CENTERS PLAN FOR HEALTHY LIVING

Centers Plan for Medicaid Advatage Plus (D-SNP)

Member Handbook

Service Areas:
Bronx, Kings, Nassau, New York,
Queens, Richmond and Rockland

CPHL_MK013_MAP_01112022

Revised 01/2022

CENTERS PLAN FOR MEDICAID ADVANTAGE PLUS (MAP)

Member Services

If you have questions or need help, please write to us at:

Centers Plan for Healthy Living
75 Vanderbilt Ave, Suite 700
Staten Island, NY 10304

Or call us between 8 am and 8 pm, 7 days a week at
1-833-CPHL MAP (1-833-274-5627) (toll free).
TTY/TDD please call: 1-800-421-1220.

If you have an urgent concern, CPHL staff is available to help.
To contact us 24 hours a day, 7 days a week please call:

1-833-274-5627 (toll free)
TTY/TDD: 1-800-421-1220

Call us if you need to reach a member of your Care Management Team, ask about benefits and services, get help with referrals, replace any MAP plan materials, need help choosing or changing your doctor, or if you have questions.

If you do not speak English, we can provide you with a written member handbook in other languages. We also use a service that can provide translation services in multiple languages. Please contact us toll free at 1-833-274-5627 for additional information.

Si no habla inglés, podemos suministrarle una versión impresa del manual de miembro en otros idiomas. También utilizamos un servicio que puede suministrar servicios de traducción en diferentes idiomas. Llámenos sin costo al número 1-833-274-5627 para obtener información adicional.

如果您不使用英語，我們將為您提供您所需語言的會員手冊。
我們的服務同樣提供多語言翻譯服務。請致電免費電話
1-833-274-5627 連絡我們以獲得更多資訊。

Special services are available for people with special needs. If you have special needs, call us and we will provide extra help. We will help you find services from providers who understand, and are prepared to meet, your special needs. We can provide materials in large print upon request. We can assist you in obtaining VCO (Voice Carry-Over) or TTY (Text Telephone Device) to help make communication easier. TTY/TDD users please call us at 1-800-421-1220.

About Centers Plan for Medicaid Advantage Plus

Centers Plan for Medicaid Advantage Plus is designed for people with Medicare and Medicaid, who need health and long-term services, such as home care and personal care services. Our goal is to help our members remain safely in their homes and communities.

About this Member Handbook

The Member Handbook is given to you during our enrollment process to help you learn about the program. Additionally, the Centers Plan for Medicaid Advantage Plus (HMO D-SNP) Medicare Evidence of Coverage (EOC) outlines the benefits you receive under the Medicare portion of the plan. Please read both this Member Handbook and the EOC carefully and refer to them when you need information about how the plan works. You will need both to learn what services are covered, and how to get services.

If you decide to enroll in Centers Plan for Medicaid Advantage Plus, this handbook along with the Centers Plan for Medicaid Advantage Plus (HMO D-SNP) Medicare Evidence of Coverage become your guide to services.

You can find an electronic version of these documents on our website at www.centersplan.com or you may request them at any time by calling us at 1-833-274-5627.

Membership Card

Your Centers Plan for Healthy Living (CPHL) Member Identification card (ID card), which will be provided shortly after enrollment, will let providers know that you are enrolled in Centers Plan for Medicaid Advantage Plus (MAP). It is advised that you carry this card, along with any other insurance cards, with you at all times.

Tips for New Members

- Keep this Member Handbook along with the Centers Plan for Medicaid Advantage Plus (HMO D-SNP) Medicare Evidence of Coverage in a place where you know you can easily find them.
- Keep the welcome letter to which your ID card is attached. It includes important numbers for accessing services such as dental, hearing, vision, and medical transportation.
- Post the CPHL contact telephone numbers near your telephone or another easily accessible place such as your refrigerator.

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1. Welcome to Centers Plan for Healthy Living

Centers Plan for Healthy Living (CPHL) is pleased to introduce you to Centers Plan for Medicaid Advantage Plus (MAP) Plan. We welcome you as a member, and urge you to review this booklet carefully. Please feel free to ask questions about any of the sections.

If you need help understanding the information in this handbook, please contact CPHL's Member Services seven days a week from 8 am to 8 pm at 1-833-274-5627. TTY/TDD users can call 1-800-421-1220.

To enroll in our program, you must meet eligibility criteria as outlined in Section 9, Eligibility.

CPHL will help you remain as independent as possible. CPHL provides and coordinates services designed to keep you living in your own home for as long as possible. CPHL does this by providing a comprehensive benefit package of covered services, and by coordinating your Medicaid and Medicare services. Your Care Management Team will work with you and your family to coordinate and provide you with the care you need.

If you have an urgent concern, CPHL staff is available to help. To contact us 24 hours a day, 7 days a week please call:

1-833-274-5627 (toll free)
TTY/TDD: 1-800-421-1220

2. Special Features of Centers Plan for Medicaid Advantage Plus

Centers Plan for Medicaid Advantage Plus (MAP) helps people 18 years and older by coordinating and providing health care services to live safely at home for as long as possible. Should you be eligible and choose to enroll in Centers Plan for Medicaid Advantage Plus, you agree to receive covered services (see Section 4) only from CPHL and its network of providers, as described in your care plan. The following elements are key to Centers Plan for Medicaid Advantage Plus (MAP):

A. The CPHL Care Management Team: Upon your enrollment, you will be assigned a Care Management Team. To help manage your chronic health problems, the CPHL Care Management Team will monitor changes in your health status, provide appropriate care and encourage independence. The Care Management Team is comprised of nurses, social workers and service coordinators. If at any time you are not happy with your Care Management Team, you can discuss a change with the Care Management Team Supervisor.

Your Care Management Team members are available to assist you with any issues. For specific areas of concern, you may call your Care Management Team as outlined below:

- Contact your Care Management Team for health-related issues (such as medications, symptoms, supplies, coordination with your doctor, etc.),
- Contact your Care Management Team for issues related to Medicare and Medicaid, other insurance, housing,

community resources and programs and/or individual or family counseling.

To decide what services are most important to help you remain at home, your Care Management Team will regularly monitor and evaluate your health status. In collaboration with you and your doctor, your team will develop a plan of care designed to meet your health care needs. The plan of care will include your goals, objectives and special needs. Your plan of care will change as your needs and conditions change, and will be re-evaluated at least every 6 months.

Your Care Management Team will coordinate the services you receive and will communicate with your doctor as needed. When we coordinate your services, members of our Care Management Team may help arrange your medical appointments and transportation to and from these appointments as needed. Your Care Management Team could also communicate with providers regarding all services covered by CPHL.

