1. INTRODUCTION

Dear Member:

We are pleased to welcome you to the Extended Managed Long Term Care (MLTC) Program. The Extended MLTC Program is especially designed for people who need health and long-term care services, such as home care and personal care, in order to live independently and stay in their homes and communities as long as possible.

To help you achieve this goal, you will be assigned to your own Care Manager, a Registered Nurse (RN). Your Care Manager will work with you, your family and your physician to facilitate in the delivery of quality health services in the most appropriate and least restrictive manner. Your Care Manager will assess your personal health status and adjust your services to meet your individual needs.

This Handbook tells you about the benefits that the Extended MLTC Program covers. It also tells you how to request a service, file a complaint or grievance and/or disenroll from the Extended MLTC Program.

HELP FROM YOUR CARE MANAGER OR MEMBERSHIP SERVICES

We are always available for you 24 hours a day, 7 days a week at the toll-free numbers listed below:

1-855-299-6492
TTY/TDD Dial 711
Or visit our Website at www.extendedmltc.org

These are the only phone numbers you will need to call for assistance – even after normal business hours and on weekends. During normal business hours (Monday through Friday 8:30 AM through 8:00 PM and Saturday 10:00am through 6:00pm), please ask for your Care Manager when seeking assistance. If your Care Manager is not available, please speak to a Membership Services Representative who will assist you. After normal hours of operations, your call will be automatically transferred to our Nursing On-Call Service. While many of our Extended MLTC Program Staff and Membership Service Representatives speak a wide variety of languages, we can also access oral interpretation services.
services through the ATT Language Line to make sure that you receive all the information you need and that your questions are answered in your language. After hours, you will also have access to interpreter services through our Nursing On-Call Service.
2. ELIGIBILITY FOR ENROLLMENT

You are eligible to join the Extended MLTC Program if you:

- Are age 21 and older
- Reside in New York City (the boroughs of the Bronx, Brooklyn, Manhattan, Queens and Staten Island) or the counties of Nassau or Suffolk
- Are able to stay in your home and community at the time you join the plan without jeopardy to your health and safety provided by the department
- Are expected to need one or more of the following services for more than 120 days from the expected date of enrollment:
  - Nursing services in the home
  - Therapies in the home
  - Home health aide services
  - Personal care services in the home
  - Adult day health care
  - Private Duty Nursing or Consumer Directed Personal Assistance services
- Eligible for Medicaid as determined by the Local Department of Social Services (LDSS) or New York City Human Resources Administration (HRA)
- Are determined eligible for MLTC by the MLTCP using an eligibility assessment tool designated by the New York State DOH
- The potential that an applicant may require acute hospital inpatient services or nursing home placement during such 120 day period shall not be taken into consideration when assessing an Applicant’s eligibility for enrollment

An Applicant who is a hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), psychiatric facilities, the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office For People With Developmental Disability (OPWDD), or is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, or OPWDD Day Treatment Program or is receiving services from a hospice may be enrolled with the Extended MLTC Program only after being discharged or terminated from the inpatient hospital, psychiatric facility, facility licensed by the OMH, OASAS or OMRDD, other managed care plan, hospice, Home and Community-Based Services waiver program, or OPWDD Day Treatment Program.
The coverage explained in this Handbook becomes effective on the effective date of your enrollment in the Extended MLTC Program. Enrollment in this Extended MLTC Program is voluntary.

A. Enrollment Process

Eligibility for enrollment in the Extended MLTC Program must be established through a clinical assessment process and reviewed and approved by the New York City Human Resources Administration (HRA).

Medicaid recipients seeking to enroll in the Extended MLTC Program must first contact the Conflict-Free Evaluation and Enrollment Center (CFEEC) to schedule an initial evaluation to determine CBLTC eligibility at:

1-855-222-8350

You may call anytime Monday through Friday from 8:30 am to 8 pm or Saturday from 10 am to 6 pm.

After CFEEC determines initial eligibility, Extended MLTCP will complete its own initial assessment for each prospective enrollee to determine the plan of care. This assessment will be conducted within (30) days of first contact by an individual requesting enrollment or of receiving a referral from the Enrollment Broker or other source. Interested individuals and/ or their representatives may contact the Plan for information and to learn how to enroll. If you are interested in transferring from another plan you can contact Extended MLTC directly without being evaluated by the CFEEC. Enrollment Coordinators will review the basic eligibility criteria with you, help you determine if you meet the minimum eligibility requirements (age, residence, Medicaid eligibility) to continue with the enrollment process and explain what can be expected once you are enrolled in the Extended MLTC Program. If you then would like to continue with the enrollment process, the Enrollment Coordinator will schedule a home visit with one of the Enrollment Specialist RNs who will complete your enrollment eligibility health assessment.

Enrollment Specialists are registered nurses who have experience and expertise in home care and community based long-term care services. Enrollment Specialists will determine clinical eligibility by visiting you in your home and completing a health assessment to establish the level of care needed, and to do
a health and safety assessment as well as a social and environmental assessment. Home assessment visits will be scheduled as soon as possible, generally within (10) business days of your expressing interest in applying for membership. During the home visit, the Enrollment Specialist will develop a plan of care to meet your needs. Your participation is needed and input from any family, participating provider and/or informal supports will be encouraged. The Enrollment Specialist will present you with a proposed care plan for review, together with an enrollment application, will answer any questions that you may have at that time and will assist with the completion of the enrollment application.

If you are then interested in joining the Extended MLTC Program, you can sign the Enrollment Agreement & Attestation Form, a HIPAA Release of Information Form and a Medical Release of Information Form at the end of the enrollment visit. You will only be requested to sign a Medical Release of Information Form if the eligibility criteria are met and the decision is made to enroll in the Extended MLTC Program. It is necessary to sign a Medical Release of Information Form so that Care Managers can speak with participating providers in order to establish and coordinate the services included in the plan of care. A HIPAA Release of Information Form allows the MLTCP to contact the New York City Human Resource Administration. Following the enrollment visit, the Care Manager will contact your participating provider to discuss the proposed plan of care.

