VillageCareMAX
Managed Long Term Care Plan (MLTC)
MEMBER HANDBOOK

MEMBER HANDBOOK (English)

Welcome to VillageCareMAX!

VillageCareMAX, a Medicaid Managed Long-Term Care (MLTC) plan, has been created to help you keep living in your home for as long as you possibly can. Many of the services that you will receive as a member of VillageCareMAX will be provided right in your own home. As a member of VillageCareMAX, you will have a team of health care professionals working with you to help you get the care you need. One of the best things about VillageCareMAX is that you will have a Care Manager, who is a Registered Nurse or a Social Worker, helping you to get the care that you need so that you can live the life you want. They will help you understand your health needs, arrange for the services you need, and teach you ways to stay as healthy as possible.

We urge you to review this Member Handbook carefully. Please feel free to ask questions about the Plan by either calling or writing:

VillageCareMAX
112 Charles Street
New York, NY 10014
1-800-469-6292
TTY 711

If you do not speak English, VillageCareMAX will provide you with staff and/or translation services to communicate with you in person or by telephone in whatever language you speak. This is a free service. Also, written material from VillageCareMAX is available in Spanish, Russian and Chinese.

If you have a special hearing or vision need, VillageCareMAX will be happy to accommodate you. Arrangements will be made on an individual basis as necessary. This is also a free service to all members of VillageCareMAX.

Important
VillageCareMAX
Telephone Numbers:

Member Services
7 days a week
8 a.m. to 8 p.m.

VillageCareMAX
1-800-469-6292
Toll-Free Number
TTY 711

During non-business hours after 8 p.m. and before 8 a.m., weekends and holidays, our answering service will be happy to take your message and will contact on-call staff to assist you. The person on-call will contact you as soon as possible. Assistance is available 24 hours a day, 7 days a week

Table of Contents

What Makes VillageCareMAX Special?

.

When you join VillageCareMAX, you are joining a Managed Long Term Care program, that provides a broad range of services that are designed to keep you safe in your home.

In VillageCareMAX, a team of health care professionals will work closely with you to help you get the care you need. This team of health care professionals (your care team) is made up of your primary care doctor, a social worker, a member service representative, your caregivers, and your VillageCareMAX Care Manager, who is a Registered Nurse or a Social Worker. Your care manager will lead your care team, making sure that you get the care you need. The care you need may include Medicaid covered long-term care services such as home care, personal care, rehabilitative therapies and adult day health care. It may also include other services not covered by VillageCareMAX that you may need to keep you healthy. These services are called coordinated services and include, among other things, doctor visits, hospital care, and lab services.

Your Care Manager will visit your home on a schedule determined by your health care needs to make sure that you are doing well, and to make sure that you have what you need to keep you living safely at home for as long as possible. Your Care Manager will assess your health care needs on an ongoing basis with you and your care team. He/she will make sure that you have a plan of care that is just right for you and that meets your health care needs. Your plan of care will include the covered and coordinated services that you need to meet the goals and outcomes that you and care team want achieve. Working with your care team, your Care Manager will formally evaluate your plan of care every six months, or more frequently if your condition changes and he or she will make sure that the covered and coordinated services that you need to stay well and keep living safely at home are in place.

One of the many nice things about VillageCareMAX is that if you need anything or have any questions, all you have to do is call our toll free member services number to get help. One of our member service representatives will answer the phone. They can help you with your questions and they can help you get the care you need by putting you in touch with your care manager, if that is what is needed. Your member service representatives will be working with you very closely throughout your membership, so please feel free to ask for him or her when you call. Just remember, all of our member service representatives are trained and ready to help you.

Another great thing about VillageCareMAX is that you do not have to change your doctors when you join VillageCareMAX. If you do not have a primary care doctor, your Care Manager can help you to choose one.

When you join the Plan you will receive a member identification card (member ID). You should use this card to get services covered by VillageCareMAX.

As a member of VillageCareMAX, you must use our network providers for covered services. We have a network of qualified providers including: home care agencies, dentists, podiatrists, optometrists, audiologists and other providers. You will receive a VillageCareMAX provider directory which is a list of network providers with their names, addresses, phone numbers and languages spoken. You will receive this list when you enroll. From time to time we update the directory. You can find up-to-date directory on our website www.villagecaremax.org or call us at 1-800-469-6292 (TTY 711) and we will send you one by mail. You will also receive updated information on our providers throughout the year when there is a change in providers or their information. VillageCareMAX has a veteran's home in its network. Long term placement in veteran's home is available to each veteran, spouse of a veteran, and Gold Start parent member. Please let VillageCareMAX know if need services in a veteran's home.

VillageCareMAX is sensitive to the needs of its members. We will provide for the needs of hearing/vision-impaired members by offering services such as documentation with enlarged print and TTY service. VillageCareMAX has the ability to communicate with all members in their native language either directly through Plan employees or through a translation service. This service is free of charge to our members. In addition our Member Handbook and written materials are available in English, Spanish, Chinese and Russian.

VillageCareMAX values its members and we are here to help you. From time to time, we will ask you for your advice on how we can make the Plan better, how we can make it easier for you to get the care you need and how we can improve the quality of services that we provide to you. Your input is important to us and important to your care. If you need to tell us something about your care, you can do that at any time by calling Member Services at 1-800-469-6292 (TTY 711).

