Medicaid Advantage Plus Model Handbook

WELCOME TO INTEGRA SYNERGY MEDICAID ADVANTAGE PLUS (MAP) (HMO SNP) PROGRAM

Welcome to Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP). The Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Program is especially designed for people who have Medicare and Medicaid and who need health and long-term care services like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) covers since you are enrolled in the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Program. It also tells you how to request a service, file a complaint or disenroll from Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Program. The benefits described in this handbook are in addition to the Medicare benefits described in the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Medicare Evidence of Coverage. Keep this handbook with the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

HELP FROM CUSTOMER SERVICE

You can call us at any time at the Customer Service number below.

There is someone to help you at Customer Service:
Seven days a week from October 1 through March 31, 8:00 a.m. to 8:00 p.m.
Monday through Friday from April 1 through September 30, 8:00 a.m. to 8:00 p.m.
Call (877) 388-5195; For TTY, call 711.
If you need help at other times, call us at (877) 388-5195

Integra provides the following: Free aids and services to people with disabilities to help you communicate with us, such as Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) at (877) 388-5195. For TTY, call 711.

ELIGIBILITY FOR ENROLLMENT IN THE INTEGRA SYNERGY MEDICAID ADVANTAGE PLUS (MAP) (HMO SNP) PROGRAM

The Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) is a program for people who have both Medicare and Medicaid. You are eligible to join the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Program if you are also enrolled in Integra Synergy (HMO SNP) for Medicare coverage and:

1) Are age **18** and older
2) Reside in the plan's service area which is Bronx, Kings, New York, Queens and Nassau counties
3) Have Medicaid
4) Have evidence of Medicare Part A & B coverage,
5) Are eligible for nursing home level of care (as of time of enrollment) using the Uniform Assessment System (UAS)
6) Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety
7) Are expected to require at least one of the following Community Based Long Term Care Services (CBLTCS) covered by the Medicaid Advantage Plus Plan for more than 120 days from the effective date of enrollment:
    a. Nursing services in the home
    b. Therapies in the home
    c. Home health aide services
    d. Personal care services in the home
    e. Adult day health care,
    f. Private duty nursing; or
    g. Consumer Directed Personal Assistance Services

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), 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 Contractor upon discharge or termination from the inpatient hospital, facility licensed by the OMH, OASAS or OPWDD, 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 Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP). Enrollment in the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Program is voluntary.

Enrollment Process

The enrollment process will determine your eligibility for the program and ensure that you are making an informed decision. We take pride in performing our role in this process in a manner that is as convenient as possible for prospective members.

Verification of Interest Call

We will contact you by phone in order to confirm your interest in joining Integra Synergy MAP (HMO SNP) and to gather information that is relevant to the scheduling of your in-home assessment. We will also answer any questions you might have about the assessment and Integra Synergy MAP's (HMO SNP) Program at this time.

If necessary, we will transfer you to the Conflict Free Evaluation and Enrollment Center (CFEEC). You will need an assessment by the CFEEC if you are joining a MAP plan for the first time, if you have not been in an MAP or MLTC plan for forty-five (45) days or longer, or if too much time has elapsed since an earlier CFEEC evaluation. You do not need a CFEEC evaluation if you are already receiving Medicaid home care outside of a managed care plan or if you are already enrolled in an MLTC or MAP plan and would like to switch to Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP).

CFEEC Assessment

The CFEEC is a program of New York State Medicaid and is independent of Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) or any other MAP plan. It is responsible for scheduling and performing the in-home assessment that will determine whether you are eligible to join Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP)
or any other MAP plan.

Once you are connected with the CFEEC, a Counselor will schedule the assessment. You will be asked to confirm your full name, address, birth date, phone number, and Medicaid ID or Social Security Number, so be sure to have this information handy. The CFEEC should be able to schedule the assessment within five (5) to (7) business days.

A CFEEC Registered Nurse will then visit you at your home at the appointed time to conduct the assessment, which takes about three (3) hours. Afterwards, you will be informed whether you qualify for long term care. If you believe that you qualify and the nurse disagrees, you can request a Fair Hearing in order to appeal the nurse's decision (see "State Fair Hearings" under "Actions and Appeal of Actions" below).

