Member Handbook

CENTERS PLAN FOR HEALTHY LIVING
MANAGED LONG TERM CARE (MLTC) PLAN

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
1-855-270-1600 (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:

1-855-270-1600 (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 MLTC 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 1-855-270-1600 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 1-855-270-1600 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

1-855-270-1600 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 this Member Handbook

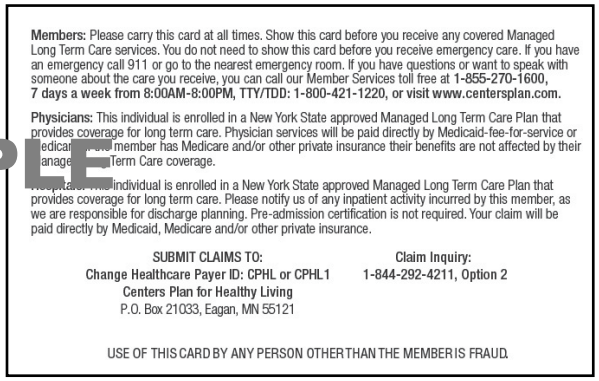
The Member Handbook is given to you during our assessment to help you learn about the program. It is designed to help you understand Centers Plan for Healthy Living's (CPHL's) Managed Long-Term Care (MLTC) plan. Please read it carefully and refer to it when you need information about how the plan works including:

- Which services are covered by CPHL and how to receive them
- What to do in an emergency
- What to do if you are unhappy with services or decisions about your health care benefits

If you decide to enroll in CPHL, this handbook becomes your guide to services. This handbook, along with the enrollment agreement/attestation, is your contract with CPHL. You will receive the Member Handbook and Participating Provider Directory prior to enrollment and whenever significant changes are made. Additionally, 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 1-855-270-1600.

Membership Card

Your CPHL Member Identification card (ID card), which will be provided shortly after enrollment, will let providers know that you are enrolled in the CPHL Managed Long Term Care Plan (MLTCP). 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 in a place that you know you can find it.
- 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.

Table of Contents

1. Welcome to Centers Plan for Healthy Living

Centers Plan for Healthy Living (CPHL) is pleased to introduce you to our Managed Long Term Care Plan (MLTCP). 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 1-855-270-1600. 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 (this may include coordination of your Medicare services when applicable). CPHL does this by providing a comprehensive long-term care benefit package of covered services, and by coordinating the Medicaid services that you need but are not covered by CPHL. 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:

1-855-270-1600 (toll free)
TTY/TDD: 1-800-421-1220

2. Special Features of Centers Plan for Healthy Living

CPHL is a managed long term care (MLTC) plan that helps people 21 years and older in need of long term care 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 CPHL, you will be participating in a New York State MLTC plan. Managed long term care provides the health and long-term care services you need. If you choose CPHL, 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 the CPHL MLTC program:

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 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 help arrange your medical appointments and transportation to and from these appointments. Your Care Management Team could also communicate with providers regarding all services covered by CPHL and even some services that CPHL does not cover.

When needed, your Care Management Team might 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 DentaQuest at 1-844-824-2023. For optometry call VSP at 1-800-877-7195.

C. **Where You Will Receive Services:** Most of your covered health care services are provided in your home. Other services are available in the community through our contracted adult day centers and other contracted providers. You can also access services in a medical office for dental, podiatry, audiology or optometry services. If needed, you may receive inpatient nursing home services from providers in our contracted network.

D. **Primary Care Doctors and Other Non-CPHL Covered Service Providers**: You can choose your own doctor and change your doctor at any time. Your doctor continues to be covered by Medicare or Medicaid on a fee-for-service basis. Your doctor must agree to write orders for covered services that allow you to receive care from the CPHL network of providers and participate in the development of your plan of care. If you do not have a doctor, your Care Management team can help you find a doctor.

   If you need our assistance in finding or changing your doctor, contact a member of your Care Management Team at the telephone number listed in this Member Handbook and on your Member ID card.

   Your Care Management Team will help you identify providers of non-covered services if you do not already have a provider. See the end of Section 4 for a listing of Non-CPHL Covered Services that are covered by Medicare or Medicaid on a fee-for-service basis.

E. 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.

F. 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 Healthy Living

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]

The following benefits are fully covered when specified in your service plan. **CPHL 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 MLTC plan-covered services as well as non-covered services.
• Nursing Home Care	• 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.