Who Is Eligible to Join VillageCareMAX?

If you need certain kinds of home and community-based long term care services and you have Medicaid and Medicare, you must join a Managed Long Term Care plan in order to obtain them. These services include:

- In-home personal care services
- Home health services
- Adult day health services
- Consumer directed personal assistance services.
- Private duty nursing

Registered Nurse will assess you and determine if you are eligible to join VillageCareMAX. To enroll in VillageCareMAX you must:

1. Be at least 18 years of age.
2. Be a resident of the Bronx, Brooklyn, Manhattan or Queens.
3. Show a need and require one of the following Community Based Long Term Care Services (CBLTCS) for a continuous period of more than 120 days from the effective date of enrollment. We will document your needs in the assessment that a Registered Nurse will complete.

    - ✓ Nursing services in the home
    - ✓ Therapies in the home
    - ✓ Health aide services in the home
    - ✓ Personal care services in the home
    - ✓ Consumer directed personal assistance services
    - ✓ Adult day health care
    - ✓ Private duty nursing

4. Be determined by the local Department of Social Services (in New York City, this is the Human Resources Administration, known as "HRA"), to be eligible for benefits under the Medicaid program.

5. For persons with Medicaid only or those with Medicare and Medicaid who are 18 to 20 years old, you must be assessed as eligible for nursing home level of care, at the time of enrollment, as determined by the New York State assessment tool and need CBLTCS for a continuous period of more than 120 days as listed in #3 above.

VillageCareMAX will not discriminate against any potential enrollee who meets the above criteria based on their health status and need for, or cost, of covered services.

During the enrollment process, if it is determined that you are not eligible for enrollment, you will be advised and will be given an opportunity to withdraw your application.

If you are a resident of a residential facility of the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office of People With Developmental Disabilities (OPWDD), or OPWDD Day Treatment Program, you cannot enroll in MLTC. However, you can enroll in VillageCareMAX MLTC after you disenroll from these programs.

If you were previously involuntarily disenrolled and would like to return to VillageCareMAX, the Plan will be more than happy to review your case for possible re-enrollment.

You may enroll in two ways:

You can call VillageCareMAX at 1-800-469-6292. TTY users, call 711. We will talk with you about your health needs and put you in touch with the Conflict Free Evaluation and Enrollment Center (CFEEC). CFEEC Registered Nurse will visit you to complete an evaluation and decide if you are eligible to enroll in MLTC. If CFEEC determined that you are eligible for MLTC, they will refer you back to VillageCareMAX or another plan you choose. If you name VillageCareMAX as a plan of your choice, call us and our nurse will come to your home to complete an assessment and discuss the services you would receive when you enroll.

During the enrollment process, if it is found that you are not eligible for enrollment into VillageCareMAX, you will be informed in writing of the decision. Anytime your enrollment is going to be denied, the state must approve this decision.

VillageCareMAX will deny your enrollment under the following conditions:

- You do not meet the eligibility criteria listed above;
  You have Medicaid only (and not Medicare) are not eligible for nursing home level of care;
- You do not need community-based long-term care services of the Plan for a continuous period of more than 120 days;
- You are enrolled in one of the following: another managed care plan capitated by Medicaid, a Traumatic Brain Injury or Nursing Home Transition and Diversion Waiver program, a hospice, a State Office for People with Developmental Disabilities (OPWDD) program and you do not want to disenroll from any of these services;
- You are a resident of psychiatric facility, alcohol/substance abuse long term residential treatment or assisted living programs;
- You are expected to have Medicaid for less than 6 months, have Emergency Medicaid or are in Medicaid family planning expansion program;
- You are in the Foster Family Care Demonstration;
- You are a resident of an Assisted Living Program (ALP);
- You are under sixty-five (65) years of age in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need

treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage.

You may also call Conflict Free Evaluation and Enrollment center at: 1-855-222-8350 Monday-Friday, from 8:30 am to 8:00 pm and Saturday, from 10:00 am to 6:00 pm.

If you are transferring from another Managed Long Term Care Plan, you should **call the State's enrollment broker at:** 1-888-401-6582. TTY: 1-888-329-1541**.**

The state's enrollment staff will ask you which Managed Long Term Care program you wish to join, and will let the program know. If you have selected VillageCareMAX, our staff will contact you to arrange a time for a nurse to come to your home. The nurse will talk with you about the program in more detail, will complete an assessment of your needs, and talk with you about the services you need as a member of VillageCareMAX.

What Services Are Covered By VillageCareMAX?

