covered services identified in the Person Centered Service Plan (PCSP). This includes help with referrals, assistance in or coordination of medical, social, educational, psychosocial, financial and other services in support of your PCSP. The services may not always be covered by MetroPlus UltraCare.	As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a healthcare 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. Requests for new or additional covered services can be obtained through your care manager by you, your designated representative, or your provider. Requests can be made verbally or in writing. If you call us after hours, on weekends or on holidays, please call our 24/7 Member Services Help Line at 1-866-986-0356 (TTY: 711) and a representative will assist you.	Every member will be assigned to a Care Manager.

Service(s)	What Do I Get?	Coverage Rules
Outpatient Rehabilitation (Physical Therapy, Occupational Therapy, and Speech Therapy)	Physical therapy is rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level. Occupational therapy is rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level. Speech-language therapy is rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.	Rehabilitative therapies may be covered by Medicare. You must get services from an in-network UltraCare Provider. You must obtain a Prior Authorization from the Plan for more than 10 visits in a year. Your doctor will need to provide signed written orders to the Rehabilitation Therapist. UltraCare will assist your Rehabilitative provider in obtaining doctor's orders, if needed.
Personal Care	Personal care is some or total assistance with activities such as personal hygiene, toileting, housekeeping, dressing, feeding, and nutritional and environmental support function tasks.	You must get personal care services from UltraCare's Provider Network, and you must obtain prior authorization from the Plan. Your doctor will need to provide signed written orders to the agency providing Personal Care. MetroPlus UltraCare will

		assist your Personal Care provider in obtaining doctor's orders, if needed.
Consumer Directed Personal Assistance Services (CDPAS)	An enrollee in need of personal care services, home health aide services or skilled nursing tasks may receive such by a consumer directed personal assistant under the instruction, supervision and direction of the enrollee or the enrollee's designated representative.	You must coordinate your CDPAS with a Fiscal Intermediary that works with UltraCare. You must also obtain Prior Authorization from the Plan.
Home Health Care Services Not Covered by Medicare	Medicaid-covered home health services include skilled services not covered by Medicare (e.g., physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and/or home health aide services as required by an approved plan of care.	These services may also be covered by Medicare. You will have to use an in-network provider and obtain prior authorization from the Plan. Your doctor will need to provide signed written orders to the Home Health Care provider.
Nutrition	Nutrition services include the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs.	These items may be covered by Medicare. You must get services from an in-network UltraCare Provider. You must obtain a Prior Authorization from the Plan. Your doctor will need to provide signed written orders to the provider. UltraCare will assist your provider in obtaining doctor's orders if needed.

Medical Social Services	Medical social services include assessing the need for, arranging for and providing aid for social problems related to the maintenance of a patient in the home where such services are performed by a qualified social worker and provided within a plan of care.	You must get Medical Social Services from the MetroPlus UltraCare Provider Network, and you must obtain Prior Authorization from the Plan.
Home-Delivered Meals and/or Congregate Meals	Home delivered and congregate meals are meals provided at home or in congregate settings such as senior centers to individuals unable to prepare meals or have them prepared.	You must get home delivered or congregate meals from the UltraCare Provider Network, and you must obtain Prior Authorization from the Plan.
Social Day Care	Social day care is a structured program that provides functionally impaired individuals with socialization, supervision, 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 personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance and case coordination and assistance.	You must get Social Day Care from the MetroPlus UltraCare Provider Network, and you must obtain Prior Authorization from the Plan.
Non-Emergency Transportation	Non-Emergency Transportation is transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the member's condition to obtain necessary medical care and	These services may also be covered by Medicare. You must get non-emergency transportation from the MetroPlus UltraCare Provider Network, and you must obtain Prior