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

Covered Services	Definition
• Respiratory Therapy	• The provision of preventive, maintenance and rehabilitative airway-related techniques and procedures including oxygen and other inhalation therapies prescribed by a physician and provided by a qualified company/respiratory therapist.
• 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.

Covered Services	Definition
• 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.
• 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.

Covered Services	Definition
• 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.
• 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	• Rehabilitative health that uses specially designed exercises and equipment to help patients regain or improve their physical abilities.
• Occupational Therapy	• Rehabilitative health that uses specially designed exercises and equipment to help patients regain or improve their abilities to perform activities of daily living.
• Speech Therapy	• Rehabilitation services for the restoration of the patient to his or her functional level in speech or language. CPHL has removed service limits on physical therapy (PT), occupational therapy (OT), and speech therapy (ST). Instead, CPHL will cover medically necessary PT, OT, and 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.

Non-Covered Services:

The following services are not covered by CPHL but are covered by Medicare or Medicaid on a fee-for-service basis:

- In-patient Hospital Services
- Out-Patient Hospital Services
- Laboratory /Radiology Services
- Prescription and non-prescription drugs
- Physician Services
- Psychiatry and Mental Health Services
- Alcohol and Substance Abuse Services
- Chronic Renal Dialysis
- Emergency transportation
- Family Planning Services
- Office for People with Developmental Disabilities (OPWDD) services

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 may no longer be 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, and you will continue to be a member of the plan.

When nursing home care is required, placement and care will be provided in a network facility. The CPHL 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 Managed Long Term Care Plan (MLTC) 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. The PCSP includes such services as education about the consumer directed personal assistance services and coordination of any hospice care that you may receive while you are a CPHL member.

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 once a year. Your PCSP will be updated at that time. 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 at the time of the assessment.

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 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 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. 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:

1-855-270-1600
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.

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[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:

1-855-270-1600
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 CPHL if you are:

- At least 21 years old;
- Living in CPHL's service areas (Bronx, Erie, Kings, Nassau, New York, Niagara, Queens, Richmond, Rockland, Suffolk or Westchester counties);
- Deemed eligible for Medicaid by the Human Resources Administration (HRA) or Local Department of Social Services (LDSS);
- Seeing a Primary Care Physician (PCP) or are willing to choose a PCP who is willing to work with CPHL;
- 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

- If you are enrolled in another managed care plan, a Home and Community Based Service Waiver Program, an Office for People with Developmental Disabilities (OPWDD) Day Treatment Program or are receiving services from a hospice program and not already a member of a MLTC plan, you may be enrolled in CPHL only upon termination from these plans or programs.
- In addition to meeting these criteria, you must also sign an Enrollment Agreement and agree to abide by the conditions of CPHL, as explained in this Member Handbook.

  Enrollment is subject to the approval of New York Medicaid Choice (NYMC).

Conditions for Denial of Enrollment

You will be denied enrollment if any of the following conditions apply:

- If you are unable or unwilling to provide/give us documentation needed to establish a safe plan of care.
- You were previously a member of CPHL and do not meet our requirements for re-enrollment. See Section 12, Re-enrollment Provisions.

If you are denied enrollment for any reason, NYMC will send you a notice advising you of your right to a fair hearing.

10. Enrollment and Effective Dates of Coverage

Enrolling in CPHL is voluntary. If you are interested in joining CPHL, you or your representative can call CPHL's Member Services department to find out more about our program.

If you meet the eligibility requirements as outlined in Section 9, we will follow the assessment process outlined in "**New York Independent Assessor - Initial Assessment Process"** below.

New York Independent Assessor Program - Initial Assessment Process

On May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) became the New York Independent Assessor Program (NYIAP). The NYIAP now manages the initial assessment process. The initial assessment process includes completing the:

- *Community Health Assessment (CHA)*: The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a Managed Long Term Care plan.
- *Clinical appointment and Practitioner Order (PO)*: The PO documents your clinical appointment and indicates that you:
    - have a need for help with daily activities, and
    - that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIAP will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIAP will complete a clinical appointment and PO a few days later.

CPHL will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/or CDPAS

for more than 12 hours per day on average, a separate review by the NYIAP Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care and any other medical documentation. If more information is needed, someone on the panel may examine you or discuss your needs with you. The IRP will make a recommendation to CPHL about whether the plan of care meets your needs.