The following services are covered by VillageCareMAX:

Service	Coverage Rules
Care Management 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 referral, 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 VillageCareMAX.	Every member will be assigned to a Care Manager.
Nursing Home Care Care provided in a Skilled Nursing Facility	Short term rehabilitative stays may be covered by Medicare. If your stay in a nursing home is covered by Medicare, you may get care from a nursing home that is not in the VillageCareMAX Provider Network. Once your stay becomes Medicaid covered, you will have to use an in-network provider and obtain authorization from the Plan. Your doctor will need to provide signed written orders to the nursing home. VillageCareMAX 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 and obtain authorization from the Plan.
Home Care Includes the following services, which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and	These services may be covered by Medicare. When a service is covered by Medicare, you may get the care from a provider that is not in the VillageCareMAX Provider Network. When your care is covered by Medicaid, you will have to use an in-network provider and obtain authorization from

Service	Coverage Rules
speech/language pathology.	the Plan. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Personal Care Personal care is some or total assistance with activities such as personal hygiene, dressing and feeding and nutritional and environmental support function tasks	You must get personal care from the VillageCareMAX Provider Network, and you must obtain authorization from the Plan. Your doctor will need to provide signed written orders to the agency providing care. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Private Duty Nursing Private Duty Nursing are medically necessary services provided at enrollee's 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 care available from certified home health care agencies (CHHAs).	You must get private duty nursing from the VillageCareMAX Provider Network, and you must obtain authorization from the Plan. Your doctor will need to provide signed written orders to the agency providing care.
Consumer Directed Personal Assistance 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 consumer directed personal assistance services with a Fiscal Intermediary that works with VillageCareMAX, and you must obtain 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	You must get Adult Day Health Care from the VillageCareMAX Provider Network, and you must obtain authorization from the Plan. Your doctor will need to provide signed written orders to the Adult Day Health Care provider. VillageCareMAX will assist your

Service	Coverage Rules
functionally impaired but who are not homebound. To be eligible, you must require certain preventive, diagnostic, therapeutic and rehabilitative or palliative items or services. 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 leisure time activities that are a planned program of diverse meaningful activities.	provider in obtaining doctor's orders if needed.
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. 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 VillageCareMAX Provider Network, and you must obtain 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 services reimbursed under the Medicaid or the Medicare programs.	You must get non-emergency transportation from the VillageCareMAX Provider Network, and you must obtain authorization from the Plan.
Optometry/Eyeglasses Optometry includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.	You must get optometry services and eyeglasses from the VillageCareMAX Provider Network. Prior authorization may be required.

Service	Coverage Rules
Audiology/Hearing Aids Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, earmolds, batteries, special fittings and replacement parts.	Audiology exams may be covered by Medicare. When a service is covered by Medicare, you may get the care from a provider that is not in the VillageCareMAX Provider Network. When the service is covered by Medicaid, you will have to use an in-network provider and obtain authorization from the Plan.
Podiatry Podiatry means services by a podiatrist, which must include 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 when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcer, and infections. 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 not covered in the absence of pathological condition.	Podiatric exams may be covered by Medicare. When a service is covered by Medicare, you may get the care from a provider that is not in the VillageCareMAX Provider Network. When the service is covered by Medicaid, you will have to use an in-network provider.
Dentistry Preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.	Dental services may be covered by Medicare. When a service is covered by Medicare, you may get the care from a provider that is not in the VillageCareMAX Provider Network. When the service is covered by Medicaid, you will have to use an in-network provider.
Home-Delivered or Congregate Meals	You must get home delivered or congregate meals from the VillageCareMAX Provider Network, and you must obtain authorization from the Plan.

Service	Coverage Rules
Physical Therapy, Occupational Therapy, Speech Pathology in a setting outside of the home 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 pathology 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. When the service is covered by Medicare, you may get the services from a provider that is not in the VillageCareMAX Provider Network. When the service is covered by Medicaid, you will have to use an in-network provider and obtain authorization from the Plan. Your doctor will need to provide signed written orders to the Rehabilitation Therapist. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
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 administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.	You must get respiratory therapy from the VillageCareMAX Provider Network, and you must obtain authorization from the Plan. Your doctor will need to provide signed written orders to the therapist providing care. Your doctor will need to provide signed written orders to the respiratory care provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Nutrition Services/Counseling 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.	You must get Nutritional Services/Counseling from the VillageCareMAX Provider Network, and you must obtain authorization from the Plan.

Service	Coverage Rules
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 device 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.	These items may be covered by Medicare. If an item is covered by Medicare, you may get the item from a provider that is not in the VillageCareMAX Provider Network. When the item is covered by Medicaid, you will have to use an in-network provider. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Durable Medical Equipment 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 of time, • are primarily and customarily used for medical purposes, • are generally not useful in the absence of an illness or injury • are not usually fitted, designed or fashioned for a particular individual's use. Where equipment is intended for use by only one patient, it may be either custom- made or customized.	These items may be covered by Medicare. If an item is covered by Medicare, you may get the item from a provider that is not in the VillageCareMAX Provider Network. When the item is covered by Medicaid, 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 provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
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	These items may be covered by Medicare. If an item is covered by Medicare, you may get the item from a provider that is not in the VillageCareMAX Provider Network. When the item is Medicaid covered, you will have to use an in-network provider,

Service	Coverage Rules
and devices used to support a weak or deformed body member or to restrict or eliminate 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.	and obtain prior authorization from the plan. Your doctor will need to provide signed written orders to the provider. VillageCareMAX will assist your provider in obtaining doctor's orders if needed.
Social and Environmental Supports Social and environmental supports are services and items that maintain the medical needs of the member and include the following: home maintenance tasks, homemaker/chore services, housing improvement and respite care.	You must get social and Environmental supports from the VillageCareMAX Provider Network, and you must obtain authorization from the Plan.
Personal Emergency Response Systems (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 VillageCareMAX Provider Network, and you must obtain authorization from the Plan.
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 between a member and a provider; transmission of recorded health history through a secure electronic communications system; and use of mobile devices to provide supportive services.	Telehealth can be received to support covered services only. You must obtain authorization from the Plan.