	services reimbursed under the Medicaid or the Medicare programs.	Authorization from the Plan.
Private Duty Nursing	Provides home care aides, companion care, and homemaker services and may include nursing services in your home or place of residence.	Services are covered when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time or continuous. You must obtain prior authorization from the Plan. Services must be provided in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan. Services must be provided by a person possessing a license and current registration from NYSE Education Department to practice as a registered professional nurse or licensed practical nurse.
Dental	Medicaid-covered dental services include medically necessary preventive, prophylactic and other dental care, services, supplies, routine exams, prophylaxis (i.e. fluoride treatment), oral surgery (when not covered by Medicare), and dental prosthetic and orthotic appliances required to alleviate a serious health condition.	Dental services must be obtained through the HealthPlex dental network and prior authorization may be required.
Social and Environmental Supports	Social and environmental supports are services and items that support the	You must get social and environmental supports from the UltraCare Provider

	medical needs of the member and are included in the member's plan of care. These services and items include but are not limited to: home maintenance tasks, homemaker/chore services, housing improvement and respite care.	Network, and you must get a Prior Authorization from the Plan.
Personal Emergency Response Services (PERS)	PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.	You must get PERS from the UltraCare Provider Network, and you must get Prior Authorization from the Plan.
Adult Day Health Care	Adult Day Health Care provides care and services in a residential health care facility or approved extension site. Adult Day Health Care centers are under the medical direction of a physician and are set up for those who are functionally impaired but who are <u>not</u> homebound. Adult Day Health Care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy and dental, pharmaceutical, and other ancillary services, as well as	To be eligible, you must require certain preventive, diagnostic, therapeutic and rehabilitative or palliative items or services. You must get Adult Day Health Care from the UltraCare Provider Network, and you must obtain prior authorization from the Plan. Please see limitations on page 18. Your doctor will need to provide signed written orders to the Adult Day Health Care In-Network provider you select. UltraCare will assist your In-

	leisure-time activities that are a planned program of diverse meaningful activities.	Network Adult Day Health Care Provider with obtaining doctor's orders, if needed.
Nursing Home Care Not Covered by Medicare (only if you are eligible for institutional Medicaid)	Nursing Home Care is care provided to members by a licensed facility.	These services may also be covered by Medicare. Your doctor will need to provide signed written orders to the nursing home. UltraCare will assist your provider in obtaining doctor's orders if needed. Permanent placement may be covered only if you are eligible for institutional Medicaid. You must use an in-network Provider/Facility and obtain prior authorization from the Plan. Please see Limitations on page 18.
Inpatient Mental Health Care over the 190-day Lifetime Medicare Limit	You are covered for unlimited inpatient mental health days, as medically necessary, beyond the 190-day lifetime Medicare limit.	You must use an in-network Provider/Facility and obtain prior authorization from the Plan.

Service(s)	What Do I Get?	Coverage Rules
Hearing Services (Audiology)	Medicaid-covered hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts.	These services may also be covered by Medicare. You must get audiology and hearing services from the MetroPlus UltraCare Provider Network, and you must obtain a Prior Authorization from the Plan.
Durable Medical Equipment (DME)	Durable medical equipment is made up of devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition and which have the following characteristics: • can withstand repeated use for a protracted period, • are primarily and customarily used for medical purposes, • are generally not useful in the absence of an	These items may be covered by Medicare. You must get DME from a UltraCare Provider and obtain Prior Authorization from the Plan. Your doctor will need to provide signed written orders to the In-Network DME provider. UltraCare will assist your DME provider in obtaining doctor's orders, if needed.

	illness or injury • are not usually fitted, designed or fashioned for an individual's use. Where equipment is intended for use by only one patient, it may be either custom-made or customized.	
Medical Surgical Supplies/Enteral Feeding and Supplies/ Parenteral Nutrition and Supplies	Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and devices and durable medical equipment or orthopedic footwear that treat a specific medical condition, which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.	You must get medical surgical supplies and enteral, parenteral feeding supplies, nutrition and supplies from the UltraCare Provider Network, and you must obtain Prior Authorization from the Plan. Your doctor will need to provide signed written orders to the provider providing care. UltraCare will assist your provider in obtaining doctor's orders, if needed. Please see Limitations on page 18.
Prosthetics, Orthotics and Orthopedic Footwear	Prosthetic appliances and devices are appliances and devices that replace any missing part of the body. Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate	These items may be covered by Medicare. You must get prosthetics, orthotics and orthopedic footwear from an in-network UltraCare provider. You must get a Prior Authorization from the Plan.