If N.Y. Medicaid Choice receives notice of enrollment by the 20th of the month, membership will usually begin on the 1st day of the next month. If N.Y. Medicaid Choice receives notice of enrollment after the 20th of the month, enrollment will usually begin on the 1st day of the month following the next month. For example, if the N.Y. Medicaid Choice receives the enrollment notice on August 24, enrollment will usually begin on October 1.

B. Denial of Enrollment

You (the applicant) can be denied enrollment by the Extended MLTC Program and/or N.Y. Medicaid Choice for one or more of the following reasons:

- Applicant is not at least 21 years of age
- Applicant is not Medicaid eligible
- Applicant is not eligible for nursing home level of care
- Applicant is not capable of returning to or remaining in the home without jeopardy to his/her health and safety
Applicant does not require long-term care services for 120 days or more
Applicant has been previously involuntarily disenrolled from the Extended MLTC Program
Applicant is currently enrolled in another Medicaid managed care plan, a Home and Community based Services waiver program, an OMRDD Day Treatment Program, or is receiving services from a hospice and does not wish to end his/her enrollment in one of these programs
Applicant is an inpatient or resident of a hospital, psychiatric facility or residential facility operated by the State Office of Mental Health, Office of Alcohol and Substance Abuse Services or the State OMRDD (applications for enrollment may be taken but enrollment may only begin upon discharge to the applicant’s home in the community)
Individuals eligible only for breast and cervical cancer services, tuberculosis-related services or family planning expansion program
Individuals expected to be Medicaid eligible for less than six months
Residents of intermediate care facilities for the mentally retarded
Individuals eligible for emergency Medicaid

If the eligibility criteria for age, county of residence, and Medicaid are not met, the applicant will not be assessed for enrollment and will be so informed by letter. If the applicant chooses to pursue enrollment despite a lack of eligibility, the Extended MLTC Program will send this information to N.Y. Medicaid Choice for review and eligibility determination. If the Extended MLTC Program determines that the enrollment should be denied based on failure to meet the enrollment criteria, the Extended MLTC Program will recommend to N.Y. Medicaid Choice that the enrollment application be denied. N.Y. Medicaid Choice makes the final determination in the denial of enrollment and N.Y. Medicaid Choice will notify the applicant of his/her Fair Hearing rights.

If the applicant disagrees with the Extended MLTC Program regarding ineligibility due to age, residence or Medicaid eligibility, information that has been provided to the Extended MLTC Program will be sent in writing to N.Y. Medicaid Choice with a copy to the applicant. The N.Y. Medicaid Choice will decide if the Extended MLTC Program was correct in informing the applicant that he/she is ineligible to enroll. If N.Y. Medicaid Choice agrees that the applicant is ineligible to enroll, then the applicant will be denied enrollment. If the applicant is determined to be clinically ineligible for enrollment, the applicant will be advised and may withdraw the application. Clinical ineligibility means that based on the in-home assessment the applicant does not require a nursing home level of care based on assessment instrument specified by the department and/or that the
applicant does not meet health and safety criteria, and/or the applicant does not require managed long-term care services for at least 120 days. If the applicant does not wish to withdraw the application for clinical denial, the enrollment application will be processed as a proposed denial, pending N.Y. Medicaid Choice agreement.

Applicant will be assured that his/her enrollment in the Extended MLTC Program will not be subject to discrimination based upon health status or change in health status and the need for or cost of covered services.

**C. Withdrawal of Enrollment**

An Applicant may withdraw an application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment by indicating his/her wishes orally or in writing. The Extended MLTC Program will confirm applicant’s request for withdrawal in writing.

**D. Your ID Card**

Each Member will receive an Extended MLTC ID Card. Extended MLTC Program phone numbers will appear on the ID Card and you should carry it with you at all times. You will use your ID Card to receive covered services and benefits provided by the Extended MLTC Program. You do not need to present your ID Card before you receive emergency care services – in this case call 911 or go to the nearest emergency room.

**E. Transitional Care**

New Extended MLTC Program members may continue an ongoing course of treatment for a transitional period of up to (90) calendar days from the enrollment effective date with a non-network health care provider, provided that such provider: (a) accepts payment at an agreed upon rate with the extended MLTC Program; (b) adheres to the Extended MLTC Program’s requirements for quality assurance and other policies and procedures; and (c) provides necessary medical information about the care being rendered to the Extended MLTC Program.
In addition, Extended MLTC Program members may continue an ongoing course of treatment for a transitional period of up to (90) calendar days should the member’s participating provider leave the Extended MLTC Program Provider Network, provided that such provider: (a) accepts payment at an agreed upon rate with the Extended MLTC Program; (b) adheres to the Extended MLTC Program’s requirements for quality assurance and other policies and procedures; and (c) provides necessary medical information about the care being rendered to the Extended MLTC Program.

Extended MLTC must continue to provide services authorized under enrollee’s pre-existing service plan for a minimum of ninety (90) days and issue a notice of action for any restriction, in addition to reduction, suspension or termination of authorized services for enrollees who transition to MLTC from

- Medicaid fee-for-service community-based long term care program.
- Mainstream Managed Care (MMC) CBLTC services

This applies to individuals who were in receipt of CBLTC services from an MMC plan, and who were dis-enrolled either due to a change in Medicaid eligibility status or receipt of Medicare.

Extended MLTC shall authorize and cover CBLTCS and ILTSS at the same level, scope and amount as the Enrollee received under the FFS Program for 90 days following Enrollment or until the Extended MLTC’s Person-Centered Service Plan (PCSP) is in place, whichever is later.

Extended MLTC Program may not deny payment to providers of transitional care CBLTCS and ILTSS solely on the basis that the provider failed to request prior authorization.