When needed, your Care Management Team may also help you modify your home to increase safety and convenience as well as arrange for assistance from family, friends, and neighbors.

By helping you manage all aspects of your care, your Care Management Team can identify problems early, prevent problems from getting worse, and help you avoid trips to the hospital or the emergency room.

B. Access to Care: Before you can receive most covered services, CPHL must authorize the service. Some covered services require a doctor's order. However, authorization is not required in an emergency or an urgent situation as described in Section 6.

You can also go to the podiatrist, dentist, audiologist, and optometrist for evaluation and routine services without any prior authorization by CPHL. For dental care, call Healthplex at 1-800-468-9868. For optometry call VSP at 1-800-877-7195.

C. Where You Will Receive Long Term Care Services: Covered long term care services are most often provided in your home. Other services are available in the community through our contracted adult day centers and other contracted providers. You will access dental, podiatry, and audiology services from contracted providers in medical offices. If needed, you may receive inpatient nursing home services from providers in our contracted network. For the Medicare portion of covered services be sure to consult the Centers Plan for Medicaid Advantage Plus (HMO D-SNP) Medicare Evidence of Coverage.

Your Care Management Team will help you identify providers of covered and non-covered services.

D. Provider Network: You will receive a Provider Directory upon enrollment. You can also request a Provider Directory at any time and we will mail one to you. You have the freedom to choose any network provider from this list for covered services. CPHL will assist you in choosing or changing a provider for covered or non-covered services. You can switch to another network provider at

any time. The provider will be changed as soon as possible, based upon the availability of your request.

Network providers will be paid in full directly by CPHL for each service authorized and provided, with no co-pay or cost to you. Although there is no cost to you for individual services, if you have a Medicaid Monthly Spend Down, as determined by the NYC Human Resources Administration (HRA) or Local Department of Social Services (LDSS), CPHL will send you a bill for this amount. See Section 13, Monthly Spend Down.

If you receive a bill for covered services authorized by CPHL please contact our Member Services. You may be responsible for payment of covered services that were not authorized by CPHL, or for covered services that are obtained by providers outside of CPHL's network.

If you have questions about the qualifications of any provider, you can ask your Care Management Team or call Member Services.

E. Flexibility of Care: CPHL has flexibility in providing care according to your needs and can provide you with the services that are necessary to meet those needs.

3. Advantages of Enrolling in Centers Plan for Medicaid Advantage Plus

CPHL was designed and developed specifically to promote independence among frail adults by offering comprehensive, coordinated long-term care services through a single organization. Other advantages of participating in the plan include:

- A Care Management Team of dedicated and qualified professionals who get to know you personally.
- A Care Management Team that is there to oversee and coordinate your care whether at home, in a hospital or in a nursing home.
- Support for family and caregivers in their efforts to help you remain in your own home.

4. Benefits and Coverage/Coordination of Other Medical Services[1]

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 Centers Plan for Medicaid Advantage Plus Medicare Evidence of Coverage (EOC). Chapter 3 of CPHL's MAP EOC explains the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Chapter 4 of the CPHL MAP EOC under the column of "What you must pay when you get these covered services".

Because you have joined CPHL's MAP, and you have Medicaid, CPHL will pay these amounts. You do not have to pay these deductibles and co-payments except for those that apply to chiropractic care and pharmacy items. If there is a monthly premium for benefits (see Chapter 4 of the CPHL MAP EOC) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The chart below explains what is covered.

[1] Benefits can't be transferred from you to any other person or organization.

Centers Plan for Medicaid Advantage Plus Covered Services:

Covered Services	Definition
• Care Management	• Care Management is a process that ensures consistent oversight, coordination and support to members and their families in accessing MAP plan-covered services as well as non-covered services.
• Nursing Home Care (for stays not covered by Medicare)	• Short or long-term care provided in a NYS licensed residential facility or NYS licensed Skilled Nursing Facility. Care is provided to members through CPHL network facilities.
• Inpatient mental health care (for care not covered by Medicare)	• Inpatient mental health care over the 190-day lifetime Medicare limit requires a physician order, prior approval, and must be medically necessary. Care is provided to members through CPHL network facilities.

Covered Services	Definition
• Non-emergency Medical Related Transportation	• Travel by ambulette, taxi or livery service to obtain necessary covered medical care and services.
• Podiatry, including routine foot care	• Services by a podiatrist which may include routine foot care when they are performed as a necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections.
• Optometry (includes eyeglasses)	• Includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses, medically necessary contact lenses and other low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the member's condition.

Covered Services	Definition
• Audiology • Hearing Aids and Batteries	• Audiology services include examination, testing, hearing aid evaluation, and prescription. • Hearing aid services include selecting, fitting, repairs, replacement, special fittings and batteries.
• Dental Care	• Includes but not limited to: routine exams, preventive and therapeutic dental care, dentures and supplies.
• Medical Equipment	• Includes Hearing Aid Batteries, Prosthetics, Orthotics, and Orthopedic Footwear.
• Medical Supplies	• Items for medical use other than drugs, which treat a specific medical condition such as diabetes. This may include wound dressings and other prescribed therapeutic supplies.

Covered Services	Definition
• Enteral and Parenteral Nutritional Supplements	• Liquid nutritional supplements as prescribed. Limited to beneficiaries who are fed via nasogastric, gastrostomy or jejunostomy tubes, and beneficiaries with inborn metabolic disorders.
• Personal Emergency Response System	• An electronic device which enables members 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.
• Social and Environmental Supports	• Services and items include, but are not limited to, home maintenance tasks, homemaker/care services, housing improvement and respite care.

Covered Services	Definition
• Dietary Counseling	• A Registered Dietician (RD) or Diet Technician (DT) make specific recommendations for services to the Care Management Team and the member.
• Home Health Care	• Services include: nursing, personal care aide, home health aide, nutrition, social work and rehabilitation such as physical therapy, occupational therapy, and speech language pathology.
• Nursing	• Intermittent, part-time nursing services. Nursing services must be provided by RNs or LPNs. Nursing services include care rendered directly to the individual and instructions given to a caregiver on the procedures necessary for the member's treatment or maintenance.

Covered Services	Definition
• Health Education	• Members receive our quarterly newsletter, "Healthy Living," which contains helpful education about our members' wellbeing. Please check CPHL's website for additional educational resources.
• Personal Care	• Assistance with one or more activities of daily living such as walking, cooking, cleaning, bathing, using the bathroom, personal hygiene, dressing, feeding, nutritional and environmental support functions.