VillageCareMAX will coordinate third party insurance. If Medicare covers any of the above services, then Medicare will be billed first. If you have any additional insurance (other than Medicare or Medicaid), which covers any of the above services, the other insurance will be billed after Medicare. VillageCareMAX will always be the last one billed.

When one of the services listed above is covered by Medicare, you have the freedom to choose your own provider. However, when the service stops being covered by Medicare and is covered by Medicaid, you will have to switch to a network provider. To ensure continuity of care, it is always best to use a network provider, even when the service is covered by Medicare or other insurance. You can always call Member Services at 1-800-469-6292 (TTY 711), if you have any questions about coverage for above services.

Except for Vision and Dental Providers, VillageCareMAX reimburses providers for each individual service provided to a member on a fee for service basis. Dental and Vision providers are paid a fixed amount of money for each member every month.

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 each year, or you must meet additional eligibility criteria. The benefit limits for VillageCareMAX are listed below:

- Outpatient Physical Therapy, Occupational Therapy and Speech Therapy are limited to 20 visits per year, per therapy (limitation does not apply to individuals with developmental disabilities).
- 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.

You must get these services from the providers who are in VillageCareMAX network. If you cannot find a provider in our plan, please call Member Services at 1-800-469-6292. TTY users, please call 711.

What Services Are Not Covered By VillageCareMAX?

VillageCareMAX does not cover the services listed on this page. However, these services may be included in your plan of care and coordinated by your Care Manager. You should speak with your Care Manager and your Doctor if you need any of these services.

Service	Description
Inpatient and Outpatient Hospital Care	Includes care you may receive while hospitalized or care you may receive in a hospital clinic.
Physician Services	Includes care rendered by an M.D., physician assistant or nurse practitioner.
Laboratory and Diagnostic Tests	Includes such tests as blood tests, urine tests, and electrocardiograms.
Radiology & Radio-Isotope X-rays	Includes X-rays, bone scans, CAT scans and MRIs.
Hospital Emergency Room Care	Includes visits to the emergency room. Renal dialysis, including hemodialysis or peritoneal dialysis.
Hospice Care	Includes a range of home-based and inpatient services for people at the end of life.
Mental Health Services	Includes inpatient and outpatient treatment for mental health problems such as, but not limited to, depression and schizophrenia.
Alcohol & Substance Abuse	Includes care received for treatment of alcohol or drug abuse. This would include hospitalization or outpatient treatment.
Office for People with Developmental Disabilities	Includes Services received through the New York State Office for People with Developmental Disabilities such as day programs and vocational training.
Emergency Transportation	Includes emergency ambulance transportation service. **Please dial 911 in an emergency.**
Family Planning	Medical treatment such as vasectomies or tubal ligation.
Prescription Drugs, Compound Prescriptions and Non-Prescription Drugs	Use your Medicare Prescription Drug card and/or your Medicaid card for your medications.

Services not covered by VillageCareMAX may be covered by Medicaid fee-for-service, Medicare, or if you have another third party insurer, that insurer may pay for services not covered by VillageCareMAX. Your Care Manager will assist you in coordinating and obtaining these services, even though VillageCareMAX does not cover them.

You can contact providers for services not covered by VillageCareMAX directly, without a referral or authorization from VillageCareMAX. However, so that we can coordinate and manage your care in the best way possible, it is always best to let your Care Manager know about any appointments you have with providers of services not covered by the Plan.

If you require non-emergency transportation to any health related appointment, you must call VillageCareMAX so that we can arrange and provide you with non-emergency transportation.

As a member of VillageCareMAX you must have Medicaid. Your Medicaid card remains active provided you maintain Medicaid eligibility. As a Medicaid recipient you may continue to receive all services covered by Medicaid even those not covered by VillageCareMAX.

What If I Have Other Health Insurance?

If you have any additional health insurance, it is important for you to keep your insurance to cover services that VillageCareMAX does not cover. VillageCareMAX will coordinate benefits with your insurance company.

What About My Medicare Coverage?

Your Medicare coverage does not change when you join VillageCareMAX. There are some things, however, you need to know.

Medicare coverage only applies to persons that are Medicare eligible. As a member of VillageCareMAX you will continue to receive all of the same Medicare benefits that you received prior to enrollment. 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, pharmacy services and renal dialysis services.

VillageCareMAX will be responsible for payment of the co-pays and deductibles for any of the services that are covered by both VillageCareMAX and Medicare. VillageCareMAX is not responsible for co-pays or deductibles for Medicare-covered services that are not also covered by VillageCareMAX, or for co-pays or deductibles for

non-Medicare covered services.

You do not need authorization from VillageCareMAX to get a service that is covered by Medicare, even if it is also covered by VillageCareMAX. However, if a service is covered by VillageCareMAX, once Medicare stops paying you will have to get authorization from VillageCareMAX in order to continue the service.

Please keep your Medicare card and carry it with you to your appointments.

How Do I Enroll?