	motion in a diseased or injured part of the body. Orthopedic footwear includes shoes, shoe modifications or shoe additions that are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot. Orthopedic footwear also is used to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.	Your doctor will need to provide signed written orders to the provider giving you these services. UltraCare will assist your provider in obtaining doctor's orders, if needed.
Vision	Medicaid-covered vision services include services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently	These services may also be covered by Medicare. You must get vision services from the MetroPlus UltraCare Provider Network, and you must obtain Prior Authorization from the Plan.

	than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed.	
Podiatry	Podiatry means services by a podiatrist, which include medically necessary routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot or lower limbs when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcer, and infections. Routine foot care is covered up to 4 visits per year. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is <u>not</u> covered in the absence of a pathological condition.	These services may also be covered by Medicare. You must get podiatry services from the UltraCare Provider Network, and you must obtain a Prior Authorization from the Plan.
Respiratory Therapy	The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, aerosol, intermittent positive pressure, continuous artificial ventilation, the	You must get respiratory therapy from the UltraCare Provider Network, and you must obtain Prior Authorization from the Plan. Your doctor will need to provide signed written orders to the therapist

	administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.	providing care. Your doctor will need to provide signed written orders to the respiratory care provider. UltraCare will assist your provider in obtaining doctor's orders, if needed.
Telehealth	Telehealth is the use of technologies to deliver or support clinical health care for covered services from a distance to reduce the need for in-office visits. The services include live video and audio between a member and a provider; transmission of recorded health history through a secure electronic communication system; and use of mobile devices to provide supportive services.	These items may be covered by Medicare. Telehealth can be used to support covered services only. You must use an In-Network UltraCare provider for all covered telehealth services. A referral is required for all covered telehealth services except for Behavioral Health telehealth services. You must get a Prior Authorization from the Plan, whenever needed.

LIMITATIONS

PLEASE NOTE: Several of the benefits outlined above are subject to benefit limitations. This means that you are entitled to only a certain amount of service(s) each year, or you must meet certain additional eligibility criteria based upon medical necessity.

The benefit limits for UltraCare are listed below:

- **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 urgent care services outside your coverage area, your care manager should be contacted to assist you in arranging services. Please call our 24/7 Help Line at 1-866-986-0356 (TTY: 711) and a representative will assist you.

Emergency Services
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 services. However, you should notify UltraCare within 24 hours of the emergency. You may need long-term care services that can be provided only through UltraCare.

If you are hospitalized, a family member or other caregiver should contact UltraCare 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 (PCP) or hospital discharge planner to contact UltraCare so that we may work with them to plan your care upon discharge from the hospital. Please call our 24/7 Help Line at 1-866-986-0356 (TTY: 711) and a representative will assist you.

Transitional Care Procedures
New enrollees in UltraCare may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network healthcare provider if the provider accepts payment at the Plan rate, adheres to UltraCare quality assurance and other policies, and provides medical information about the care to the Plan. Please call our 24/7 Help Line at 1-866-986-0356 (TTY: 711) and a representative will assist you.

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. Please call our 24/7 Help Line at 1-866-986-0356 (TTY: 711) and a representative will assist you.

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 if you:

- Have lived in a nursing home for three months or longer
- Have health needs that can be met through services in the 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 *health.ny.gov/mfp* or *ilny.org*.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that UltraCare 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 our 24/7 Member Services Help Line at 1-866-986-0356 (TTY: 711) if you have a question about whether a benefit is covered by UltraCare or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Assisted Living Program

Certain Mental Health Services, including:

- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Continuing Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospitalization (not covered by Medicare)
- Assertive Community Treatment (ACT)

- Personalized Recovery Oriented Services (PROS)

Comprehensive Medicaid Case Management

Directly Observed Therapy for Tuberculosis Disease

Home and Community Based Waiver Program Services

Medicaid Pharmacy Benefits as allowed by State Law (select drug categories excluded from the Medicare Part D benefit)

Methadone Maintenance Treatment Programs

Office for People with Developmental Disability Services

Out of network Family Planning services under the direct access provisions
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).

Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs

SERVICES COVERED BY ORIGINAL MEDICARE

- Hospice services provided to Medicare Advantage members

SERVICES NOT COVERED BY ULTRACARE OR MEDICAID

You must pay for services that are not covered by UltraCare 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 UltraCare 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 UltraCare sends you to that provider)

If you have any questions, call our 24/7 Help Line at 1-866-986-0356 (TTY: 711).

SERVICE AUTHORIZATION, APPEALS AND COMPLAINTS PROCESSES

You have Medicare and get assistance from Medicaid. Information in this chapter covers your rights for all 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 34 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 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 or your provider may call our toll-free 24/7 Help Line number at 1-866-986-0356 (TTY:711) or send your request in writing to:

MetroPlus Health Plan
Utilization Management
50 Water Street, 7th Floor
New York, NY 10004

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

Prior Authorization
Some covered services require **prior authorization** (approval in advance) from the UltraCare Utilization Management department 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:

- Inpatient Hospital Care
- Diagnostic Radiology Services (CT/MRI/MRA and PET Scans)
- Hearing Aids
- Comprehensive Dental Services
- Certain Medicaid-covered vision services
- Inpatient Mental Health Care
- Partial Hospitalization
- Skilled Nursing Facility
- Cardiac and Pulmonary Rehabilitation Services
- Supervised Exercise Therapy (SET)
- Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy)
- Non-Emergency Ambulance Services
- Prosthetics/Medical Supplies & Durable Medical Equipment (DME)
- Diabetic Services and Supplies
- Medicare Part B Drugs
- Home Health Agency Care

- Home Infusion Therapy
- Opioid Treatment Program Services (inpatient services)
- Acupuncture (to treat chronic low back pain)
- Chiropractic Services
- Private Duty Nursing
- Personal Care Services
- Nutrition
- Medical Social Services
- Social and Environmental Supports
- Home Delivered and Congregate Meals
- Adult Day Health Care
- Social Day Care
- Personal Emergency Response Services (PERS)
- Consumer Directed Personal Assistance Services (CDPAS)
- Nursing Home Care not covered by Medicare
- Podiatry
- Non-Emergency Transportation

To get approval for these services or treatments, call our toll-free 24/7 Member Services Help Line at 1-866-986-0356 (TTY: 711). You or your doctor may also submit a service authorization request by fax at 1-212-908-3126 or mail:

MetroPlus Health Plan
Utilization Management
50 Water Street, 7th Floor
New York, NY 10004

Concurrent Review
You can also ask the UltraCare Utilization Management department 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 working 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 working 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 decide 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 of your EOC: 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 track service authorization."**

- A fast review of a prior authorization request means we will give you an answer within 1 working day 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 decide 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 track 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 track service authorization, we will automatically agree to give you a fast track service authorization.

If you ask for a fast track 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 track 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 track 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 of your EOC: What To Do If You Have A Complaint About Our Plan later in the 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 decide 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 decide 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 *UltraCare Evidence of Coverage* (EOC).

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 can 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).

- UltraCare can also explain the complaints and appeals processes available to you depending on your complaint. You can call our 24/7 Member Services Help Line at 1-866-986-0356 (TTY: 711) 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 Plan Level 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.

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 our 24/7 Member Services Help Line at 1-866-986-0356 TTY: 711 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 the 24/7 Help Line and ask for the form. You can also get the form on the Medicare website at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at metroplusmedicare.org. 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. 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 acting.
- 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 1-866-986-0356 TTY: 711 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 decide

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 of the UltraCare EOC: *What To Do If You Have A Complaint About Our Plan* or see 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 decide 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 "Office of Administrative Hearings" 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 would 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 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 28 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 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.

