HEALTHFIRST COMPLETECARE (HMO SNP)

January 1 – December 31, 2019

MEMBER HANDBOOK

MEDICAID ADVANTAGE PLUS PLAN

NEW YORK: BRONX, KINGS, NASSAU, NEW YORK, QUEENS, RICHMOND, AND WESTCHESTER COUNTIES

1-888-260-1010 (TTY 1-888-542-3821)
7 days a week, 8 a.m. to 8 p.m.

www.healthfirst.org/medicare

Healthfirst Health Plan, Inc., is an HMO plan with a Medicare contract and a contract with the New York Medicaid program. Enrollment in Healthfirst Medicare Plan depends on contract renewal.

H3359_MSD19_48 CCHB_C CMS Approved 03132019
TELEPHONE NUMBERS

Member Services ............................................................... 1-888-260-1010
7 days a week, 8am-8pm (TTY 1-888-542-3821)

New York State Health Dept. (Complaints) ............... 1-866-712-7197

New York City Human Resources Administration .......... 1-718-557-1399

New York Medicaid CHOICE ........................................... 1-888-401-6582
(For Long-Term Care Information) (TTY 1-888-329-1541)

New York Medicaid CHOICE (All Other Reasons) ........ 1-800-505-5678
(TTY 1-888-329-1541)

The Health Insurance Information Counseling and Assistance Program (HIICAP) .............. 1-800-701-0501
# Table of Contents

- **Welcome to Healthfirst CompleteCare (HMO SNP)** ................................................................. 4
- **Medicaid Advantage Plus Program** .......................................................................................... 4
- **Help from Member Services** ....................................................................................................... 4
- **Eligibility for Enrollment in the Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program** .................................................................................................................. 4
- **Enrollment in Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program** ................................................................................................................................. 5
- **Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program Will Treat Your With Fairness and Respect at All Times** ................................................................. 6
- **Transitional Care** .......................................................................................................................... 6
- **Monthly Spend Down** ................................................................................................................... 7
- **Services Covered by the Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program** .............................................................................................................................. 8
- **Medicaid Services Not Covered by Our Plan** ............................................................................. 16
- **Services Not Covered by Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program** .......................................................................................................................... 17
- **Service Authorizations and Actions** .......................................................................................... 17
- **What to Do If You Have a Complaint About Our Plan or Want to Appeal a Decision About Your Care** ..................................................................................................................... 20
- **Medicaid Rules for Appeals and Complaints** .......................................................................... 21
- **Disenrollment from Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program** ............................................................................................................................. 28
- **Rights and Responsibilities** ......................................................................................................... 30
- **Advanced Directives** ................................................................................................................... 32
- **Notice of Information Available on Request** ........................................................................... 34
WELCOME TO HEALTHFIRST COMPLETECARE (HMO SNP)
MEDICAID ADVANTAGE PLUS PROGRAM

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

HELP FROM MEMBER SERVICES

There is someone to help you at Member Services:
7 days a week
8 am to 8 pm
Call 1-888-260-1010 (TTY 1-888-542-3821)

ELIGIBILITY FOR ENROLLMENT IN THE HEALTHFIRST COMPLETECARE (HMO SNP) MEDICAID ADVANTAGE PLUS PROGRAM

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

1) Are age 18 and older
2) Reside in the plan’s service area (Bronx, Kings, Nassau, New York, Queens, Richmond and Westchester Counties)
3) Have a chronic illness or disability that makes you eligible for nursing home level of care
4) Are able to stay safely at home at the time you join the plan
5) Are expected to require one or more of the Community Based Long-Term Care Services (CBLTCS) for more than 120 days from the date that you join our plan:
   a. Nursing services in the home
   b. Therapies in the home
   c. Home health aide services
   d. Personal care services in the home
   e. Private duty nursing
   f. Adult day health care, or
   g. Consumer Directed Personal Assistance Services
6) You do not have End Stage Renal Disease
7) You are determined eligible for long term care services by Healthfirst or an entity designated by the Department of Health using the current NYS eligibility tool.
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, a Comprehensive Medicaid Case Management Program (CMCM) 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, CMCM or OPWDD Day Treatment Program.

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program. Enrollment in the Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program is voluntary.