Covered Services	Definition
Outpatient Rehabilitation: • Physical Therapy • Occupational Therapy • Speech Therapy	• Rehabilitative health that uses specially designed exercises and equipment to help patients regain or improve their physical abilities. • Rehabilitative health that uses specially designed exercises and equipment to help patients regain or improve their abilities to perform activities of daily living. • Rehabilitation services for the restoration of the patient to his or her functional level in speech or language. • CPHL will cover medically necessary physical therapy (PT), occupational therapy (OT), and speech therapy (ST) visits that are ordered by a doctor or other licensed professional.

Covered Services	Definition
• Social Services	• Information, referral and assistance obtaining or maintaining benefits of financial assistance, medical assistance, food stamps, and housing to assist the member to remain in the community.
• Home-Delivered Meals	• Meals delivered for members without cooking facilities or with other special circumstances.
• Adult Day Health Care	• Care and services provided in a health care facility which includes: medical, nursing, nutrition, social services, rehabilitation therapy, leisure time activities, dental or other services.
• Social Day Care	• Care and services provided in a facility which provides socialization, supervision, monitoring and nutrition.
• Telehealth	• Remote electronic care and education.

Covered Services	Definition
• CDPAS: Consumer Directed Personal Assistance Services	• A specialized program where the member or a designated representative officially acting on the member's behalf, self- directs and manages the member's personal care and other authorized services. A CDPAS member has freedom in choosing his/her personal aide. The member and/or designated representative is responsible for hiring, training, supervising and if necessary, terminating the employment of his/her aide. If you are interested in CDPAS, speak with your Care Manager.

Medicaid and Medicare Services Not Covered by Our Plan

There are some Medicaid and Medicare services that Centers Plan for Medicaid Advantage Plus does not cover but may be covered by regular Medicaid or Medicare. You may be able to get these services from any provider who takes Medicaid or Medicare by using your Medicaid or Medicare Benefit Card. Call Member Services at 1-833-274-5627 if you have a question about whether a benefit is covered by CPHL MAP, Medicare, or, Medicaid.

Below is a list of some of the services covered by Medicaid using your Benefit Card:

Pharmacy

Most prescription drugs are covered by CPHL MAP Medicare Part D as described in Chapter 5 of CPHL's MAP EOC. Regular Medicaid will cover some drugs not covered by Centers Plan for Medicaid Advantage Plus or Medicare. Medicaid may also cover drugs that we deny.

Certain Mental Health Services, including:

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

- Comprehensive Medicaid Case Management
- Home and Community Based Waiver Program Services
- Directly Observed Therapy for Tuberculosis Disease
- AIDS Adult Day Health Care, and
- Assisted Living Program

Certain Mental and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services

- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management

Family Planning

- Non-network Family Planning services
    - 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).

Below is a list of some of the services covered by Medicaid or Medicare using your Benefit Cards:

Hospice Services provided to Medicare Advantage Plan members

- These services could be obtained by use of your Medicare or Medicaid card.

Services *not* Covered by Centers Plan for Medicaid Advantage Plus or Medicaid

You must pay for services that are not covered by Centers Plan for Medicaid Advantage Plus 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 CPHL MAP 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 Centers Plan for Medicaid Advantage Plus sends you to that provider)

If you have any questions, call Member Services at 1-833-274-5627.

Nursing Home Care

There may be times when your doctor, your Care Management Team, you and your family, decide that the best short or long-term care for you is placement in a nursing home. This may be because your home is no longer the best place for you to be taken care of safely and comfortably. The CPHL Care Management Team will carefully coordinate and assist with this placement. You will continue to be a member of Centers Plan for Medicaid Advantage Plus during your nursing home stay.

When nursing home care is required, placement and care will be provided in a network facility. The plan does not cover personal conveniences such as telephone, radio or television rental.

CPHL is committed to placing members in need of skilled nursing facility care in the most integrated, least restrictive setting available. Recommendation for placement in a nursing home may be based on medical necessity and whether or not a member has the ability to safely remain in his/her home and community. If an in-network nursing home can't meet your needs, an out-of-network nursing home may be chosen. If CPHL decides to end a contractual agreement with the nursing home you live in, you can continue living in that nursing home. CPHL will focus on your needs, desires and goals.

Services for Veterans

We are proud to offer veterans home care for our members who are: veterans of the U.S. Armed Forces, spouses of veterans of the U.S. Armed Forces or Gold Star Parents. Our Care Management Team will identify CPHL members eligible for these special services. If you are eligible to receive our special veteran's services and would like to get your nursing home care at a NY State Veterans' Home in our service area, we will strive to provide this care through an in-network veterans home. If, despite our best efforts, we are unable to make arrangements for your care at an in-network veterans home, we will provide you with out of network care at a veterans home until you are able to switch to a Medicaid Advantage Plus (MAP) plan that has an in-network State veterans home. We will also assist you in notifying the New York Medicaid Choice (NYMC) of your request for care at a State Veterans' Home.

Money Follows the Person (MFP)/Open Doors

This section will explain the services and supports that are available to you 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, and,
- Have health needs that can be met through services in your 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 by:

- Giving you information about services and supports in your community.
- Finding services offered in your 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.

5. Care Planning

Care Planning and Care Management

When you enroll, you, your doctor, and the CPHL Care Management Team, will work together to develop a plan of care that meets your needs and is medically necessary.

The Person Centered Service Plan (PCSP) is a written description of all the services you need. It is based on your Care Management Team's assessment of your health care needs, the recommendations of your doctor, and input from you and your family or caregivers.

Your Care Management Team will continuously monitor and evaluate your health status and care needs. Your PCSP will include at least 1 call from our Care Management Team per month and 1 home visit from our Care Management Team every 6 months. As your needs change, your PCSP will be changed to make sure that the plan includes all of the services you currently need. This will include increasing or decreasing services and changing the services provided. (Please see Requesting Additional Services or Changes to the Care Plan Service and Authorization for Services later in this section). A formal reassessment will occur at least every one hundred and eighty 180 days. When we make our initial assessment or any reassessment, we will provide you with information about services, including services such as CDPAS, which you may be eligible for.

To make monitoring your care and evaluating your needs easier, it is important that you talk with the members of your Care Management Team to let them know what you need. It is also important to let them know when you have used a non-covered service. See Section 4 for a list of Covered and Non-Covered services. By doing so, you will help your Care Management Team manage your care in the best way possible.

A member of your Care Management Team will arrange the covered services that you need. This includes such items as: setting up transportation to and from all non-emergent medically related appointments, providing you with home delivered meals, and arranging for home care.

A member of your Care Management Team can also assist you with accessing non-covered services if you need assistance. This means, for example, that your Care Management Team can help you identify providers of non-covered services and assist with scheduling your appointments with your doctor, or with a laboratory, and arrange for transportation to and from these appointments. It could also mean that your Care Management Team will assist you with accessing hospital outpatient services.