Enrolling in VillageCareMAX 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 obtain services may contact VillageCareMAX by phone. Our staff is available during normal business hours, from 8:00 a.m. to 8:00 p.m. to talk to you about the 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 1-800-469-6292 (TTY 711).

- A VillageCareMAX representative will talk to you and explain the program. He/she will determine that you meet age requirements, reside in our service area, and have Medicaid benefits.

- H/she will connect you to Conflict Free Evaluation and Enrollment Center (CFEEC) to schedule evaluation. This evaluation is required for the nurse to make sure you are eligible to enroll into a Managed Long Term Care plan.

- After you complete your evaluation with CFEEC, you may tell the Nurse that you want VillageCareMAX as your MLTC Plan. The nurse from CFEEC can help you schedule a second assessment by the MLTC plan you choose.

- When we receive your enrollment request or a referral to enroll you in our plan, we have 30 days to complete our assessment. We will contact you to schedule an appointment with our enrollment nurse in your home.

- If you don’t already have Medicaid but are interested in applying for Medicaid benefits, our staff can also help you with your Medicaid application.

- At the time of your appointment, our enrollment nurse will come to your home to complete a physical, social and environmental assessment of you and your home. The nurse will ask about your past and current health status. If you are eligible based on the assessment done by our enrollment nurse, you will need to sign an enrollment

agreement with us to enroll in VillageCareMAX MLTC plan. The nurse will also provide you with important information about the program, and he/she will talk with you about the services you would receive at the time your enrollment in VillageCareMAX is approved and effective.

- Once all the above is complete, your enrollment will be submitted to New York Medicaid CHOICE, the State's Enrollment Broker. They are responsible for processing all enrollments.

    - If NYMC receives the completed enrollment package by the 20th day of the month, the enrollment will take effect on the first day of the next month. (For example: If your completed enrollment package is submitted by January 20, your enrollment would take place on February 1.)
    - If the enrollment package is received after the 20th day of the month, the enrollment must take effect no later than the first day of the second month. (For example: If your completed enrollment package is submitted on January 22, your enrollment would take place on March 1.)

The enrollment process begins with the initial nursing visit. If you want to stop the enrollment process after the initial visit, but before the start of your care, you can call us at 1-800-469-6292 (TTY 711) to let us know that. You need to tell this to us in writing or over the phone, before the noon of the 20th day before your enrollment becomes effective. VillageCareMAX will work with HRA to process your request.

NOTE: You can also call CFEEC at 1-855-222-8350 Monday through Friday, from 8:30 am to 8:00 pm and Saturday, from 10:00 am to 6:00 pm. They will schedule your evaluation.

How Do I Get the Services That I Need?

When you enroll, you and your care team (your doctor, your Care Manager, your caregiver(s), Member Services and other health care providers) will work together to develop a plan of care that meets your needs. The plan of care is a written description of all the services you need. It is based on an assessment of your health care needs, the recommendation of your doctors and your personal preferences. You will be given a copy of the plan of care for your records, which will include a listing of how often and how long you will receive the services included in your plan of care.

Your Care Manager will follow-up with you on regular basis to check on your health care status by visiting you in your home or calling you on the phone. He/she will work with your physician, and other health care providers, to ensure that you are receiving all needed and ordered service.

A request for services or a request for changes in your current plan should be made by calling Member Services at 1-800-469-6292 (TTY 711). Your provider can make a request on your behalf, as well. Member Services will put you or your provider in touch with your Care Manager. Your Care Manager will be happy to discuss any request for additional services or changes in your services with your doctor, when necessary. Your doctor will order most health care services for you, so your Care Manager will be in close contact with him or her. In order for you to get a covered service, the Plan will have to decide that the service is medically necessary. If the service is medically necessary, the Plan will authorize the service. To decide this, VillageCareMAX staff will evaluate the service and your health status against established guidelines. These guidelines are available to you upon request.

Getting a new service

VillageCareMAX will review your request for new services (prior authorization) and will decide and notify you of our decision by phone and in writing within three (3) business days of receipt of necessary information, but no more than 14 days of receipt of request for services.

An expedited review may be requested if you or a health care provider believes a fast decision is warranted for your safety. VillageCareMAX will review your request and will notify you of our decision by telephone and in writing, within three (3) business days from receipt of the request.

Changing an existing service

If the services are included in your plan of care but you feel that you require more of the services you must call your Care Manager to inform them of your request (called, concurrent review). VillageCareMAX will review your request and will notify you of our decision by telephone and in writing, within one business day of receipt of all necessary information but no more than 14 calendar days from receipt of the request.

An expedited review may be requested if you or a health care provider believes a fast decision is warranted for your safety. VillageCareMAX will review your request and will notify you of our decision by telephone and in writing, within one business day of receipt of all necessary information but no more than three business days from receipt of the request. In the case of a request for Medicaid-covered home health care services following an inpatient admission, we will notify by phone or in writing one business day after receipt of necessary information, except when the day subsequent to the request for services falls on a weekend or holiday. In that case, we will notify you by phone and in writing within 72 hours after receipt of necessary information, but in any event, no more than three business days after receipt of the request for services.

Our review period can be increased by up to 14 days if you request it or if we need more information and the delay is in your interest.