To schedule an in-home assessment with the CFEEC:

Monday through Friday 8:30 AM to 8:00 PM
Saturday 10 AM to 6 PM
Call 1-855-222-8350 (TTY: 1-888-329-1546),
CFEEC counselors are fluent in all languages.

Integra Synergy MAP's (HMO SNP) Pre-Enrollment Assessment

Once it is determined you are eligible to join a long-term care plan, Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) will schedule your in-home assessment to establish the most appropriate and effective plan of care for you. This will be conducted by one of our Registered Nurses and will take place within thirty (30) days of your initial contact with Integra.

At the time of the assessment, the Assessment Nurse will answer questions you or your caregiver may have and make sure that your decision to enroll in Integra Synergy Medicaid Advantage Plus (MAP)

(HMO SNP) is an informed one. If you decide to enroll, you will complete the enrollment agreement and associated paperwork, and we will let you know when you can expect your enrollment with Integra to start. You will receive a copy of the Provider Directory, which lists all providers available in the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) network. The coverage explained in this Handbook begins the effective date of your enrollment with Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP).

At that time, you may be found not to be eligible if the following happens:

- Unable or unwilling to provide all documentation needed to establish a safe plan of care;
- Unwilling to sign Application Form;
- Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) assessment disagrees with CFEEC assessment, and New York Medicaid Choice (NYMC) upholds the Integra Synergy (HMO SNP) determination; and
- Your PCP refuses to support member's enrollment in Integra Synergy MAP (HMO SNP) and member is unwilling to select an alternative PCP.

The choice of Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) as your MAP plan is completely voluntary on your part. At any time before or during the enrollment process, you can change your mind and withdraw your application. Even after you have completed the application process, you can withdraw from the plan orally or in writing until noon of the 20th day of the month preceding the start date of your enrollment. (So if you were scheduled to start your membership March 1st, you can withdraw until noon on February 20th.) After this point, you will still be able to leave the plan by requesting disenrollment.

Information about your Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) benefits and everything you need to know to make the most of your enrollment is provided in this Handbook. We encourage you to review it and keep it for future reference.

In addition to the process described above, to enroll in Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP), you must also complete a Medicare application. To enroll you in the Medicare benefit program of Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP), we will send a licensed health insurance representative to your home to gather all the needed documents and fill out an application. Within 10 calendar days from the visit, Integra Synergy (HMO SNP) will let you know if any information is missing, or if your Medicare enrollment is accepted or denied. If we need more information, we will send you a letter. Once any missing information is provided and if Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) confirms you are eligible, we will send your application request to Medicare within 7 calendar days. Usually, your enrollment will be in place on the first day of the following month. You must also complete an application for the Medicaid part of the plan.

Denial of Enrollment

If you do not meet eligibility criteria for both the Medicare and Medicaid benefits of Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP), we will send you a letter denying your enrollment in our plan.

If your application is denied, we will let you know within 10 calendar days. Your application can be denied for the following reasons: you do not have both Medicare Parts A and B, you are not legally in the United States, are incarcerated, reside outside our service area of Bronx, Kings, New York, Queens

or Nassau counties, did not provide requested information within the required timeframe, the request was made by someone other than you and that you did not request that person to be your authorized representative or you are ineligible for the Medicaid portion of the MAP plan or you do not meet eligibility requirements.

Withdrawn Requests

If you submit an application to us and change your mind for any reason, you may withdraw your application before noon on the 20th of the month during the enrollment process by calling Customer Service.

If New York Medicaid and/or Medicare have already approved your enrollment and your request to withdraw is after noon on the 20th of the month, your request will be processed as a disenrollment for the following month. Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) will confirm your withdrawal or disenrollment in writing.

Plan Member (ID) Card

You will receive your Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) identification (ID) card within 14 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your identification card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Customer Service at 1-877-388-5195 (TTY: 711).

SERVICES COVERED BY THE INTEGRA SYNERGY MEDICAID ADVANTAGE PLUS (MAP) (HMO SNP) PROGRAM

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Medicare Evidence of Coverage. Sections 2 and 3 of Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Medicare Evidence of Coverage explain the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Section 4 of Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP), and you have Medicaid, Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) will pay these amounts. You do not have to pay these deductibles and co-payments except for those that apply to chiropractic care and pharmacy items. If there is a monthly premium for benefits (see Section 8 of the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Medicare Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

Care Management Services

As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a health care professional – usually a nurse or a social worker. Your care manager will work with you and your doctor to decide the services you need and develop a care plan. Your care manager will also arrange appointments for any services you need and arrange for transportation to those services.