A member of the CPHL Care Management Team is available 24-hours a day, seven days a week, to answer questions about your plan of care, and to assist you in accessing both covered and non-covered services.

Authorization for Services

Upon enrollment you, your networked doctor and Care Manager will create a plan of care that meets your health needs.

Most of the covered services that you receive must be authorized by CPHL. Some of the services also require a doctor's order. The services that require a doctor's order include home health care, nursing home care, rehabilitative therapies, respiratory therapy, durable medical equipment, prosthetics, and orthotics. Non-emergent transportation, environmental supports, and home delivered meals must be authorized by your Care Management Team, but do not require a doctor's order. You can go to the podiatrist, dentist, audiologist, and optometrist for evaluation and routine services without a prior authorization by your Care Management Team.

If you access these services on your own, CPHL recommends that you contact a member of your Care Management Team at your earliest convenience to inform them. This will help the Care Management Team better manage your health care needs.

If you need help to access any covered service, you should talk to any member of your Care Management Team. A member of your Care Management Team can help you schedule transportation and make an appointment with a provider.

Emergency or urgent care services do not have to be ordered by your doctor, or authorized by your Care Management Team.

If CPHL decides to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, we will provide you a written notice at least 10 days prior to the effective date of the intended Action. You have the right to appeal our Action. See Section 14, Resolving Member Problems and Complaints, for details.

Requesting Additional Services or Changes to the Plan of Care

If you or your doctor feel that you need a covered service or would like to change your plan of care, you should contact any member of your Care Management Team. Your Care Management Team will review the request and re-assess your needs to determine if it is medically necessary. Your Care Management Team may consult with your doctor about the services and other changes you have requested.

If CPHL determines that your request is medically necessary, the service will be provided and your plan of care modified. If your request is denied, you will receive a Notice of Action regarding the denial. CPHL will provide you with a Notice of Action anytime we deny or limit services requested by you or a provider on your behalf. See Section 14, Resolving Member Problems and Complaints.

There are specific types of requests called Prior Authorization or Concurrent Review, which can be handled as either Standard or Expedited. The following are definitions for each of these:

Prior Authorization Request – is a review of a request by either yourself or by your provider on your behalf for coverage of a new service or change in service as determined in the plan of care for a new authorization period. These requests are made before you receive the requested services from us.

Concurrent Review Request - is a review of your or your health care provider's request 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 after you had an inpatient hospital admission.

Expedited and/or Standard Reviews - Most requests are handled using standard time frames unless the Care Management Team in conjunction with the Medical Director determine, or the provider indicates, that a delay would seriously jeopardize your life, health or ability to attain, maintain, or regain maximum function. You may request an expedited review of a Prior Authorization or Concurrent Review. The request for expedited review may be made either by phone or in writing, but, if you make the request by phone you do not have to follow it up with a written request. If the Care Management Team in conjunction with the Medical Director feel that a delay would not jeopardize your life, health or ability to attain, maintain, or regain maximum function, the request for an expedited review will be denied in writing. If we deny your expedited review request, we will send you a notice that we have denied it and that we will be treating

your request as a standard review. We will handle appeals of actions resulting from a Concurrent Review as expedited reviews.

There are specific time frames that CPHL must adhere to for reviewing your requests. Based on whether the request is a Prior Authorization or a Concurrent Review, these time frames are:

Prior authorization

- Expedited – 3 business days from your request for service.
- Standard – within 3 business days of receipt of all necessary information, but no more than 14 days of receipt of your request for services.

Concurrent review

We will make a determination and provide you with a notice of the determination by phone and in writing as fast as your condition requires and no more than:

- Expedited- 1 business day after receipt of necessary information, but no more than 3 business days after receipt of your request for services.
- Standard- 1 business day after receipt of necessary information, but no more than 14 days of receipt of your request for services.

Extensions

Extensions of expedited or standard time frames may be requested for up to 14 days by you or a provider on your behalf (written or verbal to the Care Management Team). CPHL may also initiate an extension if we can justify the need for additional information and if the extension is in your best interest. If we request an extension, we will notify you in writing and help you locate the information that we

are requesting by pointing you to the potential places where you can find this information.

You will be notified verbally and in writing regarding your request. CPHL will respond to your request for a change in service as per the above time frames. If your request is denied, you have the right to file an appeal. Either you or the provider who requested the expedited decision may appeal the decision. See Section 14, Resolving Member Problems and Complaints, for details.

6. Emergency Services

An emergency[2] is a sudden change in a medical condition or behavior that is so severe that if you do not get medical attention it would result in placing your health in serious jeopardy.

A medical emergency can include severe pain, an injury, or sudden illness.

When you have a medical emergency, you or your caregiver should call **911**. This is the best way for you to receive the care you need as quickly as possible.

You can contact our after-hours call line to speak to a care manager if you have urgent questions, or need guidance in health matters. Someone will be able to assist you 24 hours a day 7 days a week. If you need to reach us you can call:

1-833-274-5627
TTY/TDD: 1-800-421-1220

You are not required to obtain prior approval from CPHL to receive emergency services and/or emergency care. You are also not required to notify us in advance that you are seeking emergency care or services.

After you receive emergency care, we ask that you or your caregiver notify us as soon as possible. This will help us manage your care in the best way.

[2] *An emergency is a medical or behavioral condition, the onset of which is sudden and so severe that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing your health or another's in serious jeopardy.*

7. Care Received Outside the Centers Plan for Healthy Living Service Area

Planned Services

Before you leave the service area for an extended period, you must be sure to notify your Care Management Team. You can contact us 24 hours a day 7 days a week at:

1-833-274-5627
TTY/TDD: 1-800-421-1220

If you notify us before you leave, we will be better able to assist you in making care arrangements such as making sure you have sufficient medications before you leave.

If you have notified us that you are leaving the service area, you must return within 30 days in order for us to keep you as a member of CPHL. If you do not return by then, we will unfortunately have to begin the disenrollment process at the end of the thirty (30) day period.

8. Transitional and Specialty Care

If you are transferring from a traditional Medicaid community long term care plan to CPHL, we will continue to provide the same services that you have been receiving for a minimum of ninety (90) days. If your Doctor's order for services is about to expire and we are unable to get a new medical order, we will work with your health care provider to obtain the best possible care for you, including a higher level of care.

If our internal assessment leads to a restriction, reduction, suspension or termination of previously authorized services, we will provide you with a notice that outlines the appeals and fair hearing process, your rights during this process, and your rights to have authorized services continue when requesting a fair hearing.

If, before you enroll, you are being treated by a non-network provider for an ongoing course of treatment, we will pay the provider after you are enrolled for a period of up to ninety (90) days for any covered service that you receive as part of the treatment. However, in order for us to do this, the provider must agree to all of the following:

- Accept CPHL's payment rate as payment in full;
- Abide by CPHL's policies and procedures and;
- Provide CPHL's Care Management Team medical information about your plan of care.