Where an existing medical order has or is about to expire, and a new medical order is required for the continued provision of CBLTCS and ILTSS during the transitional period but cannot be obtained after reasonable effort, the Extended MLTC shall work with the CBLTCS and ILTSS provider to arrange a safe transition for the Enrollee, which may be to a higher level of care.

**F. Permanent Nursing Home placement for dual eligible persons**

You must join a Managed Long Term Care Plan if you:

- Are age 21 or older and have Medicaid and Medicare
- Are seeking or referred for permanent nursing home placement
- Get approved by Medicaid for long term nursing home care
Once determined eligible for Long Term Placement in a nursing home you are allowed sixty (60) days to select an MLTCP for enrollment.

If you do not enroll in an MLTCP within the allotted time you will be auto-assigned to an MLTCP which contracts with the nursing home where you are currently placed.

You may contact New York Medicaid Choice at 1-888-401-6582 or TTY: 1-888-329-1541 Monday to Friday, 8:30 am – 8:00 pm Saturday, 10:00 am – 6:00 pm for education and assistance regarding all MLTC Plan options available to you, including Community Based Long-Term Care alternatives.

If an MLTCP you choose does not have a nursing home to meet your needs of its members, the plan must authorize out of network placement. If beds are not available at the time placement is indicated, the plan must authorize out of network placement.
3. COVERED SERVICES AND PROVIDERS

The following is a listing of those medically necessary covered services available through membership in the Extended MLTC Program. These services are provided directly by or through providers contracted with the Extended MLTC Program. You are not responsible for payment of covered services as long as they are authorized in your plan of care.

As a member of the Extended MLTC Program, you will receive Care Management Services. We will provide you with a Care Manager who is a health care professional – usually a registered nurse. Your Care Manager will work with you, your caregivers, and your physician to decide the services you need and develop a Person Centered Service Plan (PCSP). Your Care Manager will also assist you in accessing the services needed in order to have you remain as independent and as healthy as possible. She/he will also:

- Call you at least once per month and visit with you and your family or other individuals who may be assisting you at least every six (6) months to ensure that you are satisfied with the care and services that you are receiving
- Work with your physician to obtain the medical orders needed for covered services as required by the plan of care
- Authorize covered services for you based on medical necessity
- Talk to your physician about changes or updates to the plan of care
- Arrange and coordinate services that are covered by the Extended MLTC Program
- Help arrange for and coordinate services that are needed but which are not covered by the Extended MLTC Program (such as Hospice), or are not available within the Program’s existing network
- Provide health education on preventive health and public health topics
- Be available to you, or provide coverage by another Care Manager, 24 hours a day, 7 days a week to assist you with urgent care or other issues

Level and degree of Care Management and the Plan of Care for each enrollee will address the needs of the enrollee and be based upon the acuity and severity of enrollees’ physical and mental conditions.

Care Management Services do not require a physician order unless a change to your plan of care is recommended by your Care Manager.
Extended MLTC staff will educate and inform enrollees, as applicable, about Consumer Directed Personal Assistance Services (CDPAS) and other service options when creating the Plan of Care with the enrollee after the assessment and reassessments.

A. Covered Services

You may get the services described below as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your Care Manager will help identify the services and providers you need.

For some covered services listed below, you may need a physician's order and/or prior authorization from the Extended MLTC Program to get these services. For other covered services, you may access them directly.

Authorization is the process by which a covered service is determined to be medically necessary for the member's condition, illness, or ailment by the member's physician and the Extended MLTC Program. When you need a physician's order or prior authorization to access certain covered services, simply call your Care Manager who will gladly assist you with your needs and coordinate services with your physician.

- **Personal Care**: If you require assistance with activities such as bathing, eating, dressing, toileting and walking, you will be provided with a qualified Aide who will assist you in performing these activities. These services do not require a Physician’s order if they are specified in your plan of care and have been prior authorized by the Extended MLTC Program.

- **Home Health Care Services**: Among the services that may be provided to you in your home are nursing visits (including, but not limited to, assessments, aide supervision, teaching and treatments), home health aide, physical therapy, occupational therapy and speech therapy visits. These services do not require a Physician’s order if they are specified in your plan of care and have been prior authorized by the Extended MLTC Program.

- **Outpatient Physical, Occupational, Speech or Other Therapies (provided in a setting other than your home)**: Subject to the service limitations described below, licensed therapists will perform these services in a setting other than your home to assist you in achieving your best
functional level. These services require a Physician’s order and prior authorization by the Extended MLTC Program.

- **Respiratory Therapy Services**: These services will be provided by a licensed respiratory therapist and include, but are not limited to, instruction in the use of nebulizer treatments and oxygen. These services require a Physician’s order and prior authorization by the Extended MLTC Program.

- **Nutritional Counseling**: A Registered Dietician will provide you with nutritional counseling to assist you with diet planning. These services do not require a Physician’s order if they are specified in your plan of care and have been prior authorized by the Extended MLTC Program.

- **Durable Medical Equipment, Medical/Surgical Supplies, Prosthetics, Orthotics, Orthopedic Footwear, Enteral and Parenteral Formulas**: Subject to the service limitations described below, the Extended MLTC Program will provide all necessary equipment, supplies and appliances for you, such as: canes, walkers, wheelchairs, commodes, oxygen and respiratory equipment, wound care supplies, colostomy and diabetic supplies, enteral and parenteral nutrition and supplies, artificial limbs, braces, and shoe inserts or orthopedic shoes. These services require a Physician’s order and prior authorization by the Extended MLTC Program.

- **Medical Social Services**: A qualified social worker will assess your need for, and arrange for the provision of, aid to assist you in dealing with social problems and maintaining your home. These services require a Physician’s order and prior authorization by the Extended MLTC Program.