Intake Process

If, based on the NYIAP assessment, you qualify to join CPHL and wish to continue with the enrollment, our Intake Nurse will ask you to sign an Application Form that includes a "Plan Enrollment Understanding and General Membership Rules and Responsibilities." By signing the application, you agree to the terms in it and to participate in CPHL according to the terms and conditions described in this Member Handbook and the enrollment agreement/attestation.

Our Intake Nurse will ask you to sign a consent form that allows your health care providers to release your medical information to us.

Along with your doctor and through discussion with you and your caregivers, the Intake Nurse will develop an initial care plan designed to meet your care needs.

During the time prior to your enrollment, the Intake Nurse will maintain contact with you to answer any of your questions, discuss your plan of care, and help you with any service needs prior to your enrollment date.

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). 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.

Withdrawal of Enrollment

If after you have submitted your application to enroll with CPHL 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 with CPHL for one month. You will be disenrolled after one month. CPHL will send you a letter to confirm your withdrawal or disenrollment.

Transfers

If you want to transfer to another MLTC Medicaid Plan

You can try us for 90 days. You may leave Centers Plan for Healthy Living (CPHL) Medicaid Managed Long Term Care Plan (MLTCP) and join another health plan at any time during that time. If you do not leave in the first 90 days, you must stay in Centers Plan for Healthy Living for nine more months, unless you have a good reason (good cause). Some examples of Good Cause include:

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving Centers Plan for Healthy Living is best for you.
- Your current home care provider does not work with our plan

- We have not been able to provide services to you as we are required to under our contract with the State

If you qualify, you can change to another type of managed long term care plan like Medicaid Advantage Plus (MAP) or Programs of All-Inclusive Care for the Elderly (PACE) at any time without good cause.

To change plans: Call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. Centers Plan for Healthy Living will provide the care you need until then.

Call New York Medicaid Choice if you need to ask for faster action because the time it takes to transfer plans will be harmful to your health. You can also ask them for faster action if you have told New York Medicaid Choice that you did not agree to enroll in Centers Plan for Healthy Living.

11. Disenrollment and Termination of Benefits

Voluntary Disenrollment

To begin disenrollment from our plan, you or your designee must make an oral or written request. **(Please see "Transfers" section of Chapter 10 for more information regarding transferring to a different Managed Long Term Care Medicaid Plan).** 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. Written confirmation of disenrollment will be mailed to you after disenrollment becomes effective.

Please note that if you are enrolled in CPHL and you apply to receive services from another Managed Long Term Care Plan contracted with Medicaid, a Home and Community Based Services waiver program, or an Office for People with Developmental Disability Day Treatment, 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.

CPHL **must** disenroll you if:

- You move out of the service area;
- You leave our service area for any reason for more than thirty (30) days;
- You are no longer eligible to receive Medicaid benefits;
- You have been assessed as no longer requiring community-based long term care services;
- You are not receiving at least one of the following services:
    - Nursing services
    - Rehabilitation therapies in the home
    - Home health aide services
    - Personal care services in the home
    - Adult day health care (medical model)
    - Private duty nursing
    - Consumer Directed Personal Assistance Services (CDPAS)
- You are hospitalized or enter an Office of Mental Health, Office for People with Developmental Disabilities or Office of Alcohol Substance Abuse Services residential program for 45 days or longer;
- You are incarcerated. The effective date of disenrollment shall be the first day of the month following incarceration;
- Your only community-based long term care service is provided by a Social Day Care program.

CPHL **may** disenroll you if:

- You or a family member engages in behavior that seriously impairs CPHL's ability to furnish services for reasons other than those resulting from your particular needs;
- You fail to pay your Medicaid spend down fee within 30 days after it is due;
- You knowingly fail to complete and submit any necessary consent or release forms;
- You provide false information or otherwise engage in fraudulent conduct.

Termination of Enrollment for Other Reasons

Your enrollment in CPHL 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 last day of the month after it is processed by NYMC. Until your disenrollment becomes effective, CPHL 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 CPHL), 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 grievance 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 grievance or an appeal. We will maintain your privacy. We will give you any help you may need to file a grievance or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a grievance or to appeal a plan action, please call:

1-855-270-1600 TTY/TDD Users 1-800-421-1220

or write to:

Centers Plan for Healthy Living
Attention: Grievances and Appeals Department
75 Vanderbilt Ave. Suite 700
Staten Island, NY 10304

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Grievance?

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

The Grievance Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information
2. For all other types of grievances, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your best interest.

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

How do I Appeal a Grievance Decision?

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

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

What is an Action?