If your network provider leaves our network while s/he is seeing you for an ongoing course of treatment, and s/he continues to treat you after s/he has left the network, we will continue to pay the provider for any covered service that you receive for a period of up to ninety (90) days. However, in order for us to do this, the provider must agree to all of the following:

- Accept CPHL's payment rate as payment in full;
- Abide by CPHL's policies and procedures, and;
- Provide CPHL's Care Management Team medical information about your plan of care.

As a CPHL member you may obtain a referral to a health care provider outside the network in the event CPHL does not have a provider with appropriate training or experience to meet your needs. In the event you require an out-of-network provider please contact your Care Management Team to assist you to obtain a referral.

9. Eligibility

You may be eligible to enroll in Centers Plan for Medicaid Advantage Plus if you are seeing or willing to see CPHL network doctors and are:

- At least 18 years old;
- Living in the Centers Plan for Medicaid Advantage Plus service area (Bronx, Kings, Nassau, New York, Queens, Richmond, or Rockland counties);
- Deemed eligible for full Medicaid by HRA/LDSS;
- Eligible for Medicare Parts A and B;
- Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety
- If new to long term care, you must be deemed eligible for nursing home level by York Medicaid Choice's 'Conflict Free Evaluation and Enrollment Center' (CFEEC) at the time of your enrollment;
- Must require long-term care services offered by CPHL for more than 120 days from the date of enrollment. You must require at least one of the following services:
    a. Private duty nursing services
    b. Therapies in the home (Occupational, Physical, or Speech)
    c. Home health aide services
    d. Personal care services in the home
    e. Adult day health care (medical model)
    f. Consumer Directed Personal Assistance Services

- In addition to meeting these criteria, you must also sign an Enrollment Agreement and agree to abide by the conditions of CPHL membership, as explained in this Member Handbook.

Conditions for Denial of Enrollment

You may be identified as ineligible for enrollment into Centers Plan Medicaid Advantage Plus for the following reasons:

- Live outside the CPHL service area;
- Younger than 18 years old;
- CFEEC determines that you are not eligible for long term care;
- Under most circumstances, if you have a diagnosis of End Stage Renal Disease;
- If it is determined that you are not able to return to or remain in your home and community without jeopardy to your health and safety;
- Ineligible for Medicare Parts A or B;
- Ineligible for full Medicaid
- Only eligible for the Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLIMB) or the Qualified Individual-1 (QI-1) and is not otherwise eligible for Medical Assistance;
- A resident of a State-operated psychiatric facility or a resident of State-certified or voluntary treatment facilities for children and youth;
- Have access to comprehensive private health care coverage other than Medicare;
- Enrolled in the Restricted Recipient Program;

- Admitted to a Hospice program prior to the time enrollment;
- A resident of a facility operated under the auspices of the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office for People with Developmental Disabilities (OPWDD).

At the point of an RN in-home assessment, you may be found ineligible for the following reasons:

- Unable or unwilling to provide all documentation needed to establish a safe plan of care;
- Unwilling to sign Application Form;
- CPHL's assessment disagrees with the CFEEC assessment, and New York Medicaid Choice (NYMC) upholds the CPHL determination.

If you do not agree with CPHL's denial of enrollment, you may request to pursue an application with NYMC. You can reach NYMC at 1-800-505-5678. The information collected by CPHL will be forwarded to NYMC and they will make the final decision about your eligibility.

10. Enrollment and Effective Dates of Coverage

Enrolling in Centers Plan for Medicaid Advantage Plus is voluntary. Applications for enrollment will be processed in the order received.

If you are new to long term care you will require a Conflict Free Evaluation and Enrollment Center (CFEEC) assessment as part of your application process.

If you meet the eligibility requirements as outlined in Section 9, CPHL will have an Intake Nurse come to your home and collect more information about you and your health care needs. This visit will take place within 30 days of your initial contact with CPHL. You may have a family member, or anyone else you wish, present when the Intake Nurse comes to your home. The Intake Nurse will describe the program to you, assess your health care needs and clinical eligibility. During the visit, the Intake Nurse will:

- Explain the benefits of the program and go over the Member Handbook with you
- Complete an initial assessment using the current NYS eligibility tool that determines your need for long-term care services
- Provide you with information regarding Advance Directives and the form to complete a Health Care Proxy,
- Discuss your health care and service needs with you, and
- Along with your doctor and through discussion with you and your caregivers, develop an initial care plan designed to meet your care needs.

If you qualify and wish to join Centers Plan for Medicaid Advantage Plus our Intake Nurse will ask you to sign an Application Form that includes a “Plan Enrollment Understanding and General Membership Rules and Responsibilities.”

Following the visit by CPHL's Intake Nurse you will be visited by a Medicare Licensed CPHL Marketing Representative who will complete the enrollment process.

Your enrollment is effective on the first day of the month following the month in which your enrollment application is processed by New York Medicaid Choice (NYMC) and accepted by CMS. CPHL will mail you a membership letter and a CPHL membership identification card. Within a few days of joining our program, your Care Management Team will contact you to review your satisfaction with the plan of care, and discuss any concerns you may have. Changes in your plan of care can be made as needed based on your care needs. Your Care Management Team will ask you, your physician and your family/caregivers for input regarding any changes to your plan of care. If your services have been changed you will receive a letter explaining the change.

Conflict Free Evaluation and Enrollment Center

For anyone seeking long-term care services for the first time, an assessment by a Conflict Free Evaluation and Enrollment Center (CFEEC) Registered Nurse (RN) is the first step towards enrollment. Only after a CFEEC RN has evaluated you and determined your eligibility, will a CPHL Intake Nurse then visit you in your home, complete an assessment and propose a safe plan of care. You can call CPHL Member Services at **1-833-274-5627** to begin the process of enrollment. You can also reach CFEEC directly at 1-855-222-8350.

Withdrawal of Enrollment

If after you have submitted your application to enroll with Centers Plan for Medicaid Advantage Plus you change your mind and decide that you don't want to enroll, you may withdraw your application. If you inform us after the 20th of the month that you don't want to be enrolled, it may be too late to stop your enrollment and you may be enrolled in the plan for the upcoming month. CPHL will send you a letter to confirm your withdrawal or disenrollment.

11. Disenrollment and Termination of Benefits

Enrollees shall not be disenrolled from the Medicaid Advantage Plus Product based on any of the following reasons: High utilization of covered medical services, an existing condition or a change in the Enrollee's health, diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs unless the behavior results in the Enrollee becoming ineligible for Medicaid Advantage Plus.