**ENROLLMENT IN HEALTHFIRST COMPLETECARE (HMO SNP) MEDICAID ADVANTAGE PLUS PROGRAM**

Individuals interested in enrolling in Healthfirst CompleteCare (HMO SNP) and new to Community Based Long Term Care Services must contact the Conflict-Free Evaluation and Enrollment Center (CFEEC) at 1-855-222-8350, Monday to Friday, 8:30 am-8 pm, Saturday, 10 am-6 pm, or visit [www.nymedicaidchoice.com](http://www.nymedicaidchoice.com) to find out if they are eligible to enroll. A conflict free evaluation is only needed if you are new to long-term care services and enrolling for the first time or if you have not been enrolled in a plan for 45 days. If you are transferring from an MLTC, mainstream Medicaid or another MAP, you’re not required to get a conflict free evaluation. Healthfirst CompleteCare (HMO SNP) will process applications in the order in which they are received.

Once New York Medicaid Choice and Healthfirst CompleteCare (HMO SNP) have determined that you are eligible to enroll, your Medicare application will be submitted to CMS. If CMS confirms your enrollment into Healthfirst CompleteCare (HMO SNP), the application and corresponding Medicare Advantage Plus attestation will be submitted to New York Medicaid Choice (NYMC). All enrollment applications must be signed no later than the 15th of the month in order for the application to be reviewed and submitted to NYMC by noon on the 20th of the month to ensure an effective date of the first day of the following month. The effective date of enrollment will be given to you at the time of enrollment. If the effective date changes, Healthfirst CompleteCare (HMO SNP) will notify you of the revised effective date. Healthfirst CompleteCare (HMO SNP) members will receive a confirmation of enrollment letter which will indicate your effective date of enrollment.

After your application is verified and approved, Healthfirst CompleteCare (HMO SNP) will send your Member ID card within 10 calendar days. However, if we received and processed your enrollment request towards the end of the month, you may not receive your ID card before your effective date for the following month. If you don’t have your ID card and need to see a doctor, call Member Services to verify your coverage and they will fax your eligibility information to your provider. If you have received your confirmation of enrollment letter, you may also use this letter as a proof of coverage until you get Member ID card.

If CMS rejects the enrollment, after the enrollment has been submitted to NYMC or LDSS, Healthfirst CompleteCare (HMO SNP) will notify NYMC or LDSS within five (5) days of receiving the rejection and you will receive a denial of enrollment letter. If NYMC or LDSS rejects the enrollment because you did not meet the eligibility requirements, NYMC or LDSS will notify the plan in writing. If Healthfirst CompleteCare (HMO SNP) disagrees with NYMC’s...
decision, we will follow the dispute resolution process that is approved by SDOH. If the plan does not dispute the rejection or you are found not to meet the criteria for enrollment after the dispute process is completed, NYMC or LDSS will proceed with your denial of enrollment. If you decide to withdraw your enrollment application prior to the effective date of enrollment, Healthfirst CompleteCare (HMO SNP) will notify NYMC or LDSS of the withdrawal via fax. Your request for withdrawal must be received by the 20th of the month. Healthfirst CompleteCare (HMO SNP) will send you a confirmation of cancellation notice.

Long-term care services are no longer covered by New York’s Fee-For-Service Medicaid Program so the state may require you to join a managed long-term care plan (MLTCP) to receive these services. If you need to contact NY Medicaid Choice, please call 1-888-401-6582 (TTY 1-888-329-1541).

HEALTHFIRST COMPLETECARE (HMO SNP) MEDICAID ADVANTAGE PLUS PROGRAM WILL TREAT YOU WITH FAIRNESS AND RESPECT AT ALL TIMES

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on age, sex (including gender identity or status of being transgender), race, creed, physical or mental disability (including gender dysphoria), developmental disability, national origin, sexual orientation, type of illness or condition, or the need for health services.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. If you need to contact NY Medicaid Choice, please call 1-888-401-6582 (TTY 1-888-329-1541).

If you have a disability and need help with access to care, please call Member Services at 1-888-260-1010 (TTY 1-888-542-3821). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Network providers will be paid in full directly by Healthfirst CompleteCare (HMO SNP) 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 Healthfirst CompleteCare (HMO SNP), you are not responsible to pay the bill, please contact your Care Manager. You may be responsible for payment of covered services that were not authorized by Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program or for covered services that are obtained by providers outside of the Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program network.