If the service has already been provided
If a service is obtained without prior approval, other than emergency care, the provider may be denied payment. If the service has already been provided and you are requesting VillageCareMAX to reimburse you or the provider of the service, please call Member Services with the request within 30 days of the date of service. VillageCareMAX will review your request and inform you in writing of approval or denial within 45 days.

Disagreement with our decision
If you disagree with any of the decisions, you may appeal our decision by following the process described on pages 28-31 of this Member Handbook. If you disagree with any other services on the care plan or have a complaint about accessing services you may use the grievance process described on pages 25-31 of this handbook.

Changing Providers
Your nurse Care Manager will arrange for all medically necessary services. If you have or are receiving services from one of our network providers and wish to switch providers, please call Member Services and inform them of your request. Member Services will ask you some questions such as why you are requesting to change providers. If necessary, Member Services will put you in touch with your Care Manager. It is important for us at VillageCareMAX to know if you are not happy with any of our network providers. We will work with you in resolving any concerns you may have regarding a provider, or changing providers if necessary.

Generally, whenever you need a service you may call your nurse Care Manager. Your Care Manager can be reached by calling Member Services at 1-800-469-6292 (TTY 711). If you have any questions about the Plan, please call Member Services. You will be put in touch with a staff member who can answer your question or help you with your concern.

Using an Out-Of-Network Provider
In the event that we do not have a network provider who can meet a specialized health care need that you may have (for example, a specialized wheelchair), VillageCareMAX will make a referral, and assure payment, (unless covered by Medicare or a third-party payer) to the out-of-network provider.

If you are a new member and you are receiving long term care services from fee for service Medicaid, like personal care, adult day health care, care in the nursing home and others, we must continue to cover these services for at least 90 days after you join the plan.

If you are enrolled in the Plan and your network provider leaves VillageCareMAX network, we will continue to cover the services that you are receiving from the provider for up to 90 days, in order to facilitate transition to another provider. Providers must agree

to accept VillageCareMAX payment as payment in full and adhere to a Quality Improvement program during the transition period.

Access Standards
VillageCareMAX expects our network providers to give you prompt service. We have told our providers that they need to see and treat you within the following time-frames:

Service	**Standard**
Optical Appointments:	Appointment within two (2) weeks of the date you called to arrange the appointment.
Dental Appointments:	Appointment within two (2) weeks of the date you called to arrange the appointment.
Podiatry Appointments:	Appointment within two (3) weeks of the date you called to arrange the appointment.
Home Nursing Appointments:	Within 48 hours of request unless otherwise required by your doctor.
Home Rehab Appointments:	Within 48 hours of request unless otherwise required by your doctor.
Non-emergency Transportation	Will be arranged as needed for medical appointments. Please call to arrange for transportation 24-48 hours in advance.

Participant Ombudsman Program
The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide participants with free, confidential assistance on any long term care services.

These services include, but are not necessarily limited to:

- Provide pre-enrollment support, such as unbiased health plan choice counseling and general program-related information,
- Compile enrollee complaints and concerns about enrollment, access to services, and other related matters,
- Help you understand the fair hearing, grievance and appeal rights and processes within the health plan and at the State level, and assisting you through the

process if needed/requested, including making requests of plans and providers for records, and
- Inform plans and providers about community-based resources and supports that can be linked with covered plan benefits.

ICAN is available Monday through Friday from 8:00 am to 8:00 pm and can be reached toll-free at 1-844-614-8800 (TTY: 711) or online at icannys.org.

When ICAN contacts VillageCareMAX on your behalf, we will work with ICAN to help you.

Emergency Services

In Case of Emergency: **Call 911 or go to the nearest hospital**.

You are entitled to emergency care 24 hours a day 7 days a week. **Emergency services and/or Emergency care do not require pre-authorization.**

An emergency is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain. An emergency is a condition that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of behavioral condition, placing the health of the person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person, or (4) serious disfigurement of such person.

Whether you are discharged to home or hospitalized after an emergency room visit, you or your family should contact Member Services. If it is a scheduled hospitalization please notify Member Services as soon as you know the dates of your admission to the hospital. This will enable the program to cancel scheduled appointments, or if you are hospitalized, to work with hospital personnel to plan for your discharge and follow-up care.

Urgent Care

If the situation is not an emergency, but you need same day medical care, notify Member Services or call your physician directly. Member Services can assist you with arrangements and transportation to your medical appointment.

Leaving the Service Area

If you leave the service area for 30 calendar days or less on a short vacation or to visit friends/relatives and believe that you need any services covered by VillageCareMAX, contact Member Services at 1-800-469-6292 (TTY 711). Member Services will put you in touch with your Care Manager. To avoid any problems while you are out of the service area, call Member Services prior to leaving. VillageCareMAX will work with you to plan or arrange for services that are needed. However, if you require emergency or urgent medical care while you are away, seek the care that you need, and then contact your Member Services.

If you leave the service area for more than 30 calendar days we will have to disenroll you from the Plan.