Voluntary Disenrollment

You can choose to voluntary disenroll. You can ask to leave the Centers Plan for Medicaid Advantage Plus at any time for any reason. To request disenrollment, call Centers Plan for Medicaid Advantage Plus Care Management at 1-833-274-5627. It could take up to six weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require Community Based Long Term Care (CBLTC) services, like personal care, you must join another MLTC plan or Home and Community Based Waiver program, in order to receive CBLTC services.

You can request disenrollment at any time. To begin disenrollment from the program, you or your designee must make an oral or written request. You can make the request to any member of your Care Management Team and they will help you with the process. You will receive written acknowledgement of receipt of request for disenrollment as well as a disenrollment form. Disenrollment is effective on the last day of the month in which your disenrollment is confirmed by NYMC and CMS. Written confirmation of disenrollment will be mailed to you after disenrollment becomes effective.

Please note that if you are enrolled in Centers Plan for Medicaid Advantage Plus and you apply to receive services from another managed care plan contracted with Medicaid, a Home and Community Based Services waiver program, or an Office for People with Developmental Disability Day Treatment or a Comprehensive Medicaid Case Management (CMCM), you are considered to have requested disenrollment from CPHL.

Involuntary Disenrollment

There are certain circumstances under which CPHL will disenroll you, even though this is not what you wish (this is called an involuntary disenrollment). Prior to taking this step, we will make every effort to resolve the issues/concerns. You will receive a written notice of our decision to initiate involuntary disenrollment. Once your disenrollment is approved by NYMC, Human Resources Administration or the Local Department of Social Services, they will send you a notice of your right to a fair hearing. CPHL will send you written confirmation of disenrollment.

You Will Have to Leave Centers Plan for Medicaid Advantage Plus if:

- You are no longer enrolled in Centers Plan for Medicaid Advantage Plus for your Medicare coverage;
- You no longer are Medicaid eligible;
- You need nursing home care, but are not eligible for institutional Medicaid;
- You are incarcerated (go to prison);
- During 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 Centers Plan for Medicaid Advantage Plus if:

- You or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs CPHL's ability to furnish services.
- You knowingly provide fraudulent information on an enrollment form or you permit abuse of an enrollment card in the MAP Program.
- You fail to complete and submit any necessary consent or release.
- You fail to pay or make arrangements to pay the amount money, as determined by the Local District of Social Services, owed to the plan as spenddown/surplus within 30 days after amount first becomes due. (See Section 13 below)

Before being involuntarily disenrolled, CPHL will obtain the approval of NYMC or an 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.

Termination of Enrollment for Other Reasons

Your enrollment in Centers Plan for Medicaid Advantage Plus will be ended if CPHL loses its contract with New York State Department of Health, which allows CPHL to offer health care services. CPHL has a contract with New York State Department of Health that is subject to renewal on a periodic basis. Failure of CPHL to maintain this contract will result in termination of enrollment in the program.

Effective Date of Disenrollment and Coordination of Transfer to Other Service Providers

Your disenrollment will become effective on the first day of the month after it is processed and confirmed by NYMC and CMS. Until your disenrollment becomes effective, Centers Plan for Medicaid Advantage Plus will continue to provide covered services according to your plan of care. During that time, if you wish, your Care Management Team will help you identify other service providers who can meet your care needs. CPHL will assist you in contacting these providers and will coordinate the transfer of your care to them.

12. Re-Enrollment Provisions

If you voluntarily disenroll (you independently choose to leave Centers Plan for Medicaid Advantage Plus), you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled, you will be allowed to re-enroll in the program if the circumstances that were the basis for disenrollment have been resolved.

13. Monthly Surplus/Spend-Down

A Surplus, also referred to as Spend-Down, is the amount of money the Local Department of Social Services (LDSS), the NYC Human Resources Administration (HRA) or the entity designated by the Department of Health determine an individual is required to pay on a monthly basis to continue to meet Medicaid financial eligibility requirements and maintain Medicaid coverage. If the Human Resource Administration (HRA), Local Department of Social Services (LDSS), or the state designated entity determine that you owe a monthly surplus obligation, CPHL is required to bill you for these surplus charges. If the amount of the spend-down changes, CPHL will adjust the amount due accordingly. If you have any questions regarding these payments, please contact your Care Management Team.

If you are eligible for:	**You will owe:**
Medicaid (no monthly spend down)	Nothing to CPHL
Medicaid (with monthly spend down)	A monthly spend-down premium to CPHL as determined by HRA or LDSS

CPHL will notify you in writing of the monthly amount that you must pay as part of your spend-down responsibility. CPHL will send you an invoice by the 15th day of each month.

14. Resolving Member Problems and Complaints

We understand that there may be times when you are not satisfied with our services, or when you are not satisfied with one of our Network Providers. If you have a concern or complaint, we want to hear about it. You may make a complaint, or voice a concern, to any member of your Care Management Team, any CPHL staff member, or a Network Provider.

CPHL 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 CPHL 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.

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

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page 60 for more information on the External Appeals process.

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

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

When you ask for approval of a treatment or service, it is called a **service authorization request (also known as a coverage decision request)**. To get a service authorization request, you or your provider must call our toll-free Member Services number at 1-833-274-5627 or send your request in writing to 75 Vanderbilt Avenue, Staten Island, NY 10304.

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

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from Centers Plan for Medicaid Advantage Plus (HMO D-SNP) 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:

- Nursing Home Care
- Inpatient mental health care
- Podiatry, including routine foot care
- Optometry (includes eyeglasses)
- Audiology
- Hearing Aids and batteries
- Dental Care
- Medical equipment

- Medical Supplies
- Enteral and Parenteral Nutritional Supplements
- Personal Emergency Response Units
- Social and environmental supports
- Dietary Counseling
- Home Health Care
- Nursing
- Personal Care
- Outpatient Rehabilitation, including:
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
- Home Delivered meals
- Adult Day Health Care
- Social Day Care
- Telehealth
- CDPAS - Consumer Directed Personal Assistance Services

Concurrent Review

You can also ask Centers Plan for Medicaid Advantage Plus 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.

<u>What happens after we get your service authorization request</u>

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 work days of when we have all the information we need, but no later than **14 calendar days** after we get your request. If your case is a **concurrent review** where you

are asking for a change to a service you are already getting, we will make a decision within 1 work day of when we have all the information we need, but will give you an answer no later than 14 calendar days after we get your request.

- **We can take up to 14 more calendar days** if you ask for more time or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If you believe we should **not** take extra days, you can file a **"fast complaint."** When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan.)

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

- **If our answer is yes to part or all of what you asked for**, we will authorize the service or give you the item that you asked for.
- **If our answer is no to part or all of what you asked for,** we will send you a written notice that explains why we said no. Section 2: Level 1 Appeals (also known as Level 1) later in this chapter tells how to make an appeal.