All of our Care Managers are New York State licensed registered nurses, who have at least three (3) years of clinical experience. You can reach your Care Manager by calling Customer Service at (877) 388-5195 and asking for your Care Manager. For TTY, call 711.

Your Care Manager will work with your dedicated team of care management professionals who will be assigned to your care for as long as you are enrolled with us. This team of professionals will work with you, your family, and your health care provider(s) to determine your services and develop a care plan tailored to meet your specific needs. The Care Management Team will arrange for services and work with health and long term care providers to coordinate all aspects of your care. The Care Management Team also works with nurses who make periodic visits to your home to monitor and assess your care needs, ensuring that your care plan is updated as your needs change over time. You have access to your Care Management Team at all times during normal hours of operations and to an on-call Care Manager outside normal business hours. You can access Care Management after hours by calling our Customer Service line which will connect you to our on-call service. Once on-call service answers please request to speak with our on-call nurse who will be able to assist you. You will be assigned a Care Management Team within fourteen (14) days of enrollment. We will do our best to match you to the team that can best meet any special needs you might have, including any need to communicate in a language other than English.

Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) will send you a notice providing information about your Team, and your Care Manager will follow up with an outreach call to introduce him/herself to you and explain how the Care Management Team will be working with you. Your Team will include, but is not limited to, a Care Manager (a Registered Nurse), a Service Coordinator, and a Social Worker. The Team is supported by the Assessment Nurse and Care Management Team Supervisor.

Consumer Directed Personal Assistance Services (CDPAS)

Through the Consumer Directed Personal Assistance Service (CDPAS) Program, members can receive partial or total assistance with personal care tasks, home health aide tasks, and/or skilled nursing tasks. The CDPAS assistant performing these tasks is directed, instructed, and supervised by the member. This allows chronically ill and/or physically disabled members greater flexibility and freedom of choice in receiving their home care services. You may exercise the CDPAS option any time during your enrollment with Integra.

If you opt to use CDPAS, Integra will continue to be responsible for comprehensive assessment and development of a person-centered service plan. However, you (or your representative) are responsible for making decisions regarding CDPAS staff with respect to recruitment, training, scheduling, evaluation, time sheet verification and approval, and discharge.

If you desire, you may terminate CDPAS and receive Personal Care services through an Integra network provider. You also may be involuntarily disenrolled from CDPAS if:

- Continued participation in CDPAS would not permit your health, safety, or welfare needs to be met;
- You demonstrate an inability to carry out the required tasks for CDPAS;
- There is evidence of fraudulent use of Medicaid funds in relation to your participation in CDPAS, such as an indication that CDPAS documents have been falsified.

Additional Covered Services

Because you have Medicaid and qualify for the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) program, our plan will arrange and pay for the extra health and social services described below. You may get these services 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. **In some cases, you may need a referral or an order from your doctor to get these services.** You must get these services from network providers who are in Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP).

You may obtain services from out-of-network providers only in certain circumstances. For example, when you are having an emergency, or urgently need care when you are out of the area (including dialysis services), when in-network providers are not available during a disaster, or when providers of specialized services are not available in network. Except in the case of an emergency, you must receive prior authorization for all services received from out-of-network providers. The provider is responsible for obtaining authorization. For assistance, please call Customer Service at 1-877-388-5195. Our hours are 8 am to 8 pm seven days a week from October 1 to March 31, and 8 am to 8 pm Monday through Friday from April 1 to September 30.

If you cannot find a provider in our plan, and you need a medically necessary service that is covered by Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP), you or your provider can request that we pay for those services from an out of network provider. To make the request, please call Customer Service at (877) 388-5195 and ask to speak to your Care Manager. Refer to "Section 1: Service Authorization Request (also known as Coverage Decision Request)" for details regarding the authorization process.