TRANSITIONAL CARE

New enrollees 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 plan quality assistance and other policies, and provides medical information about your care to the plan.

When your health care 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.
MONTHLY SPEND DOWN

Spend down amounts or surplus amounts are the amounts of net available income determined by the New York City Human Resources Administration or Local District of Social Services that a member must pay monthly to Healthfirst CompleteCare (HMO SNP) in accordance with the requirements of the medical assistance program. Healthfirst CompleteCare (HMO SNP) members with a surplus will receive a monthly invoice on or about the 15th of each month.

The amount for which you will be responsible for paying to us will depend on your eligibility for Medicaid and Medicaid’s monthly spend down program.

<table>
<thead>
<tr>
<th>If you are eligible for:</th>
<th>You will pay:</th>
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<tbody>
<tr>
<td>Medicaid (no monthly spend down)</td>
<td>Nothing to Healthfirst CompleteCare (HMO SNP)</td>
</tr>
<tr>
<td>Medicaid (with monthly spend down)</td>
<td>A monthly spend down to Healthfirst CompleteCare (HMO SNP) as determined by New York City Human Resources Administration / Local District of Social Services</td>
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If you are eligible for Medicaid with a spend down and your spend down changes while you are a Healthfirst CompleteCare (HMO SNP) member, your monthly payment will be adjusted.

Money Follows the Person (MFP)/ Open Doors

There are 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 your community

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help 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 to mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.
SERVICES COVERED BY THE HEALTHFIRST COMPLETECARE (HMO SNP) MEDICAID ADVANTAGE PLUS 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 Healthfirst CompleteCare (HMO SNP) Evidence of Coverage. Chapter 3 of the Healthfirst CompleteCare (HMO SNP) Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. There are no deductibles and copayments. Please read Chapter 4 of the Healthfirst CompleteCare (HMO SNP) Medicare Evidence of Coverage What is Covered

If there is a monthly premium for benefits (see Chapter 1) of the Healthfirst CompleteCare (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 Management Team (CMT) which includes a nurse, a social worker, and other support staff. The care manager nurse is a licensed professional and will help you manage your medical needs. The social worker in the care management team is also a licensed professional and will help you with your long-term needs and psychosocial and environmental needs. The support coordinator will help you set up appointments and make arrangements for transportation. Your care management team will work with you and your doctor to decide the services you need and develop a care plan. The team will also arrange appointments for any services you need and arrange for transportation to those services.

The CMT works closely with the assessment nurse who conducts a face-to-face assessment when you are engaged in the enrollment process. The assessment nurse will come to your home at least every 6 months to see you and make sure your care plan is up to date with your needs. This assessment is an important part of your care.

You do not have to ask for care management services. The CMT will contact you once you are enrolled in our plan as a Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus member. You will receive a phone number for the CMT which you can call and reach them directly for any questions or requests for assistance. You will receive a call each month from a member of your Care Management Team who will ask health related questions as a monthly screening of the your condition in order to develop and update your care plan. We want you to be involved in your care plans and make some of the decisions about how to stay healthy and safe in your home.

Additional Covered Services

Because you have Medicaid and qualify for the Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus 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 the providers who are in the Healthfirst CompleteCare (HMO SNP) provider network.

If you cannot find a provider in our plan, you must seek prior authorization from Healthfirst CompleteCare (HMO SNP) before receiving any health services from an out-of-network provider, except when it is for a medical emergency or urgently needed care. In order to obtain prior authorization for the services from an out-of-network provider, you or your doctor must call Healthfirst Medical Management at 1-888-394-4327 (TTY 1-888-542-3821).

- **Personal Care**

  Personal care services are the provision of some or total assistance with such activities as personal hygiene; dressing and feeding; toileting; walking; meal preparation; and housekeeping. Such services must be essential to the maintenance of your health and safety in your own home.

  Personal care services require a physician’s order, prior approval, and must be medically necessary.

- **Consumer Directed Personal Assistance Services**

  This is a specialized program 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.