- 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 our 24/7 Help Line at 1-866-986-0356 TTY: 711 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 *dfs.ny.gov.*
- Contact the health plan at 1-866-986-0356 TTY: 711

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five working 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** 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 our 24/7 Member Services Help Line at 1-866-986-0356 TTY: 711 or write to Member Services at MetroPlus UltraCare, <50 Water Street, 7th Floor>, New York, NY 10004, Attn: 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 the 24/7 Help Line is the first step.** If there is anything else you need to do, the representative will let you know. Call 1-866-986-0356 (TTY: 711), 24 hours a day, 7 days a week.
- 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 at:** MetroPlus Health Plan, Attn: Complaints Manager, <50 Water Street, 7th Floor>, New York, NY 10004.
- If you put your complaint in writing, we will respond to your complaint in writing.
- To file by phone, call our 24/7 Help Line at 1-866-986-0356 TTY: 711, 24 hours a day, 7 days a week. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to answer your complaint, we will tell you.
- You can write us with your complaint or call the 24/7 Help Line number and request a complaint form. The letter or complete form should be mailed to MetroPlus Health Plan, Attn: Complaints Manager, <50 Water Street, 7th Floor>, New York, NY 10004.
- **Whether you call or write, you should contact the 24/7 Help Line 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 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 working 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 working 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 working days from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 working days of when we have all the information we need to decide the appeal. We will give you the reasons for our decision and our clinical rationale, if it applies.

If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866-712-7197.

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 UltraCare. 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: *icannys.org* | Email: *ican@cssny.org*

DISENROLLMENT FROM METROPLUS ULTRACARE PLAN

Enrollees shall not be disenrolled from UltraCare 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 (MAP).

You can choose to leave UltraCare at any time for any reason voluntarily (your choice).

You Can Choose to Voluntarily Disenroll
You can ask to leave UltraCare at any time for any reason.

To request disenrollment, call our 24/7 Member Service Help Line at <1-866-986-0356> and we will mail you a Disenrollment Form or you can write to us at MetroPlusHealth, Member Services, <50 Water Street, 7th Floor>, New York, NY 10004, Attn: Disenrollment Department. It could take up to six weeks to process your request, depending on when your request is received.

You may disenroll to regular Medicaid or join another health plan if 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.

UltraCare can also involuntarily (not your choice) disenroll you.

You Will Have to Leave UltraCare if:

- You no longer are in UltraCare for your Medicare Advantage (Part C) 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 UltraCare's service area
- You no longer require a nursing home level of care as determined using the Uniform Assessment System (UAS) or another tool designated by SDOH
- You are no longer eligible for nursing home level of care as determined at any comprehensive assessment using the assessment tool prescribed by the SDOH, unless the Contractor, or the LDSS or entity designated by the State agrees that termination of the services provided by the Contractor could reasonably be expected to result in the Enrollee being eligible for nursing home level of care (as determined with the assessment tool prescribed by the SDOH) within the succeeding six-month period. The Contractor shall provide the LDSS or entity designated by the State the results of its assessment and recommendations regarding continued enrollment or disenrollment within five (5) business days of the comprehensive assessment.
- At point of any reassessment while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTC services.
- 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.

We Can Ask You to Leave the Plan
We will ask that you leave UltraCare if:

- You or your 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 UltraCare enrollment card
- You fail to complete and submit any necessary consent or release
- You fail to pay or make arrangements to pay the amount of money, as determined by the Local District of Social Services, owed to the Plan as spenddown/surplus, within 30 days after the amount first becomes due. We will have made reasonable effort to collect.

Before you are involuntarily disenrolled, UltraCare will obtain the approval of NYMC or the 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.

CULTURAL AND LINGUISTIC COMPETENCY

UltraCare 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

UltraCare 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 UltraCare
- Using UltraCare's Provider Network for covered services to the extent In-Network providers are available
- Obtaining prior authorization(s) 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 UltraCare 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 UltraCare staff (with your input)
- Cooperating with and being respectful with the UltraCare staff and not discriminating against UltraCare staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status
- Notifying UltraCare within two (2) business days of receiving non-covered or non-pre-approved services
- Notifying your UltraCare healthcare team in advance whenever you will not be home to receive services or care that has been arranged for you
- Informing UltraCare before permanently moving out of the service area, or of any lengthy absence from the service area
- For 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 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 UltraCare Care Manager for assistance in completing these documents. If you already have advance directives, please share a copy with your care manager.

Information Available on Request

- Information regarding the structure and operation of UltraCare
- Specific clinical review criteria relating to a health condition and other information that UltraCare 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 UltraCare certified financial statement; and policies and procedures used by UltraCare to determine eligibility of an In-Network Provider.