Your Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Evidence of Coverage explains all of your Medicare and Medicaid benefits. The following is a list of benefits covered by the Medicaid portion of Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP). Some services require prior authorization by the plan, services listed below with an asterisk "*****" require authorization. Referrals required for specialty services. Covered benefits include:

- ***Home Delivered Meals and/or meals in a group setting such as a day care -** Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or have them prepared.
- ***Medical Social Services** - Assessment, arranging and providing aid for social problems related to helping you stay at home.
- ***Personal Care** (such as assistance with bathing, eating, dressing, toileting and walking) - Medically necessary assistance with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks.

- ***Consumer Directed Personal Assistance Services (CDPAS) -** Allows you to receive assistance with personal care services, home health aide services, and skilled nursing tasks from a consumer-directed personal assistant.
- ***Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical and speech therapies. Referral required. Services must be provided by a certified home health agency. Your physician must prescribe these services and obtain authorization from us by calling (877) 388-5195 or sending a request in writing or by fax to (516) 321-4639. Covered services include:
    - Nursing services provided on a part-time or intermittent basis by a registered nurse;
    - Home health aide services as ordered by a physician;
    - Physical therapy, occupational therapy, or speech pathology and audiology services;
    - Medical equipment and supplies.
- ***Nutrition -** These are services provided by a qualified nutritionist that include assessment of nutritional status/needs, development and evaluation of treatment plans, nutritional education, in– service education, and the planning of your diet. This also includes cultural considerations.
- ***Social Day Care -** Structured comprehensive program providing socialization; supervision, monitoring; personal care, nutrition in a protective setting **-** during any part of the day, but for less than a twenty-four (24) hour period.
- ***Non-Emergency Transportation -** Transportation you might need that is NOT an emergency, in order to obtain plan-covered, necessary medical care and services under the plan´s benefits or Medicaid fee–for–service. Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to your medical condition. Includes a transportation attendant to accompany you, if necessary. Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) partners with Modivcare to fulfill your non-emergent transportation needs.
- ***Private Duty Nursing -** Private duty nursing services are covered only when determined by your physician to be medically necessary. Nursing services may be intermittent, part-time or continuous and must be provided in the home in accordance with the ordering physician's or certified nurse practitioner's written treatment plan. These services must be provided through an approved certified home health agency, a licensed home care agency, or a private practitioner. Your PCP or plan specialist must call us to get authorization for these services. Referral required.
- ***Dental** – Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) partners with HealthPlex to provide Medicare and Medicaid covered dental services. Medicaid-covered dental services include necessary preventive, prophylactic and other routing dental care, services and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services require prior authorization. Oral surgery, when not covered by Medicare, requires authorization.
- ***Social/Environmental Supports** (such as chore services, home modifications or respite) - this includes services and items to support your medical need. May include home maintenance tasks, homemaker/chore services, housing improvement, and respite care.
- ***Personal Emergency Response System -** This is an electronic alarm device that allows you to more easily signal for help in the event of an emergency.
- ***Adult Day Health Care -** Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.

- ***Nursing Home Care not covered by Medicare** (provided you are eligible for institutional Medicaid) - Most nursing home care is custodial care. Custodial care helps you with activities of daily living (like bathing, dressing, using the bathroom, and eating) or personal needs that could be done safely and reasonably without professional skills or training.
- ***Outpatient Rehabilitation -** Occupational therapy (OT), physical therapy (PT) and speech and language therapy (ST). Medicaid covered OT and ST
- ***Medical and Surgical Supplies, Parenteral Formula, Enteral Formula, Nutritional Supplements and Hearing Aid Batteries** - These items are generally considered to be one-time only use, consumable items routinely paid for under the Durable Medical Equipment category of fee-for–service Medicaid. Limitations are described in the next section below.
- ***Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit -** If you exceed the inpatient mental health benefit limit under your Medicare Evidence of Coverage, you are eligible for up to 365 days per year of medically necessary care under the Medicaid portion of Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP). These services require pre-authorization. Your physician should call us at (877) 388-5195 or send a request in writing or by fax to (516) 321-4639.
- ***Audiology -** This includes examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts.
- ***Durable Medical Equipment (DME) -** Medicare and Medicaid covered durable medical equipment, including devices and equipment other than prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use. Must be ordered by a qualified practitioner. No homebound prerequisite and including non-Medicare DME covered by Medicaid (e.g. tub stool; grab bars).
- ***Prosthetics and Orthotics -** Medicare and Medicaid covered prosthetics, orthotics and orthopedic footwear. Prosthetic appliances and devices which replace any missing part of the body. Orthotic appliances and devices are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.
- ***Optometry -** Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed.