- **Home Delivered Meals (and/or meals in a group setting such as a day care)**: If you are unable to prepare your own meals, congregate meals can be provided at local senior centers or you may have meals delivered to your own home. These services do not require a Physician’s order if they are specified in your plan of care and have been prior authorized by the Extended MLTC Program.

- **Social Day Care**: Extended MLTC members who are able to attend Social Day Care centers will be provided with the following services, as needed: socialization, supervision, monitoring, and congregate meals. Additional services may include recreational and other cultural activities, personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and
assistance. These services do not require a Physician’s order if they are specified in your plan of care and have been prior authorized by the Extended MLTC Program.

- **Non-Emergency Transportation:** You will be provided with non-emergency transportation not only to medical appointments but also to other health and social service appointments. If you are able to use public transportation and are not currently enrolled in the New York City Transit Metro card Program, your Care Manager will assist you in obtaining this discount transit card. If you are unable to use public transportation, ambulette or car service will be provided. In order to arrange for non-emergency transportation, you will need to make prior arrangements with your Care Manager 24 to 48 hours before your appointment date and time. These services do not require a Physician’s order but must be prior authorized by the Extended MLTC Program.

- **Private Duty Nursing:** You will be provided with skilled nursing care by properly licensed registered professional or licensed practical nurses (RNs or LPNs) at your permanent or temporary place of residence, as medically necessary and in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies (CHHAs). These services require a Physician’s order and prior authorization by the Extended MLTC Program.

- **Dental Services:** Covered dental services include, but are not limited to, preventive, prophylactic and other dental care, services and supplies, routine exams, oral surgery, and dental prosthetic or orthotic appliances required to alleviate a serious health condition. These services do not require a Physician’s order but must be prior authorized by the Extended MLTC Program.

- **Podiatry:** A licensed Podiatrist will provide medically necessary foot care. These services do not require a Physician’s order but must be prior authorized by the Extended MLTC Program.

- **Audiology/Hearing Aids and Hearing Aid Batteries:** A registered Audiologist will perform hearing examinations and you may be fitted for a hearing aid. New hearing aids may also be issued if your hearing level has changed and you need a different prescription. Hearing aids that are lost will be replaced and hearing aid batteries will also be covered. These
services do not require a Physician’s order but must be prior authorized by the Extended MLTC Program.

- **Optometry/Eyeglasses:** Annual preventive eye examinations will be covered and, if necessary, prescription eyeglasses will be provided through a participating network Optometrist. Eyeglasses will be replaced if lost or damaged. These services do not require a Physician’s order but must be prior authorized by the Extended MLTC Program.

- **Social/Environmental Supports:** Environmental supports, such as chore services, home modifications or respite care may be necessary to ensure your health and safety. These services do not require a Physician’s order but must be prior authorized by the Extended MLTC Program.

- **Personal Emergency Response System (PERS):** You will be provided with an electronic warning device, called a PERS, which can be activated in the event of an emergency or injury. This service does not require a Physician’s order but must be prior authorized by the Extended MLTC Program.

- **Adult Day Health Care:** Day care programs will provide you with the following services as may be needed: nursing care, personal hygiene and grooming, therapy services, nutritional counseling, therapeutic recreational activities, social work counseling, podiatry, dental and optometry services, as well as socialization. Congregate meals and non-emergency transportation will be provided. This service does not require a Physician’s order but must be prior authorized by the Extended MLTC Program.

- **Nursing Home Care:** Subject to the limitations listed below, nursing home care for short-term rehabilitative stays (which occur mainly after hospitalizations) and for long-term stays (permanent placement), is covered when medically necessary. These services require a Physician’s order and prior authorization by the Extended MLTC Program.

- **Consumer Directed Personal Assistance services:** As part of your managed long term care services, you may be eligible to self direct your care. Consumer Directed Personal Assistant Service (CDPAS) is a type of service where a member or a person acting on a member’s behalf known as a designated representative, self directs and manages the member’s personal care and other authorized services. These services require a Physician’s order and prior authorization by the Extended MLTC Program.
• **Health care services delivered by telehealth:** Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee.

**Limitations**

- Outpatient physical, occupational and speech therapies are limited to 20 visits per year per therapy (limitation does not apply to individuals with developmental disabilities).

- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: (1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and (2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Coverage of certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

- Nursing Home Care is covered for individuals who are considered a permanent placement, provided you are eligible for institutional Medicaid coverage.

- Institutional Long Term Services and Supports (ITLSS) mean Residential Health Care Facility (Nursing Home) services as included in the MLTC Benefit Package and provided by the Extended MLTC Program when medically necessary.

- Long Term Placement (Permanent Placement) Status means the status of an individual in a Residential Health Care Facility (RHCF) when the entity designated by the State determines that the individual is not expected to return home based on medical evidence affirming the individual's need for long term (permanent) RHCF placement.

For services covered by the Extended MLTC Program, you may choose any provider from our participating provider network that offers the services that you need. These network providers have a contractual obligation with the Extended
MLTC Program. In addition, we have the ability to monitor the services provided by our network providers and hold them to our professional standards.

As an Extended MLTC Program member, you have the right to obtain a referral to a health service provider outside of our participating provider network in the event that we do not have a provider with appropriate experience to meet your needs within our network. Should you require an out-of-network provider, you must first contact your Care Manager to assist you with obtaining an authorization for this referral before seeing the provider. Without first obtaining the required authorization, the out-of-network provider will not be paid for services rendered to you. If you have any questions regarding this process, please contact your care Manager or a Membership Services Representative at 1-855-299-6492.

Network providers will be paid in full directly by the Extended MLTC Program for each service authorized and provided to you with no copayment or cost to you. If you receive a bill for covered services authorized by the Extended MLTC Program, you are not responsible to pay the bill, and please contact your Care Manager should this occur. You may be responsible for payment of covered services that were not authorized by the Extended MLTC Program, or for covered services that are obtained by providers outside of the Extended MLTC Program participating provider network.