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

Timing of Notice of Action

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

Contents of the Notice of Action

Any notice we send to you about an action will:

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

The notice will also tell you about your right to a NY State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing;
- It will say that that you do not have to file an appeal before asking for a Fair Hearing;
- It will explain how to ask for a Fair Hearing; and
- If we are reducing, suspending, or terminating an authorized service and you want your services to continue while your appeal is decided, you must ask for a Fair Hearing within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?

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

How do I Contact my Plan to file an Appeal?

We can be reached by calling:

1-855-270-1600; **TTY/TDD Users 1-800-421-1220**

or writing to:

Centers Plan for Healthy Living
Attention: Grievances and Appeals Department
75 Vanderbilt Ave. Suite 700
Staten Island, NY 10304

You can also email us at: GandA@Centersplan.com

Or you may send us a fax to: 1-347-505-7089

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send you a letter telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

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

how to ask for a Fair Hearing, and to ask for aid to continue, see the Fair Hearing Section below.

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

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

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

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

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

Expedited Appeal Process

If you or your provider feel that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your best interest.)

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

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

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

Note: You must request a Fair Hearing within 60 calendar days after the date on the Initial Determination Notice. This deadline applies even if you are waiting for us to make a decision on your Internal Appeal.

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

If CPHL makes a restriction, reduction, suspension or termination of authorized CDPAS (including CDPAS itself) or denial of a request to change a personal assistant, it is considered an adverse determination. You are entitled to fair hearing or external appeal upon our final adverse determination.

State Fair Hearings

You may also request a Fair Hearing from New York State. The Fair Hearing decision can overrule our original decision, whether or not you asked us for an appeal. You must request a Fair Hearing within 60 calendar days of the date we sent you the notice about our original decision. You can pursue a Plan appeal and a Fair Hearing at the same time, or you can wait until the Plan decides your appeal and then ask for a Fair Hearing. In either case, the same 60 calendar day deadline applies.

The State Fair Hearing process is the only process that allows your services to continue while you are waiting for your case to be decided. If we send you a notice about restricting, reducing, suspending, or terminating services you are authorized to receive, and you want your services to continue, you must request a Fair Hearing. Filing an internal or external appeal will not guarantee that your services will continue.

To make sure that your services continue pending the appeal, generally you must request the Fair Hearing AND make it clear that you want your services to continue. Some forms may automatically do this for you, but not all of them, so please read the form carefully. In all cases, you must make your request within 10 days of the date on the notice, or by the intended effective date of our action (whichever is later).

CPHL will not restrict your right to a fair hearing or influence your decision to pursue a fair hearing. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

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

- Online Request Form: https://errswebnet.otda.ny.gov/errswebnet/erequestform.aspx

- Mail a Printable Request Form:
  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023
- Fax a Printable Request Form: (518) 473-6735
- Request by Telephone:
  Standard Fair Hearing line – 1 (800) 342-3334
  Emergency Fair Hearing line – 1 (800) 205-0110
  TTY line – 711 (request that the operator call 1 (877) 502-6155)

Request in Person:

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

Albany: 40 North Pearl Street, 15th Floor; Albany, NY 12243

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

State External Appeals

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

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal

along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

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

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

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

Contacting the New York State Department of Health

Remember, if at any time you are dissatisfied with how CPHL has treated you, or how we have handled your complaint, you can contact the New York State Department of Health by writing to:

New York State Department of Health
Bureau of Managed Long Term Care
One Commerce Plaza
Room # 1621
Albany, New York 12210
1-866-712-7197

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice regarding any questions or concerns you may have from pre-enrollment through appeals and fair hearings. ICAN staff could help you better understand your grievance, appeal, and fair hearing rights and assist you throughout the various stages of the appeals process. You could contact ICAN directly to learn more about their services:

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

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

Electronic Noticing

CPHL and our vendors can send you notices about service authorizations, plan appeals, complaints and complaint appeals electronically, instead of by phone or mail.

We can send these notices to you via a web portal. If you want to get these notices electronically, you can choose whether to be notified by email or text when a new notice has been placed on the web portal.

The email notification option will send you an email that will include a link to direct you to the portal, where you can log in and see your notice(s). To use this option, you will need access to your email and a web browser with access to the internet.

The text message notification option will send you a text message with a link to direct you to the portal, where you can log in and see your notice(s). To use this option, you will need a smartphone with the ability to access the internet. Please note that standard text messaging and data rates may apply.