Fast Track Process

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

- A fast review of a prior authorization request means we will give you an answer within 1 work 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 make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If you believe we should not take extra days, **you can file a "fast complaint"** (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.) We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 2: Level 1 Appeals, below for how to make an appeal.

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

1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a fast service authorization if your request is about payment for medical care you already got.)

2. Using the standard deadlines could cause serious harm to your life or health, or hurt your ability to function.

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

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

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

- This letter will tell you that if your provider asks for the fast service authorization, we will automatically give a fast service authorization.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan later in this chapter.
- **If our answer is yes to part or all of what you asked for,** we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service authorization on your request for a medical item or service, we will give you our answer by the end of that extended period.

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

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

If we are changing a service you are already getting

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

You may also have special **Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF)** services is ending. For more information about these rights, refer to Chapter 9 of the Centers Plan for Medicaid Advantage Plus (HMO D-SNP) Evidence of Coverage.

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

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

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).
- Centers Plan for Medicaid Advantage Plus can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at 1-833-274-5627 to get more information on your rights and the options available to you.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

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

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

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

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

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

Steps to file a Level 1 Appeal:

- If you are not satisfied with our decision, you have **60 days** from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for asking for an appeal.
- If you are appealing a decision we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a **"fast appeal."**
    - The requirements and procedures for getting a "fast appeal" are the same as for getting a "fast track service authorization." To ask for a fast appeal, follow the instructions for asking for a fast track service authorization. (These instructions are given in Section 1, in the Fast Track Process section.)

- If your provider tells us that your health requires a "fast appeal," we will give you a fast appeal.
- If your case was a **concurrent review** where we were reviewing a service you are already getting, you will automatically get a fast appeal.

- You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you. You can call Member Services at 1-833-274-5627 if you need help filing a Level 1 Appeal.
  - Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an "Appointment of Representative" form, or write and sign a letter naming your representative.
    - To get an "Appointment of Representative" form, call Member Services and ask for the form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at: https://centershealthcare.com/centersplan/plans/mapd-plan/appeals-and-grievances. 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 taking action.
- If you disagree with the action, you can file a Level 1 Appeal.
- We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.
- **Note:** If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative.

What happens after we get your Level 1 Appeal

- Within 15 days, we will send you a letter to let you know we are working on your Level 1 Appeal. We will let you know if we need additional information to make our decision.
- We will send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records we will use to make the appeal decision. If your Level 1 Appeal is fast tracked, there may be a short time to review this information.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You can also provide information to be used in making the decision in person or in writing. Call us at 1-833-274-5627 if you are not sure what information to give us.
- We will give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you asked for, we will send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we will **automatically** send your case on to the next level of the appeals process.

Timeframes for a "standard" appeal

- If we are using the standard appeal timeframes, we must give you our answer on a request **within 30 calendar days** after we get your appeal if your appeal is about coverage for services you have not gotten yet.

- We will give you our decision sooner if your health condition requires us to.
- However, if you ask for more time or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide we need to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
    - If you believe we should **not** take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
    - For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.
- If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process.
    - An independent outside organization will review it.
    - We talk about this review organization and explain what happens at Level 2 of the appeals process in Section 3: Level 2 Appeals.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision.

- **If our answer is no to part or all of what you asked for**, to make sure we followed all the rules when we said no to your appeal, **we are required to send your appeal to the next level of appeal.** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Timeframes for a "fast" appeal

- When we are using the fast timeframes, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to do so.
- If you ask for more time or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If we do not give you an answer within 72 hours (or by the end of the extra days we took), we are required to automatically send your request on to Level 2 of the appeals process which is discussed below in Section 3: Level 2 Appeals.

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

If our answer is no to part or all of what you asked for, we will automatically send your appeal to an independent review organization for a Level 2 Appeal. You or someone you trust can also file a complaint

with the plan if you don't agree with our decision to take more time to review your action appeal.

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

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 3: Level 2 Appeals

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

If we say **No** to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Hearing Office** reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- **The Hearing Office is an independent New York State agency**. It is not connected with us. Medicare and Medicaid oversee its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a free copy of your case file**.

- You have a right to give the Hearing Office additional information to support your appeal.
- Reviewers at the Hearing Office will take a careful look at all of the information related to your appeal. The Hearing Office will contact you to schedule a hearing.
- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed by waiting for a decision under a standard timeframe, you will automatically get a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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

- If you had a standard appeal to our plan at Level 1, you will automatically get a standard appeal at Level 2.
- The review organization must give you an answer to your Level 2 Appeal **within 90 calendar days** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 55 for information about continuing your benefits during Level 1 Appeals.

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

- If the Hearing Office says **yes** to part or all your request, we must authorize the service or give you the item **within one business day of when we get the Hearing Office's decision**.
- If the Hearing Office says **no** to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")

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

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

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 4: External Appeals for Medicaid Only

You or your doctor can ask for an External Appeal for **Medicaid covered benefits only**.

You can ask New York State for an independent **external appeal** if our plan decides to deny coverage for a medical service you and your doctor asked for because it is:

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

This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

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

- You can prove the plan did not follow the rules correctly when processing your Level 1 appeal.

You have **4 months** after you get the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services.

- You can call Member Services at 1-833-274-5627 if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882.
- Go to the Department of Financial Services' website at www.dfs.ny.gov.
- Contact the health plan at 1-833-274-5627.

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

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

right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

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

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

We hope our plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Member Services at 1-833-274-5627 or write to Member Services. **The formal name for "making a complaint" is "filing a grievance."**

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

How to File a Complaint:

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. To contact Member Services, call 1-833-274-5627 from 8 AM to 8 PM, 7 days a week. For TTY/TDD please call 1-800-421-1220.
- If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- 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. In some cases, CPHL will inform you that you have the option to pursue either the Medicaid compliant process outlined here or the Medicare process outlined in Chapter 9 of your Centers Plan for Medicaid Advantage Plus (HMO D-SNP) Medicare Evidence of Coverage. We will review your complaint and give you a written answer within either the fast or standard timeframes outlined below.
- **Whether you call or write, you should contact Member Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

What happens next:

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

- If you asked us to give you a “fast service authorization” or a “fast appeal” and we said we will not.
- If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made.
- When a service authorization we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines.
- When we do not give you a decision on time and we do not forward your case to the Hearing Office by the required deadline.

- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Complaint Appeals

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

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;
- You must make the complaint appeal in writing.
  - If you make an appeal by phone, you must follow it up in writing.

- After your call, we will send you a form that summarizes your phone appeal.
- If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

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

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

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

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

We will let you know our decision within 30 work days from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the appeal. We will give you the reasons for our decision and our clinical rationale, if it applies.