Services for Veterans

If you want to receive care from a Veterans’ Home, you may. Your eligibility for State Veterans’ Homes is based on clinical need and setting availability. New York State Veterans’ Homes are limited to Veterans, non-Veteran spouses, and gold star parents.

The veteran’s homes we contract with can be found in our printed Provider Directory you received in the mail or can be requested from your Care Manager by calling 855-299-6492.

If you want to receive care from a veteran’s home, and Extended MLTC does not have a Veteran’s home in our service area, we must pay for you to access veteran’s home services that are out of our network until you can transfer to another plan that has a Veteran’s home in their network.

B. Services covered by Medicare or Medicaid on a fee-for-service basis-
The following services are not covered by the Extended MLTC Program, but are covered by Medicare or Medicaid on a fee-for-service basis:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Hospice Services
- Laboratory Services
- Physician Services including services provided in an office setting, a clinic, a facility, or in the home
- Radiology and Radioisotope Services
- Emergency Transportation (Emergency or ambulance transportation to the hospital)
- Rural Health Clinic Services
- Chronic Renal Dialysis
- Mental Health Services
- Alcoholism and Substance Abuse Services
- Office of Mental Retardation and Developmental Disabilities Services
- Family Planning Services
- Prescription and non-prescription drugs
- Assisted Living Program

Although these services are not part of the Extended MLTC Program benefit package, your Care Manager will help arrange and coordinate them as needed. You have the freedom to choose providers for covered services paid for by Medicare. However, when Medicare stops paying for these services, you must use a network provider in order for the Extended MLTC Program to cover the service. The Extended MLTC Program will pay the required Medicare co-payments for covered services if Medicare is the primary payor.

We will provide you with a list of our participating network providers and you have the freedom to choose any provider from this list for non-covered services. You can also switch to another network provider at any time. The provider will be changed, as soon as possible, based upon the availability of your request.

Services not covered by the Extended MLTC Program will continue to be covered by Medicare and/or Medicaid fee-for-service. It is important to carry your plan benefit card, Medicare and Medicaid cards at all times.
C. Services available through other Medicaid programs-

Money Follows the Person (MFP)/Open Doors

This section will explain the services and supports that are available through Money Follows the Person (MFP)/Open Doors. MFP/Open Doors is a program that can help enrollees move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP if they:

- Have lived in a nursing home for three months or longer
- Have health needs that can be met through services in their community

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

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

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1844-545-7108, 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.

D. Services Not Covered by the Extended MLTC Program or Medicaid

You must pay for services that are not covered by the Extended MLTC Program 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 the Extended MLTC Program or Medicaid are:
• Cosmetic surgery if not medically necessary
• Personal and comfort items
• Infertility treatments
• Services of a provider that are not part of the Extended MLTC Program (unless the Extended MLTC Program authorizes a referral for you to see that provider)

E. Getting Care Outside the Service Area

If you are planning to spend some time away from home, please let your Care Manager know immediately. If you are out of the service area for thirty (30) calendar days or fewer, we will make every effort to assist you in arranging temporary services for you while you are away. Please inform your Care Manager at least one week in advance to obtain authorization for services if you are planning to be outside of the service area.

If you are planning to leave the service area for more than thirty (30) consecutive days, it will be difficult for the Extended MLTC Program to properly monitor your health needs. If this situation should occur, the Extended MLTC Program will no longer be appropriate for your care needs and you must be involuntarily disenrolled. In this case please call your Care Manager to discuss your options.

F. Emergency Services

Emergency services means medically necessary services required to evaluate and stabilize an emergency medical condition. An emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health or such person or others in serious jeopardy; (b) serious impairment to such person’s bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

If you have an emergency and need immediate medical attention, call 911 or rush to the nearest hospital emergency room. Should you call 911, listen to the
questions carefully, answer their questions and follow their instructions. If 911 determines that you have a medical emergency, they will take you to the nearest hospital emergency room. After your emergency, please notify your Care Manager within 24 hours of the emergency. You may be in need of long-term care services that can only be provided by the Extended MLTC Program. If your emergency results in a hospital admission, you (if possible), a family member or informal support should contact the Extended MLTC Program within 24 hours of the admission. Your Care Manager will then cancel any scheduled services or appointments that you may have. If you are in the hospital, be sure to ask your physician or discharge planner to contact the Extended MLTC Program. We will then work with them to plan for your care upon your hospital discharge.

You are not required to get prior authorization or approval from the Extended MLTC Program for treatment of emergency medical conditions. However, it is important to let us know you have received emergency services as soon as possible so that we can adjust scheduled services right away and ensure that services fit any change in your needs.

We always encourage you to call your Care Manager for any assistance. If you have an urgent need for service or assistance or have an emergent situation after normal business hours or on weekends or holidays, just call us on the toll free Nursing On-Call Hotline number, 1-855-299-6492, and our On-Call Care Manager will assist you.
4. MONTHLY SPENDDOWN

What you are required to pay to the Extended MLTC Program directly depends on the determination made by Medicaid in accordance with the requirements of the Medical Assistance Program. LDSS or HRA will review your financial status and determine the amount of your monthly income that you must “spenddown” in order to meet the income requirements for Medicaid eligibility. If Medicaid determines that you must spenddown a certain amount, the LDSS or HRA will notify you and the Extended MLTC Program of the exact amount of your spenddown that must be paid each month to the Extended MLTC Program. If Medicaid determines that you have no spenddown requirement, then you will have no monthly financial obligation to the Extended MLTC Program. Any amount that you must spenddown or pay directly to the Extended MLTC Program may change in accordance with your periodic Medicaid eligibility certification process, or upon your admission to a Skilled Nursing Facility, at which time LDSS or HRA will review your financial status and determine the amount of net available monthly income (“NAMI”) that you must pay monthly to the Extended MLTC.