There are no costs unless you have a spend-down

As part of the enrollment process, HRA reviews your financial status for Medicaid eligibility. HRA may determine that you must spend a portion of your monthly income in order to meet the maximum income eligibility amount for Medicaid. HRA will inform you and VillageCareMAX of the exact amount of "spend-down" owed by you to VillageCareMAX each month. In order to enroll and receive benefits from VillageCareMAX you must pay this amount to VillageCareMAX. We will mail you an invoice in the beginning of every month and let you know how much "spend down" you need to pay. The amount you owe is due at the end of that month. If you do not pay the "spend- down" amount within 30 days after the due date, VillageCareMAX may disenroll you from the plan.

If you have any questions regarding the Medicaid "spend-down", please contact HRA at:

Human Resources Administration Medical Assistance Program
Home Care Services Program
330 West 34th Street, Room 912 New York, NY 10001
1-212-630-1945

There are no other payments to VillageCareMAX.

If you receive a bill from any health care provider for covered services, please inform Member Services so that we may investigate the reason for you being billed.

COMPLAINT AND APPEALS

VillageCareMAX will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by VillageCareMAX staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint or to appeal a plan action, please call: *1-800-469-6292 (TTY: 711) or write to: 112 Charles Street, New York, NY 10014*. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

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

How do I Appeal a Complaint Decision?

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

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When VillageCareMAX denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

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

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

We can be reached by calling *1-800-469-6292 (TTY: 711)* or writing to: *112 Charles Street, New York, NY 10014*. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to

make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while your appeal is being decided. We must continue your service if you make your request no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later.

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

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

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

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

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases you may request an "expedited" appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

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

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

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

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

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your

services, whichever occurs later.

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

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

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

- Online Request Form: http://otda.ny.gov/oah/FHReq.asp

- Mail a Printable Request Form:

  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023

- Fax a Printable Request Form: (518) 473-6735

- Request by Telephone:

  Standard Fair Hearing line – 1 (800) 342-3334
  Emergency Fair Hearing line – 1 (800) 205-0110
  TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:

  New York City
  14 Boerum Place, 1st Floor
  Brooklyn, New York 11201

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

State External Appeals

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

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

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

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

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

SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS

Definitions

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee's behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such

service is provided to the Enrollee.

Concurrent Review: review of a request by an Enrollee, or provider on Enrollee's behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Expedited Review: An Enrollee must receive an expedited review of his or her Service Authorization Request when the plan determines or a provider indicates that a delay would seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.

General Provisions

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered health care professional when such determination is based on an assessment of the Enrollee's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit when coverage is dependent on an assessment of the Enrollee's health status, and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals, and out-of-network services.

The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance.

The Contractor shall utilize the Department's model MLTC Initial Adverse Determination and 4687 MLTC Action Taken notices.

Timeframes for Service Authorization Determination and Notification

1. For Prior Authorization requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

a. Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request
b. Standard: Fourteen (14) days after receipt of request for Service Authorization Request.

2. For Concurrent Review Requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

   a. Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request
   b. Standard: Fourteen (14) days of receipt of the Service Authorization Request
   c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

3. Up to 14 calendar day extension. Extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.

   a. The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination, and help the enrollee by listing potential sources of the requested information.

4. Enrollee or provider may appeal decision – see Appeal Procedures.

5. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.

   a. The Contractor must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee's service request will be reviewed in the standard timeframe.

Other Timeframes for Action Notices

1. When the Contractor intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:

    a. the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or
    b. the Contractor may mail notice not later than date of the Action for the following:

        i. the death of the Enrollee;
        ii. a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);
        iii. the Enrollee's admission to an institution where the Enrollee is ineligible for further services;
        iv. the Enrollee's address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;
        v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or
        vi. the Enrollee's physician prescribes a change in the level of medical care.

    c. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)-(b).

        i. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a non-business day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals

d. The Contractor must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,

e. When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

Contents of Action Notices

1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.

2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:

   a. the date the restriction will begin;
   b. the effect and scope of the restriction;
   c. the reason for the restriction;
   d. the recipient's right to an appeal;
   e. instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
   f. the right of Contractor to designate a primary provider for recipient;
   g. the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;
   h. the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
   i. the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;
   j. the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
   k. the name and telephone number of the person to contact to arrange a conference;
   l. the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
   m. the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;
   n. the right of the recipient to examine his/her case record; and
   o. the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This

information is generally referred to as “claim detail” or “recipient profile” information.

Can I Leave The Plan?

Yes. Enrollment is voluntary and you can start the disenrollment process at any time verbally or in writing. If your disenrollment is due to a complaint or concern, please contact Member Services. We value your membership in VillageCareMAX and would appreciate an opportunity to address and resolve your dissatisfaction with the Plan.

Generally, if you notify VillageCareMAX that you wish to disenroll by the 10th day of the month, your disenrollment will be effective on the first day of the next month. If you notify us after the 10th day of the month, your disenrollment will not be effective until the following month. For example, if you make a disenrollment request between January 1 and January 10, your disenrollment may take effect of February 1. If you make your request between January 11 and January 31, your disenrollment will take effect on March 1.

You will receive written notification of the date of your disenrollment. VillageCareMAX will continue to provide or arrange for the provision of covered services to you until the effective date of your disenrollment. We will also assist with the transfer to new service provider.

There are situations when we may have to disenroll a member. This is called an involuntary disenrollment. Disenrollment may <u>not</u> be based on deterioration, worsening of your health or cost of your covered services.