Limitations

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

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

Getting Care outside the Service Area
You must inform your care manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your care manger should be contacted to assist you in arranging services.

Emergency Service
Emergency Service means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial 911. As noted above, prior authorization is not needed for emergency service. However, you should notify Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) within 24 hours of the emergency. You may be in need of long term care services that can only be provided through Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP).

If you are hospitalized, a family member or other caregiver should contact Integra Synergy MAP (HMO SNP) within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) so that we may work with them to plan your care upon discharge from the hospital.

Transitional care procedures
New enrollees in Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider if the provider accepts payment at the plan rate, adheres to Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) quality assurance and other policies, and provides medical information about the care to the plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

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

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

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

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

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

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) does not cover. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Customer Service at (877) 388-5195 if you have a question about whether a benefit is covered by Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy
Most prescription drugs are covered by Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Medicare Part D as described in section 6 of the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Medicare.

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

Certain Mental Retardation and Developmental Disabilities Services, including:
- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

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

FAMILY PLANNING

Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).

SERVICES NOT COVERED BY INTEGRA SYNERGY MEDICAID ADVANTAGE PLUS (MAP) (HMO SNP) PROGRAM OR MEDICAID

You must pay for services that are not covered by Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) 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 Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a Provider that is not part of the plan (unless Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) sends you to that provider)

If you have any questions, call Customer Service at Customer Service (877) 388-5195.

SERVICE AUTHORIZATION, APPEALS AND COMPLAINTS PROCESSES

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

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page 23 for more information on the External Appeals process.

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

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

When you ask for approval of a treatment or service, it is called a **service authorization request (also known as a coverage decision request)**. To get a service authorization request, you or your doctor should call our toll-free Customer Service number at (877) 388-5195, or send your request in writing to Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP), P.O. Box 18023, Hauppauge, NY 11788. You can also submit a request by fax to (516) 321-4639.

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

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- **Outpatient Rehabilitation**
- **Personal Care** (such as assistance with bathing, eating, dressing, toileting and walking)
- **Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical and speech therapies
- **Nutrition**
- **Medical Social Services**
- **Home Delivered Meals and/or meals in a group setting such as a day care**
- **Social Day Care**
- **Non-Emergency Transportation**
- **Private Duty Nursing**
- **Dental**
- **Social/Environmental Supports** (such as chore services, home modifications or respite)
- **Personal Emergency Response System**
- **Adult Day Health Care**
- **Nursing Home Care not covered by Medicare (provided you are eligible for institutional Medicaid)**
- **Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit Audiology**
- **DME**
- **Medical Supplies**
- **Prosthetics and Orthotics**
- **Optometry**
- **Consumer Directed Personal Assistance Services**
- **Acupuncture for chronic low back pain**
- **Ambulance services**
  - Prior authorization is required for air ambulance services and non-emergency ambulance services.

- **Cardiac rehabilitation services**
- **Chiropractic services**
- **Diabetic Supplies and Services including Nutrition Services**
- **Dialysis Services**
- **Hearing services**
- **Home Health Services**
- **Home Infusion Therapy**
- **Inpatient hospital care**
- **Inpatient mental health care**
- **Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay**
- **Medicare Part B prescription drugs**
- **Opioid treatment program services**
- **Outpatient Blood Services**
- **Outpatient diagnostic tests and therapeutic services and supplies**
- **Outpatient DIAG/THERAPEUTIC RAD Services**
- **Outpatient hospital bbservation**
- **Outpatient hospital services**
- **Outpatient mental health care**
- **Outpatient rehabilitation services**
- **Outpatient substance abuse services**
- **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**
- **Physical Therapy & Speech-Language Pathology Services**
- **Podiatry services**
- **Prosthetic devices and related supplies**
- **Pulmonary rehabilitation services**
- Respite Care
- **Services to treat kidney disease**
- **Skilled nursing facility (SNF) care**
- **Supervised Exercise Therapy (SET)**
- **Other Medicare-Covered Preventive Services:**
    - **Glaucoma Screening**
    - **Diabetes Self-Management Training**
    - **Barium Enemas**
    - **Digital Rectal Exams**
    - **EKG following Welcome Visit**

To get a service authorization request you or your doctor should call our toll-free Customer Service number at (877) 388-5195, or send your request in writing to Integra Managed Care, P.O. Box 18023, Hauppauge, NY 11788. You can also submit a request by fax to (516) 321-4639.