If you must pay a spenddown, that amount must be paid by the first of each month starting with the month of enrollment. Please make your payment payable to the order of Extended MLTC, LLC and send it to Extended MLTC, LLC, 21 Penn Plaza 360 West 31st Street, Suite 304, New York, NY 10001 ATTN: Finance Department.

If you have a problem meeting this monthly spenddown responsibility, it is important that you immediately discuss this situation with your Care Manager. If you do not pay your spenddown amount within thirty (30) calendar days after the date it is due, we will notify you in writing of your arrears in payment. We have the right to involuntarily disenroll you from the Extended MLTC Program for failure to make spenddown payments that are due.
5. MEMBER COMPLAINT AND APPEAL PROCESS

EXTENDED MLTC 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 EXTENDED MLTC staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint or to appeal a plan action, please
- Call: 1-855-299-6492 or
- Write to: Extended MLTC, LLC, 360 West 31st Street, Suite 304, New York, NY 10001, Attn: Appeals and Complaints.

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

What is a Complaint?

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

The Complaint Process

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

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

*How do I Appeal a Complaint Decision?*

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

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

*What is an Action?*

When EXTENDED MLTC denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn’t provide timely services; or doesn’t make complaint or appeal determinations within the required timeframes, those are considered plan “actions”.

An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

*Timing of Notice of Action*

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

**Contents of the Notice of Action**

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

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

**How do I File an Appeal of an Action?**

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

**How do I Contact my Plan to file an Appeal?**

We can be reached by calling 1-855-299-6492 or writing to Extended MLTC, LLC, 360 West 31st Street, Suite 304, New York, NY 10001, Attn: Appeals and Complaints. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that
we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan’s initial decision or action that you are appealing.

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

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

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

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

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

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

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

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

**Expedited Appeal Process**

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

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

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

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

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

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

**State Fair Hearings**

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.
If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

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

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

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

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

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

- Request in Person:

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

For more information on how to request a Fair Hearing, please visit: [http://otda.ny.gov/hearings/request/](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.”
6. SERVICE AUTHORIZATIONS AND ACTION REQUIREMENTS

Upon your enrollment with us, the Extended MLTC Program develops a Plan of Care based on assessment of your health care needs. This Plan of Care determines the services that are covered, and we will follow this Plan of Care and make decisions regarding your care plan following these rules:

Service Authorizations

When you ask for approval of a treatment or service, it is called a Service Authorization Request. To submit a service authorization request, you or your doctor may call our toll-free number at 1-855-299-6492 to speak to your Care Manager, or send your request in writing to the Extended MLTC, LLC, 21 Penn Plaza 360 West 31st Street, Suite 304, New York, NY 10001 ATTN: Membership Services Department, who will forward your request to your Care Manager. Services will be authorized in a certain amount and for a specific period of time. This is called the authorization period.

Prior Authorization Review: your Care Manager will review a request submitted by you or by a provider on your behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period. You must receive approval from your Care Manager before you can receive these services.

Concurrent Review: your Care Manager will review a request submitted by you or by a provider on your behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient hospital stay.

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

What happens after we get your request?

After we get your request, we will review it under a standard or expedited process. A decision to deny a service authorization request or to approve it for
an amount that is less than requested is called an action. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity.

You or your doctor can ask for an expedited review if it is believed that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your request will be handled 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.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you have if you don’t agree with our decision.

We will notify you of the availability of assistance (for language, hearing, speech issues) if you want to file appeal and how to access that assistance.

**Timeframes for Service Authorization Determination and Notification**

For Prior Authorization requests:

Extended MLTC will make a Service Authorization Determination and notify you of the determination by phone and in writing as fast as your condition requires and no more than:

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

For Concurrent Review requests:

Extended MLTC will make a Service Authorization Determination and notify you of the determination by phone and in writing as fast as your condition requires and no more than:
• **Expedited**: Seventy-two (72) hours of receipt of the Service Authorization Request  
• **Standard**: Fourteen (14) days of receipt of the Service Authorization Request  
• In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

If we need more information to make either a standard or expedited decision about your service request, the timeframes above can be extended up to (14) calendar days. If Extended MLTC initiates an extension, we will:

• Notify you in writing of a plan-initiated extension of the deadline for review of your service request  
• Explain the reason for the delay and how the delay is in your best interest.  
• Tell you what additional information is needed to help make a determination or redetermination  
• Help you by listing potential sources of the requested information.  
• If your request is an expedited review, we will call you right away and send a written notice later.  
• Make a decision as quickly as we can when we receive the necessary information, but no later than (14) calendar days from the end of the original timeframe.

You, your provider, or someone you trust may also ask us to take more time (up to 14 calendar day extension) to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling your Care Manager at our toll-free number 1-855-299-6492, or send your request in writing to the Extended MLTC, LLC, 21 Penn Plaza 360 West 31st Street, Suite 304, New York, NY 10001 ATTN: Membership Services Department.

If you are not satisfied with our decision, you have the right to file an action appeal with us - see Appeal Process section.
Extended MLTC will notify you in writing if your request for an expedited review is denied, and that it will be handled as standard review.

You or someone you trust can also file a complaint with the Extended MLTC Program if you don’t agree with our decision or to take more time to review your request. 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.

Other Timeframes for Action Notices

Extended MLTC may conduct a review of the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called a retrospective review. In this process, we will tell you if we take any of these following actions.

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

a. the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or

b. the Extended MLTC may mail notice not later than date of the Action for the following:
   i. the death of the Enrollee;
   ii. a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);
   iii. the Enrollee’s admission to an institution where the Enrollee is ineligible for further services;
   iv. the Enrollee’s address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;
   v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or
   vi. the Enrollee’s physician prescribes a change in the level of medical care.

c. For CBLTCS and ILTSS, when the Extended MLTC intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously
authorized, we will provide you with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)(b).
d. For CBLTCS and ILTSS, when the Extended MLTC intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the effective date of the Action will not be set to fall on a non-business day, unless Extended MLTC provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals.
e. Extended MLTC will mail written notice to you on the date of the Action when the Action is a denial of payment, in whole or in part. You will not have to pay for any care you received that was covered by the Extended MLTC Program or by Medicaid even if we later deny payment to the provider.
f. When we do not reach a determination within the Service Authorization Determination timeframes described above, it is considered an Adverse Determination, and we will send you notice of Action on the date the timeframes expire.