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

15. Your Rights and Responsibilities as a CPHL Member

Cultural and Linguistic Competency

Centers Plan for Medicaid Advantage Plus 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

Centers Plan for Medicaid Advantage Plus 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

1. You have the Right to receive medically necessary care.
2. You have the Right to timely access to care and services.
3. You have the Right to privacy about your medical record and when you get treatment.
4. You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.

5. You have the Right to get information in a language you understand; you can get oral translation services free of charge.
6. You have the Right to get information necessary to give informed consent before the start of treatment.
7. You have the Right to be treated with respect and dignity.
8. You have the Right to get a copy of your medical records and ask that the records be amended or corrected.
9. You have the Right to take part in decisions about your health care, including the right to refuse treatment.
10. You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
11. You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
12. 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.
13. 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.
14. You have the Right to appoint someone to speak for you about your care and treatment.
15. You have the Right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

1. Receiving covered services through Centers Plan for Medicaid Advantage Plus;
2. Using Centers Plan for Medicaid Advantage Plus network providers for covered services to the extent network providers are available;
3. Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies; Being seen by your physician, if a change in your health status occurs;
4. Sharing complete and accurate health information with your health care providers;
5. Informing Centers Plan for Medicaid Advantage Plus staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions;
6. Following the plan of care recommended by Centers Plan for Medicaid Advantage Plus staff (with your input);
7. Cooperating with and being respectful to the Centers Plan for Medicaid Advantage Plus staff and not discriminating against Centers Plan for Medicaid Advantage Plus staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status;
8. Notifying Centers Plan for Medicaid Advantage Plus within two business days of receiving non-covered or non-pre-approved services;
9. Notifying your Centers Plan for Medicaid Advantage Plus health care team in advance whenever you will not be home to receive services or care that has been arranged for you;
10. Informing Centers Plan for Medicaid Advantage Plus before permanently moving out of the service area, or of any lengthy absence from the service area;

11. Your actions if you refuse treatment or do not follow the instructions of your caregiver;
12. Meeting your financial obligations.

If you have an urgent concern, CPHL staff is available to help you 24 hours a day, 7 days a week, 365 days a year. Please contact us at **1-833-274-5627.** TTY/TDD users please call: **1-800-421-1220**.

Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf. Below is additional information on the three types of Advance Directives.

Health Care Proxy

This document lets you appoint a health care agent, which is someone you trust to make health care decisions for you if you are unable to make decisions for yourself.

Living Will

A written declaration of your health care wishes that includes instructions about medical treatments you may or may not want. It serves as a guide to be followed when you are no longer able to make these decisions for yourself.

Do Not Resuscitate (DNR) Order

A document that instructs health care providers not to perform cardiopulmonary resuscitation (CPR) or lifesaving emergency procedures if your heartbeat or breathing stops.

It is your right to make Advance Directives as you wish. The CPHL enrollment packet contains a Health Care Proxy with complete instructions for proper completion.

Completing one or more of these Advance Directives could be the best way to ensure that your health care wishes are known when you are unable to make and express your healthcare decisions. These documents will guide doctors and other health care professionals involved in your care if you are terminally ill, seriously injured, are suffering from late stages of dementia, or otherwise unable to communicate your wishes about your medical care.

During the Intake Nurse's visit described in Section 10 of this Handbook, your Intake Nurse will give you information about Advance Directives and provide you with the actual documents. If you have questions about Advance Directives at any point during your enrollment with CPHL, your Care Manager could answer these questions and help you select the Advance Directive that best meets your needs and wishes. You can change your mind about Advance Directives at any time. If you would like to stop using an Advance Directive during your enrollment period, your Care Manager will be able to assist you. Your Care Manager or primary care physician could provide you with more information regarding Advance Directives.

Notice of Information Available on Request

The following information is available upon request by the member:

- Information regarding the structure and operation of Centers Plan for Medicaid Advantage Plus;
- Specific clinical review criteria relating to a particular health condition and other information that CPHL MAP 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 CPHL MAP certified financial statement; and policies and procedures used by Centers Plan for Medicaid Advantage Plus to determine eligibility of a provider to participate in the CPHL MAP provider network.

Fraud Waste and Abuse

It is everyone's responsibility to help in the fight against Fraud, Waste and Abuse. If you suspect a provider, member or CPHL staff person(s) is engaged in fraud, waste, abuse or any other questionable activity, report it by calling 1-855-699-5046 or by visiting www.centersplan.ethicspoint.com. Both modes support anonymous reporting.

16. Protection of Member Confidentiality

It is the policy of CPHL to protect the confidential information of you and your family. To protect this confidentiality:

- All information in your medical record is confidential. Staff protects against accidental release of information by safeguarding records and reports from unauthorized use.
- Only necessary information will be released to community agencies, hospitals, and long-term care facilities to ensure the continuity of your care. Information will be copied or shared with these agencies only if you or your designee have signed a release to authorize CPHL to provide medical, nursing and psychosocial information to that facility.
- CPHL will permit only legally authorized representatives of CPHL to inspect and request copies of your medical record and other records of the covered services provided to you according to the written consent which you will have been asked to execute authorizing CPHL to release such information.
- CPHL will follow all federal and New York State laws regarding confidentiality, including those that relate to HIV testing results.
- CPHL will maintain all records relating to you for a period of no less than seven (7) years after your disenrollment, in accordance with applicable state and federal law regulations and CPHL's policy and procedures. CPHL's medical and financial records are, and will remain, the property of CPHL.
- Any requests for information regarding your care received from law enforcement agencies, such as the police or district attorney's office, will be brought to the attention of the President and/or the Chief Executive Officer of CPHL prior to providing any information to ensure that the proper authorization is obtained.

17. Quality Assurance and Improvement Program

CPHL has a Quality Management System to systematically monitor and evaluate the quality and appropriateness of care and service. This comprehensive Quality Management System must meet the New York State health and long-term care quality assurance standards.

Our Quality Management System identifies opportunities for improving:

- The quality of service provided;
- The management of care including availability, access and continuity;
- Operational and Care Management practices;
- The outcomes in clinical, non-clinical and functional areas.

The Quality Management System includes a plan to look for areas where improvement is needed, a process for the continuous improvement of performance, a review of the credentials of all providers providing care or service, maintenance of health information records and review of service utilization.

We welcome your suggestions and input regarding quality improvement.

CENTERS PLAN
FOR HEALTHY
LIVING

CPHL Member Services
7 Days a week, 8:00 AM - 8:00 PM
Tel: 1-833-274-5627
TTY users call 711
E-mail: Memberservices@centersplan.com
www.centersplan.com/map