Concurrent Review
You will also need to get prior authorization if you are getting one of these services now, but need to get more of the care during an authorization period. This includes a request for Medicaid covered home health care services following an inpatient hospital stay. This is called **concurrent review**.

Retrospective Review
Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

What happens after we get your service authorization request
The health plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than you asked for. A qualified health care professional will make these decisions. If we decide that the service you asked for is not medically necessary, a clinical peer reviewer will make the decision. A clinical peer reviewer may be a doctor, a nurse, or a health care professional who typically provides the care you asked for. You can ask for the specific medical standards, called **clinical review criteria**, used to make the decision about medical necessity.

After we get your request, we will review it under either a **standard** or a **fast track** process. You or your provider can ask for a fast track review if you or your provider believes that a delay will cause serious harm to your health. If we deny your request for a fast track review, we will tell you and handle your request under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below. More information on the fast track process is below.

We will tell you and your provider both by phone and in writing if we approve or deny your request. We will also tell you the reason for the decision. We will explain what options you have if you don't agree with our decision.

Standard Process
Generally, we use the **standard timeframe** for giving you our decision about your request for a medical item or service unless we have agreed to use the fast track deadlines.

- A standard review for a prior authorization request means we will give you an answer within 3 work days of when we have all the information we need, but no later than **14 calendar days** after we get your request. If your case is a **concurrent review** where you are asking for a change to a service you are already getting, we will make a decision within 1 work day of when we have all the information we need, but will give you an answer no later than 14 calendar days after we get your request.
- **We can take up to 14 more calendar days** if you ask for more time or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

- If you believe we should **not** take extra days, you can file a **"fast complaint."** When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan.)

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

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

Fast Track Process

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

- A fast review of a prior authorization request means we will give you an answer within 1 work day of when we have all the information we need but no later than **72 hours** from when you made your request to us**.**
- We can take **up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If you believe we should not take extra days, **you can file a "fast complaint"** (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.) We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 2: Level 1 Appeals, below for how to make an appeal.

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

1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a fast service authorization if your request is about payment for medical care you already got.)
2. Using the standard deadlines could cause serious harm to your life or health, or hurt your ability to function.

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

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

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

- This letter will tell you that if your provider asks for the fast service authorization, we will automatically give a fast service authorization.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan later in this chapter.)

If our answer is yes to part or all of what you asked for, we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service authorization on your request for a medical item or service, we will give you our answer by the end of that extended period.

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

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

If we are changing a service you are already getting

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

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

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

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

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).

- Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) can also explain the complaints and appeals processes available to you depending on your complaint. You can call Customer Service at 1-877-388-5195 to get more information on your rights and the options available to you.

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

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

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

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

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

You can file a Level 1 Appeal:

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

Steps to file a Level 1 Appeal:

- If you are not satisfied with our decision, you have **60 days** from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for asking for an appeal.
- If you are appealing a decision we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a **"fast appeal."**
    - The requirements and procedures for getting a "fast appeal" are the same as for getting a "fast track service authorization." To ask for a fast appeal, follow the instructions for asking for a fast track service authorization. (These instructions are given in Section 1, in the Fast Track Process section.)
    - If your provider tells us that your health requires a "fast appeal," we will give you a fast appeal.
    - If your case was a **concurrent review** where we were reviewing a service you are already getting, you will automatically get a fast appeal.
- You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you. You can call Customer Service at 1-877-388-5195 if you need help filing a Level 1 Appeal.
    - Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage

Determination Notice, complete an "Appointment of Representative" form, or write and sign a letter naming your representative.

  - To get an "Appointment of Representative" form, call Member Services and ask for the form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf *or on our website at www.integramanagedcare.com*. The form gives the person permission to act for you. You must give us a copy of the signed form; OR

  - You can write a letter and send it to us. (Your or the person named in the letter as your representative can send us the letter.)

- We will not treat you any differently or act badly toward you because you file a Level 1 Appeal.
- You can make the Level 1 Appeal by phone or in writing.