Contents of Action Notices

1. Extended MLTC will utilize DOH-approved MLTC Initial Adverse Determination notice for all actions, except for actions based on intent to restrict access to providers under the recipient restriction program.

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

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

You may initiate disenrollment from the Extended MLTC Program, either by oral or written communication, at any time and for any reason (voluntary disenrollment), and there may be circumstances under which you will be disenrolled by the Extended MLTC Program (involuntary disenrollment). If you disenroll orally, we will provide you with written confirmation of receipt or your oral request. Your Care Manager will discuss your decision to disenroll with you and, at your request, a Nursing Supervisor can meet with you in your home and attempt to resolve the circumstance leading to your disenrollment request.

a. Voluntary Disenrollment

You can ask to leave the Extended MLTC Program at any time for any reason upon oral or written notification to the Extended MLTC. We will provide you with a Disenrollment Form that will let you know the projected date upon which you will no longer be entitled to receive covered services through the Extended MLTC Program. We will ask you to sign this form and include the reason for disenrollment. However, you are not required to complete this form, and your refusal to do so will not impede the disenrollment process. It could take up to six weeks to process, depending on when your request is received. For example, if the LDSS or HRA processes your request by the tenth of the month, the effective date of your disenrollment will be as of the first day of the following month. If the process is initiated later than the tenth of the month, your effective date of disenrollment will be as of the first day of the second month following your disenrollment request. The Extended MLTC Program will continue to provide and arrange for covered services until the effective date of your disenrollment.

If, after enrolling in the Extended MLTC Program, you enroll in or receive services from another Medicaid-capitated Managed Care Plan, a Home and Community Based waiver program, or OPWDD Day Treatment Program, this will be considered voluntary disenrollment. You may disenroll to regular Medicaid if you no longer require community-based long term services. However, if you continue to require community-based long term services at the time of your voluntary disenrollment, you will be required to join another Medicaid-capitated Managed Care Plan.
b. Involuntary Disenrollment

If the Extended MLTC Program feels that it is necessary to disenroll you involuntarily, we must obtain authorization from HRA. The Extended MLTC Program will not involuntarily disenroll you on the basis of adverse change in health status or the need for and/or cost of covered services. The reasons for involuntary disenrollment are listed below. Involuntarily disenrolled members will be notified of their Fair Hearing by HRA. The Extended MLTC Program will continue to provide and arrange for covered service until the effective date of disenrollment.

Extended MLTC must initiate your disenrollment from the Program if you:

- Need nursing home care, but are not eligible for institutional Medicaid
- Are no longer eligible for Medicaid Benefits (Medicaid only plans)
- Are out of the plan’s service area for more than (30) consecutive days
- Permanently move out of the Extended MLTC Program’s service area
- No longer require nursing home level of care
- Are hospitalized or enter an OMH, OPWDD, or OASAS residential program for more than (45) consecutive days or longer
- Are assessed as no longer demonstrating a functional or clinical need for community-based long term care services or, for non-dual eligible Enrollees, in addition no longer meet nursing home level of care as determined using the assessment tool prescribed by the Department
- Are incarcerated. The effective date of enrollment shall be the first day of the month following incarceration
- Your sole service is identified as Social Day Care

We Can Ask You to Leave the Extended MLTC Program if:

- You or a family member behaves in a way that prevents the Extended MLTC Program from providing the care you need
- You knowingly provide false information or behave in a deceptive or fraudulent way
- You or your family member fails to complete or submit any consent form or other document that is needed to obtain services for you
- Fail to pay or make efforts to pay any spenddown requirement payable to the Extended MLTC Program
c. Re-Enrollment Provisions

If you voluntarily disenroll, you will be allowed to re-enroll in the Extended MLTC Program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled, you may be allowed to re-enroll provided that: (a) you meet our eligibility requirements; and (b) that the condition or circumstance leading to your involuntary disenrollment determination has been corrected.
8. MEMBER RIGHTS AND RESPONSIBILITIES

As a member of the Extended MLTC Program, your rights include:

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the Right to get information in a language you understand (you can get oral translation services free of charge).
- You have the Right to get information necessary to give informed consent before the start of treatment.
- You have the Right to be treated with respect and dignity.
- You have the Right to receive a copy of your medical records and ask that the records be amended or corrected.
- You have the Right to take part in decisions about your health care, including the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the Right to receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the Right to be told where, when and how to receive the services you need from the Extended MLTC Program, including how you can receive covered benefits from out-of-network providers if they are not available in the provider network.
EXTENDED MANAGED LONG TERM CARE (MLTC) PROGRAM
MEMBER HANDBOOK

- 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 and necessary to resolve grievances and appeals.

- You have the Right to appoint someone to speak on your behalf regarding your care and treatment.

- You have the Right to make advance directives and plans about your care.

- You have the right to seek assistance from the Independent Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals’ options, as well as assistance with managing the appeal process.

  **ICAN** can be reached at **Phone:** 1-844-614-8800 (**TTY Relay Service:** 711), [**Web:**](http://www.icannys.org) [**Email:**ican@cssny.org]

Your exercise of these Rights will not adversely affect the way you will be treated, or any decisions that may be made, by the Extended MLTC Program. Extended MLTC may not act in any manner so as to restrict your right to a fair hearing or influence your decision to pursue a fair hearing.

MLTC Program will cooperate with, and may not inhibit, the ICAN in the exercise of its duties. MLTC Program will upon request, provide the ICAN with a current list of Participating Providers in Contractor’s MLTC Plan.