  Services include some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping, as well as home health aide and nursing tasks. This is provided by an aide chosen and directed by the member or a designated representative.

**Home Health Care Services Not Covered by Medicare**

Medicaid-covered home health services include the provision of skilled services not covered by Medicare (e.g., physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and/or home health aide services as required by an approved plan of care.

Home health care services not covered by Medicare require a physician order, prior approval, and must be medically necessary.

- **Nutrition**

  Nutrition services include the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for your physical and medical needs and environmental conditions. These services also include the provision of nutrition education and counseling to meet your therapeutic needs. In addition, these services may include planning for provision of appropriate dietary intake within your home environment and the development of a nutritional treatment plan.

  Nutritional services require a physician order, prior approval, and must be medically necessary.
• **Medical Social Services**

Medical social services include assessing the need for, arranging for and providing aid for social problems related to the maintenance of your needs in your home when such services are performed by a qualified social worker. Medical social services will assist you with concerns related to your illness, finances, housing or environment.

Medical social services must be medically necessary and appropriate for the member before it is approved by the Plan.

• **Home Delivered Meals and/or meals in a group setting**

Home delivered and meals in a group setting are meals provided at home or in group settings, e.g., day care centers or senior centers with individuals unable to prepare meals or have them prepared.

Home delivered meals and/or meals in a group setting must be medically necessary and appropriate for the member before it is approved by the Plan.

• **Social Day Care**

Social day care is a program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance and case coordination and assistance.

Social day care must be medically necessary and appropriate for the member before it is approved by the Plan.

• **Non-Emergency Transportation**

Healthfirst CompleteCare (HMO SNP) covers transportation expenses for you to obtain necessary medical care and services. Transportation services are provided by ambulance, ambulette, taxicab, public transportation or other means appropriate to your medical condition. An attendant to go with you to medical appointments is also covered, if necessary.

Transportation by an approved car service or ambulette services must be arranged in advance by Healthfirst CompleteCare (HMO SNP). Healthfirst will send authorization to the transportation vendor for approved services. All non-emergency transportation should be arranged by calling Healthfirst CompleteCare (HMO SNP) Member Services 7 days a week from 8 am and 8 pm at 1-888-260-1010 (TTY 1-888-542-3821).

All transportation should be arranged two (2) days in advance. If you do not obtain prior authorization from Healthfirst for non-emergent transportation, you will not be reimbursed for the cost of transportation and will be responsible for the full cost. If you prefer to take public transportation (i.e., MTA transit, including subway, bus, Long Island Rail Road, and/or Metro-North Rail Road, etc.), you must submit a completed Member...
Reimbursement form to Healthfirst CompleteCare (HMO SNP) in order for you to receive reimbursement for the cost of the round trip.

For your convenience, a Member Reimbursement Form is available on our website at www.healthfirst.org/medicare or you may call Member Services to request one. Simply complete the Member Reimbursement Form and mail to:

Healthfirst Medicare Plan  
Member Services  
P.O. Box 5165  
New York, NY 10274

Once your request is received, reimbursement will be mailed to you.

**Private Duty Nursing**

To receive private duty nursing, your Primary Care Provider (PCP) must order and approve the services. The ordering physician, registered physician assistant or certified nurse practitioner must provide a written treatment plan describing the required nursing services. Private duty nursing services must be provided through an approved certified home health agency, a licensed home care agency, or a private practitioner. These services may be provided in either your home or hospital.

Private duty nursing services require a physician order, prior approval, and must be medically necessary.

**Non-Medicare Covered Durable Medical Equipment (DME) and related supplies**

Generally, Healthfirst CompleteCare (HMO SNP) covers any DME equipment covered by Original Medicare. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. As a dual eligible member, you are entitled to additional Medicaid-covered DME. New York State Medicaid covers additional prosthetics, orthotics, and orthopedic footwear that Medicare doesn't cover. Here's an explanation of what Durable Medical Equipment and related supplies are:

- **Medical/Surgical Supplies** – Items for medical use other than drugs, which treat a specific medical condition such as diabetes, wound dressings and other prescribed therapeutic supplies.
- **Medical Equipment** – Adaptive devices and equipment prescribed by a medical provider.
- **Enteral and parenteral nutritional supplements** - Liquid nutritional supplements as prescribed.
- **Prosthetics** – Artificial substitute or replacement of a limb.
- **Orthotics** – Appliances and devices used to support or correct the function of a movable part of the body.
Orthopedic Footwear - Shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.

** Enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism.

Hearing Services

Members of Healthfirst CompleteCare (HMO SNP) receive Medicaid-covered hearing services not otherwise covered under Medicare, including hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing.

Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, ear molds, special fittings and replacement parts.

Members must access all Medicaid-covered hearing care, such as routine hearing exams and hearing aids, through the Healthfirst CompleteCare (HMO SNP) contracted network. All covered hearing services must be medically necessary; however, these services do not require prior authorization.

Vision

Members of Healthfirst CompleteCare (HMO SNP) receive Medicaid-covered vision services, not otherwise covered under Medicare, including 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.

In addition, Healthfirst CompleteCare (HMO SNP) members receive additional vision benefits beyond those covered by Medicare or Medicaid, including one (1) routine eye exam and annual glaucoma screenings every year (for those at high risk) and one (1) pair of eyeglasses or contact lenses every year.

Members must access all vision care, such as routine eye exams, eyeglasses, and contact lenses through the Healthfirst CompleteCare (HMO SNP) contracted vision network, Davis Vision. All covered vision services must be medically necessary.
• **Dental**

Healthfirst CompleteCare (HMO SNP) believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with DentaQuest, an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. **You do not need a referral from your PCP to see a dentist!**

**How to Access Dental Services:**

You must access all dental treatment from providers through DentaQuest, the Healthfirst Medicare Plan contracted dental network provider. All covered dental services must be medically necessary. Individual dental procedures may require prior authorization from DentaQuest.

- If you need to find a dentist or change your dentist, please call DentaQuest at 1-508-2047. Customer Services Representatives are there to help you. Many speak your language or have a contract with language Line Services.
- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.

• **Social/Environmental Supports**

Social and environmental supports are services and items that support your medical needs and are included in your plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care.

Social and environmental supports must be medically necessary and appropriate for the member before it is approved by the Plan.

• **Personal Emergency Response System**

Personal Emergency Response Services (PERS) is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist which employ different signaling devices. Such systems are usually connected to a patient's phone and signal a response center once a “help” button is activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center.

Personal emergency response system services must be medically necessary and appropriate for the member before it is approved by the Plan.

• **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.
Adult day health care requires a physician's order, prior approval, and must be medically necessary.

- **Nursing Home Care not covered by Medicare (provided you are eligible for institutional Medicaid)**

To receive nursing home care services not otherwise covered by Medicare, the services must follow the treatment plan written by the ordering physician, registered physician assistant, certified nurse practitioner or certified home health agency.

Nursing home care not otherwise covered by Medicare requires a physician's order, prior approval, and must be medically necessary.

- **Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit**

Inpatient mental health care over the 190-day lifetime Medicare limit requires a physician order, prior approval and must be medically necessary.

- **Outpatient Mental Health & Substance Abuse**

Healthfirst CompleteCare Plan (HMO SNP) members may receive outpatient mental health and substance abuse services from any network provider. You can self-refer for one assessment for each benefit from a network provider in a twelve (12) month period. Prior authorization is only required for out-of-network service requests, electroconvulsive therapy (ECT), and neuropsychological testing.

**Outpatient Rehabilitation**

Medicaid covered physical therapy is limited to forty (40) visits per calendar year. Occupational therapy and speech and language therapy are limited to twenty (20) visits per calendar year. These limits do not apply to individuals with intellectual disabilities, individuals with traumatic brain injury, and individuals under age 21.

**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**

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider. “Urgently needed services” is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care, but the plan’s network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

You are also covered for emergency care and urgent care worldwide. However, Healthfirst CompleteCare will not cover any Part D prescription drugs that you receive as part of your emergency or urgent care visit in another country.

**Emergency Service**

A “medical emergency” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.**
  - We need to follow up on your emergency care.
  - You or someone else should call to tell us about your emergency care, usually within 48 hours. You may do this by calling Member Services at 1-888-260-1010 (TTY users should call 1-888-542-3821) 7 days a week from 8 am to 8 pm.