Continuing your service or item while appealing a decision about your care

If we told you we were going to stop, suspend, or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking action.
- If you disagree with the action, you can file a Level 1 Appeal.
- We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.
- **Note:** If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative.

What happens after we get your Level 1 Appeal

- Within 15 days, we will send you a letter to let you know we are working on your Level 1 Appeal. We will let you know if we need additional information to make our decision.
- We will send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records we will use to make the appeal decision. If your Level 1 Appeal is fast tracked, there may be a short time to review this information.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

- You can also provide information to be used in making the decision in person or in writing. Call us at 1-877-388-5195 if you are not sure what information to give us.
- We will give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you asked for we will send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we will **automatically** send your case on to the next level of the appeals process.

Timeframes for a "standard" appeal

- If we are using the standard appeal timeframes, we must give you our answer on a request **within 30 calendar days** after we get your appeal if your appeal is about coverage for services you have not gotten yet.
- We will give you our decision sooner if your health condition requires us to.
- However, if you ask for more time or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide we need to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
    - If you believe we should **not** take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
    - For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.
- If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process.
    - An independent outside organization will review it.
    - We talk about this review organization and explain what happens at Level 2 of the appeals process in Section 3: Level 2 Appeals.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision.
- **If our answer is no to part or all of what you asked for**, to make sure we followed all the rules when we said no to your appeal, **we are required to send your appeal to the next level of appeal.** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Timeframes for a "fast" appeal

- When we are using the fast timeframes, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to do so.
- If you ask for more time or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

- If we do not give you an answer within 72 hours (or by the end of the extra days we took), we are required to automatically send your request on to Level 2 of the appeals process which is discussed below in Section 3: Level 2 Appeals.

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

If our answer is no to part or all of what you asked for, we will automatically send your appeal to an independent review organization for a Level 2 Appeal. You or someone you trust can also file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal.

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

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

Section 3: Level 2 Appeals

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

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

- **The Hearing Office is an independent New York State agency**. It is not connected with us. Medicare and Medicaid oversee its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a free copy of your case file**.
- You have a right to give the Hearing Office additional information to support your appeal.
- Reviewers at the Hearing Office will take a careful look at all of the information related to your appeal. The Hearing Office will contact you to schedule a hearing.
- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed by waiting for a decision under a standard timeframe, you will automatically get a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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

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

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 17 for information about continuing your benefits during Level 1 Appeals.

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

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

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

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

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

Section 4: External Appeals for Medicaid Only

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

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

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

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

Before you appeal to the state:

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

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

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

- You can call Member Services at 1-877-388-5195 if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov.
- Contact the health plan at 1-877-388-5195

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

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

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

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

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

We hope our plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Customer Service at 1-877-388-5195 or write to Customer Service. **The formal name for "making a complaint" is "filing a grievance."**

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

How to File a Complaint:

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. You can call 1-877-388-5195, TTY: 711, 8:00 a.m. to 8:00 p.m. seven days a week. Between April 1 and September 30, hours are 8:00 a.m. to 8:00 p.m. Monday through Friday.
- If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- To file by phone, call Customer Service at 1-877-388-5195, TTY: 711, 8:00 a.m. to 8:00 p.m. seven days a week. Between April 1 and September 30, hours are 8:00 a.m. to 8:00 p.m. Monday through Friday. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you.
- **Whether you call or write, you should contact Customer Service right away.** You can make the complaint at any time after you had the problem you want to complain about.

What happens next:

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

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

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

Complaint Appeals

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

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;
- You must make the complaint appeal in writing.
  - If you make an appeal by phone, you must follow it up in writing.
  - After your call, we will send you a form that summarizes your phone appeal.
  - If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

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

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

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

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

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

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

Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MAP plan like Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP). This support includes unbiased health plan choice counseling and general program related information. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)
Web: www.icannys.org | Email: ican@cssny.org

DISENROLLMENT FROM INTEGRA SYNERGY MEDICAID ADVANTAGE PLUS (MAP) (HMO SNP) PROGRAM

Enrollees shall not be disenrolled from the Medicaid Advantage Plus Product based on any of the following reasons:

High utilization of covered medical services, an existing condition or a change in the Enrollee's health, diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs unless the behavior results in the Enrollee becoming ineligible for Medicaid Advantage Plus.