**As a member of the Extended MLTC Program, you have the responsibility to:**

- Contact us when you need help or have a question.

- Receive all covered services through the Extended MLTC Program utilizing network providers.

- Follow your plan of care and request changes as needed.
- Obtain prior authorization for covered services, except for pre-approved services.

- Be seen by your physician if a change in your health status occurs.

- Share complete and accurate health information with your Care Manager and your health care providers.

- Maintain Medicaid eligibility.

- Notify your Care Manager when you go away or are out of town.

- Inform your Care Manager of any change in your health and let us know if you do not understand or are unable to follow instructions.

- Cooperate with and be respectful of the Extended MLTC Program staff members.

- If you cannot notify us in advance, to notify the Extended MLTC Program within two (2) business days of receiving non-covered services or after receiving emergency care or being admitted to a hospital.

- Take responsibility if you refuse treatment or do not follow Extended MLTC Program instructions.

- Make every effort to pay your Medicaid spenddown amount owed to the Extended MLTC Program, if any.
9. INFORMATION ABOUT ADVANCE DIRECTIVES

You have a right to make your own health care decisions. Sometimes, as a result of a serious accident or illness, that may not be possible. You can plan ahead of time for such situations by preparing an Advance Directive that will help assure that your health care wishes are followed. There are different types of Advance Directives as described more fully below:

Health Care Proxy – This document enables competent adults to protect their health care wishes by appointing someone they trust to make decisions about treatment on their behalf when they are unable to decide for themselves.

Do Not Resuscitate (DNR) Order – You have the right to decide if you want emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want cardiopulmonary resuscitation, you should make your wishes known in writing. Your physician can provide a DNR order for your medical records. You can get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

Organ Donor Card – This wallet-sized card says that you are willing to donate parts of your body to help others when you die. You can also complete the back of your NYS driver's license or non-driver ID card to let others know of and how you want to donate your organs.

Living Will – You can give specific instructions about treatment in advance of situations where you may be unable to make important health care decisions on your own.

It is your choice whether or not you wish to complete an Advance Directive and which type of Advanced Directive is best for you. You may complete any, all, or none of the Advance Directives listed above. The law forbids discrimination against providing medical care based on whether or not a person has an Advance Directive. For more information, please speak to your physician or your Care Manager. The Extended MLTC Program enrollment packet will contain Advance Directive forms. You do not need to use a lawyer, but you may wish to speak with one about this important issue. You can change your mind at any time, and simply need to contact your Case Manager should you wish to make any changes to an Advance Directive.
10. INFORMATION THE EXTENDED MLTC WILL PROVIDE UPON REQUEST

The following information will be provided upon request of a member or a potential member:

- Information on the structure and operation of the Extended MLTC Program
- A list of names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the plan
- Copy of the most recent annual certified financial statement of the plan, including a balance sheet and summary of receipts and disbursements prepared by CPA
- Procedures for protecting the confidentiality of medical records and other enrollee
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and improvement program
- Description of procedures followed by the plan in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials
- Specific written clinical review criteria relating to a particular condition or disease and where appropriate, other clinical information which the plan might consider in its utilization review process
- Written application procedures and minimum qualification requirements for health care providers

NOTICE OF NON-DISCRIMINATION

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

Extended MLTC provides the following:
Free aids and services to people with disabilities to help you communicate with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, call Extended MLTC at 1-855-299-6492. For TTY/TDD services, call 711.

If you believe that Extended MLTC has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Extended MLTC by:
- Mail: Attn: Extended MLTC Compliance Officer
  21 Penn Plaza, Suite 304
  New York, NY 10001-2851
- Phone: 1-855-299-6492 (for TTY/TDD services, call 711)
- Fax: 1-212-563-9124
- In person: 21 Penn Plaza, Suite 304, New York, NY 10001
- Email: ComplianceMLTC@extendedhc.net

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:
- Web: Office for Civil Rights Complaint Portal at
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW.,
  Room 509F, HHH Building,
  Washington, DC 20201,
  Complaint forms are available at
- Phone: 1-800-868-1019 (TTY/TDD 800-537-7697)

**LANGUAGE ASSISTANCE**

**ATTENTION:** Language assistance services, free of charge, are available to you. Call 1-855-299-6492, TTY/TDD: 711
### ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-299-6492, TTY/TDD: 711

### 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-299-6492, TTY/TDD: 711


### 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-299-6492, TTY/TDD: 711

<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
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</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-299-6492, TTY/TDD: 711</td>
</tr>
<tr>
<td>Chinese</td>
<td>注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-299-6492, TTY/TDD: 711</td>
</tr>
<tr>
<td>Russian</td>
<td>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-299-6492, телетайп: 711</td>
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<tr>
<td>Italian</td>
<td>ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-299-6492, TTY/TDD: 711</td>
</tr>
<tr>
<td>French</td>
<td>ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-299-6492, ATS : 711</td>
</tr>
<tr>
<td>French Creole</td>
<td>ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-299-6492, TTY/TDD: 711</td>
</tr>
<tr>
<td>Yiddish</td>
<td>אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-299-6492, TTY/TDD: 711</td>
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<tr>
<td>Polish</td>
<td>UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-299-6492, TTY/TDD: 711</td>
</tr>
<tr>
<td>Tagalog</td>
<td>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-299-6492, TTY/TDD: 711</td>
</tr>
<tr>
<td>Bengali</td>
<td>লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিচেরচার্চ ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-855-299-6492 (TTY: 711)।</td>
</tr>
<tr>
<td>Albanian</td>
<td>KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-299-6492, TTY/TDD: 711</td>
</tr>
<tr>
<td>Greek</td>
<td>ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-299-6492, TTY/TDD:711</td>
</tr>
<tr>
<td>Urdu</td>
<td>خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-855-299-6492,</td>
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</table>

**Page - 45 - of 46**
TTY/TDD: 711.