The link that is provided in the email or text will bring you to a web portal that will require you to enter a user name and password

If you want to get these notices electronically, you must ask us. To ask for electronic notices contact us by phone, [email], [online,] [fax,] or mail:

Phone…… 1-844-274-5227
Email…… memberportal@centersplan.com
Online…… CPHLmemberportal.centersplan.com
Fax…… 1-917-661-8121
Mail…… 75 Vanderbilt Avenue, Staten Island, NY 10304

<u>When you contact us, you must:</u>

- Tell us how you want to get notices that are normally sent by mail,
- Tell us how you want to get notices that are normally made by phone call, and
- Give us your contact information (mobile phone number, email address, fax number, etc.).

Centers Plan for Healthy Living will let you know by mail that you have asked to get notices electronically.

15. Your Rights and Responsibilities as a CPHL Member

As a CPHL member, <u>you have the Right:</u>

1. To receive medically necessary care.
2. To receive timely access to care and services.
3. To privacy about your medical record and when you get treatment.
4. To get information on available treatment options and alternatives presented in a manner and language you understand.
5. To get information in a language you understand; you can get oral translation services free of charge.
6. To get information necessary to give informed consent before the start of treatment.
7. To be treated with respect and dignity.
8. To get a copy of your medical records and ask that the records be amended or corrected.
9. To take part in decisions about your health care, including the right to refuse treatment.
10. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
11. To get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
12. To be told where, when and how to get the services you need from CPHL, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
13. To complain to the New York State Department of Health.
14. To complain to HRA or your LDSS and the right to use the New York State Fair Hearing system.
15. To appoint someone to speak for you about your care and treatment.
16. To make advance directives and plans about your care.

17. To receive information about CPHL and managed long term care in a manner which does not disclose you as participating in the Plan.
18. To seek assistance from ICAN.

In order to have the greatest benefit from enrollment in CPHL, you have the following responsibilities:

1. To actively participate in your care and care decisions.
2. To communicate openly and honestly with your doctor and Care Management Team about your health and care.
3. To ask questions to be sure you understand your plan of care and to consider consequences of not following it.
4. To share in care decisions and continue to be in charge of your own health.
5. To keep appointments or inform the Care Management Team of needs to change appointments.
6. To use the CPHL Network Providers for care except in emergency situations.
7. To notify CPHL if you receive health services from other health care providers.
8. To participate in policy development by writing to us or calling us.
9. To Support the CPHL Long Term Care Program.
10. To appropriately express opinions, concerns and suggestions in the following ways including, but not limited to, contacting your Care Management Team, or through CPHL's Grievance and Appeals Process.
11. To review the Member Handbook and follow procedures to receive services.
12. To respect the rights and safety of all those involved in your care and to assist CPHL in maintaining a safe home environment.

13. To notify your Care Management Team at CPHL of any of the following:

    - if you are leaving the service area
    - if you have moved or have a new telephone number
    - if you have changed doctors
    - any changes in condition that may affect our ability to provide care

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 **1-855-270-1600**. TTY/TDD users please call: **1-800-421-1220**.

Advance Directives

Advance Directives are legal documents that describe your future health care decisions in the event that you are unable to express these decisions for yourself. Completing Advance Directives helps ensure that your health care wishes are followed. There are three important 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:

- A list of names, business addresses and official positions of the members of CPHL's Board of Directors, officers, controlling partners, and owners or partners.
- A copy of the most recent CPHL annual certified financial statement including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant.
- Information related to member complaints and information collected about grievances and appeals.
- CPHL procedures for protecting confidentiality of medical records and other member information.
- A written description of the organizational arrangement and ongoing procedures of CPHL's Quality Assurance Program.
- A description of the procedures followed by CPHL in making decisions about the experimental, or investigational nature of individual drugs, medical devices or treatments in clinical trials.
- Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which CPHL might consider in its utilization review and how it is used in the utilization review process, provided, however, that to the extent that such information is proprietary to CPHL, the member or prospective member shall only use the information for the purpose of assisting the member/prospective member in evaluating the covered services provided by CPHL.
- Individual health practitioner affiliations with participating hospitals and other facilities.
- Licensure, certification and accreditation status of participating providers.

- Written application, procedures and minimum qualification requirements for health care providers to be considered by CPHL, and /or,
- Information concerning the education, facility affiliation, and participation in clinical performance reviews conducted by the Department of Health, of health care professionals who are licensed, registered, or certified under Article 8 of the State Education Law.

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.