<u>You Can Choose to Voluntarily Disenroll</u>

You can ask to leave the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) Program at any time for any reason.

To request disenrollment, call 1-877-388-5195 It could take up to six weeks to process, depending on when your request is received.

You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require Community Based Long Term Care (CBLTC) services, like personal care, you must join another MLTC plan or Home and Community Based Waiver program, in order to receive CBLTC services.

You Will Have to Leave Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP), MAP Program if:

- You no longer are in Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) for your Medicare coverage
- You no longer are Medicaid eligible
- You need nursing home care, but are not eligible for institutional Medicaid
- You are out of the plan's service area for more than 30 consecutive days
- You permanently move out of the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) service area
- You no longer require a nursing home level of care as determined using the Uniform Assessment System (UAS) or other tool designated by SDOH
- You are no longer eligible for nursing home level of care as determined at any comprehensive assessment using the assessment tool prescribed by the SDOH, unless the Contractor, or the LDSS or entity designated by the State agree that termination of the services provided by the Contractor could reasonably be expected to result in the Enrollee being eligible for nursing home level of care (as determined with the assessment tool prescribed by the SDOH) within the succeeding six-month period. The Contractor shall provide the LDSS or entity designated by the State the results of its assessment and recommendations regarding continued enrollment or disenrollment within five (5) business days of the comprehensive assessment;
- At point of any reassessment while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTC services;
- Your sole service is identified as Social Day Care must be disenrolled from the MAP plan
- You join a Home and Community Based Services Waiver program, or are enrolled in a program or become a resident in a facility that is under the auspices of the Offices for People with Developmental Disabilities, or Alcoholism and Substance Abuse Services.

We Can Ask You to Leave the Plan

We will ask that you leave Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) if:

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

Before being involuntarily disenrolled, Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) will obtain the approval of NYMC or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which the disenrollment is processed. If you continue to need community based long term care services, you will be required to choose another plan or you will be auto assigned to another plan to provide you with coverage for needed services.

We will notify you by mail if we need to disenroll you from our plan for one of the reasons listed above. Our Care Management staff will continue to provide and arrange for covered services until the date on which your disenrollment takes effect.

CULTURAL AND LINGUISTIC COMPETENCY

Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all enrollees. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

MEMBER RIGHTS AND RESPONSIBILITIES

Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

Member Rights

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

- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

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

Advance Directives

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

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents. If you already have an advanced directive please share a copy with your care manager.

Information Available on Request

- Information regarding the structure and operation of Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP);
- Specific clinical review criteria relating to a particular health condition and other information that Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) considers when authorizing services;
- Policies and procedures on protected health information;
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program;
- Provider credentialing policies;
- A recent copy of the Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) certified financial statement; and policies and procedures used by Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) to determine eligibility of a provider

NON-DISCRIMINATION

Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability. Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) at (877) 388-5195 (TTY: 711)

If you believe that Integra Synergy Medicaid Advantage Plus (MAP) (HMO SNP) has not provided you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Integra by:

- Mail: Integra Managed Care, Inc.
  Attn: Appeals & Grievances Department.
  P.O. Box 18023
  Hauppauge, NY 11788
- Phone: (877) 388-5195 (TTY: 711) Monday through Friday
  8:00 AM to 8:00 PM.

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 available at
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- Phone: 1-800-868-1019 (TTY/TDD: 1-800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-877-388-5195; (TTY/TDD: 711).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-388-5195; (TTY/TDD: 711).	Spanish
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1-877-388-5195; (TTY/TDD: 711).	Chinese
اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-388-5195 (TTY/TDD: 711) رقم هاتف الصم والبكم	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-877-388-5195, (TTY/TDD: 711) 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-388-5195 (телетайп: TTY/TDD: 711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-388-5195; (TTY/TDD: 711).	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-388-5195; (TTY/TDD: 711).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-388-5195; (TTY/TDD: 711).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-877-388-5195> (TTY/TTD 711)	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-388-5195; (TTY/TDD: 711).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-388-5195; (TTY/TDD: 711).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১- 1-877-388-5195: (TTY/TDD: 711).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-388-5195; (TTY/TDD: 711).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-388-5195; (TTY/TDD: 711).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-388-5195 (TTY/TDD: 711)	Urdu