We must disenroll you from the Plan if:

- You move out of the service area.
- You leave the service area for more than 30 consecutive days.
- You are hospitalized for more than 45 consecutive days.
- You are admitted to a skilled nursing facility (nursing home) and are not eligible for Institutional Medicaid.
- Your Medicaid is terminated.
- You no longer demonstrate a functional or clinical need for the community based long term care services of the plan.
- You are eligible for Medicaid only and no longer meet nursing home level of care as determined using the assessment tool we are required to use by The Department of Health.
- 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 of Mental Health, People with Developmental Disabilities, or Alcoholism and Substance Abuse Services.

You may be disenrolled from the Plan if:

- You or others in your home exhibit abusive, disruptive or uncooperative behavior to such a degree as to jeopardize the provision of care.
- You have failed to pay your spend-down within 30 days.
- You or your family provide the program with false information or engage in fraudulent conduct.
- You knowingly fail to complete and submit requested documentation.

Your Care Manager will work with you to attempt to resolve these issues. If the issues are not resolved, then VillageCareMAX will notify the State's Enrollment Broker – New York Medicaid Choice – of the request for disenrollment. NYMC must agree with any involuntary disenrollment, and will send written notification of such to you. VillageCareMAX will continue to provide or arrange for the provision of the covered services to you until the effective date of your disenrollment. Program personnel will assist you with arrangements for future services from another provider. In order to prevent a lapse in delivery of services to you, services from the new provider will be effective on the date of disenrollment from VillageCareMAX.

What Are My Rights and Responsibilities?

- ✓ 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 and 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 advised of where, when and how to get the services you need from VillageCareMAX including how you can get benefits from out-of-network providers.

- ✓ You have the Right to complain to the New York State Department of Health or your local Department of Social Services, the right to use the New York State Fair Hearing System and the right to use the New York State External Appeals Program.

  You have the Right to appoint someone to speak for you about your care and treatment.

- ✓ You have the Right to make advance directives and plans about your care. (You will receive written information on advance directives including a description of the applicable State Law).

- ✓ You have the Right to receive assistance in completing a health care proxy form and to ensure your advanced directives may be carried out.

- ✓ You have the Right to begin disenrollment from VillageCareMAX at any time.

- ✓ You have the Right to assist in the development and evaluation of new and existing programs and policies.

- ✓ You have the Right to choose your primary care physician.

- ✓ You have the Right to seek assistance from the Participant Ombudsman program.

As a Member of VillageCareMAX you have the following responsibilities:

- ✓ Accept services without regard to the race, color, religion, age, sex, national origin or disability of the caregiver.

- ✓ Obtain prior authorization for services and treatments provided by VillageCareMAX from your physician, nurse Care Manager and Member Services (emergency services do not require prior approval).

- ✓ When applicable, make payment to VillageCareMAX of any "spend-down" monies as identified by the HRA.

- ✓ Keep appointments or notify the program if an appointment cannot be kept.

- ✓ Supply accurate and complete information to caregivers.

- ✓ Participate in the development and updating of your care plan.

- ✓ Request further information from your nurse Care Manger regarding anything you do not understand.

- ✓ Assist in developing and maintaining a safe environment.

- ✓ Comply with all requirements of VillageCareMAX as noted in the Member Handbook.

- ✓ Obtain services within the VillageCareMAX Network Provider list when necessary.

- ✓ Participate in questionnaires and/or surveys and focus groups to enhance our quality of service regarding this program.

You Will Be Provided With The Following Information Upon Your Request

- ✓ List of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of VillageCareMAX.

- ✓ The most recent annual certified financial statement of VillageCareMAX.

- ✓ Information relating to consumer complaints in regard to VillageCareMAX.

- ✓ Written description of the organizational arrangements for VillageCareMAX

- ✓ Description of VillageCareMAX's procedures with regard to protecting the confidentiality of medical records and other member information and ongoing process of the quality assurance program.

- ✓ Health practitioners' affiliations with hospitals.

- ✓ Description of criteria used when making decisions regarding approval or denial of services.

- ✓ Application procedures and minimum qualification requirements for health care providers to participate in VillageCareMAX.

- ✓ A copy of your VillageCareMAX program record, upon written request.

Money Follows the Person (MFP) Program /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. 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 their community

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

- Giving you information about services and supports in the community
- Finding services offered in the community to help you be independent
- Visiting or calling you after you move to make sure that you have what you need at home

For more information about *MFP/Open Doors*, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

Notice of Non-discrimination

VillageCareMAX complies with Federal civil rights laws. VillageCareMAX does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. VillageCareMAX does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

VillageCareMAX provides the following:

- Free aids and services to people with disabilities to communicate effectively 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, contact VillageCareMAX Member Services Department at 1-800-469-6292. For TTY/TDD services, call 711.

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

Mail:	Grievances Coordinator, VillageCareMAX, 112 Charles Street, New York, NY 10014
Phone:	1-800-469-6292, TTY 711
Fax:	347-226-5181
In person:	Grievances Coordinator, VillageCareMAX, 112 Charles Street, New York, NY 10014
Email:	complaints@villagecare.org

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

Web:	Office of 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, D.C. 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone:	1-800-368-1019, 800-537-7697 (TDD)