**What is covered if you have a medical emergency?**

You may get covered emergency medical care whenever you need it, worldwide. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.
What if it wasn’t a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn’t a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- or – the additional care you get is considered “urgently needed care” and you follow the rules for getting this urgent care

Payment of medical emergency services

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- At times, you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid for the service, we will pay you back.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that Healthfirst CompleteCare (HMO SNP) does not cover. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-888-260-1010 (TTY: 1-888-542-3821) if you have a question about whether a benefit is covered by Healthfirst CompleteCare (HMO SNP) or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription drugs are covered by Healthfirst CompleteCare (HMO SNP) Medicare Part D as described in Chapter 5 of the Healthfirst CompleteCare (HMO SNP) Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Healthfirst CompleteCare (HMO SNP) or 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

Healthfirst CompleteCare (HMO SNP)
Member Services 1-888-260-1010 (TTY 1-888-542-3821)
• 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
• Comprehensive Medicaid Case Management
• Directly Observed Therapy for TB (Tuberculosis)
• Adult Day Treatment for Persons with HIV/AIDS
• 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 HEALTHFIRST COMPLETECARE (HMO SNP) MEDICAID ADVANTAGE PLUS PROGRAM

You must pay for services that are not covered by Healthfirst CompleteCare (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 Healthfirst CompleteCare (HMO SNP) or Medicaid are:

• Cosmetic surgery if not medically needed
• Personal and Comfort items
• Infertility Treatment
• Services of a Provider that are not part of the plan (unless Healthfirst CompleteCare (HMO SNP) sends you to that provider)

If you have any questions, call Member Services at 1-888-260-1010 (TTY 1-888-542-3821).

SERVICE AUTHORIZATIONS AND ACTIONS

When Healthfirst CompleteCare (HMO SNP) determines that services are covered solely by Medicaid, we will make decisions about your care following these rules:

Prior Authorization
Some covered services require prior authorization (approval in advance) from Healthfirst Medical Management 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:
The following treatments and services must be approved before you get them:

- Elective (non-emergency) inpatient admissions
- Residential health care facility care
- Home health care
- Personal care services
- Personal Emergency Response System (PERS)
- Adult and Social Day Care
- Nutritional Services
- Social and environmental services (chore services, home modifications or respite)
- Durable medical equipment (DME)
- Inpatient mental health care
- Bunionectomy and hammer toe repair
- Partial hospitalization services
- Outpatient surgery, if cosmetic
- Non-emergency transportation, including ambulance services
- Prosthetic devices and related supplies
- Outpatient diagnostic tests and therapeutic services – (i.e., PET scans and radiation therapy)
- Comprehensive Dental Services
- Private Duty Nursing

When you ask for approval of a treatment or service, it is called a service authorization request. To get a service authorization request you or your doctor may call Healthfirst Medical Management at 1-888-394-4327 or send your request in writing to:

Healthfirst Medicare Plan
Medical Management Department
P.O. Box 5166
New York, NY 10274-5166

Services will be authorized in a certain amount and for a specific period of time. This is called an authorization period.

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 is called concurrent review.

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 requested. 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.

After we get your request, we will review it under a **standard** or **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track 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 will have if you don’t agree with our decision (see Action Appeals section on page 22).

**Timeframes for prior authorization requests**

- **Standard review**: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

- **Fast track review**: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

**Timeframes for concurrent review requests**

- **Standard review**: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request.

Fast track review: We will make a decision within 1 work day of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 work day if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. We will:

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- 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.

You, your provider, or someone you trust may also ask us to take more time 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 1-888-260-1010 (TTY: 1-888-542-3821) or writing

You or someone you trust can file a complaint with the plan if you don’t agree with our decision 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.
If you are not satisfied with our answer, you have the right to file an appeal with us. See the Appeal section later in this handbook.

If for some reason you do not hear from us on time it is the same as if we denied your original service authorization request. If this happens, you have the right to request a State Fair Hearing. See the Fair Hearing section later in this handbook.

Other Decisions about Your Care

Sometimes we will do a concurrent 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 retrospective review. We will tell you if we take these other actions.

Timeframes for notice of other actions

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting within an authorization period, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving 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 the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

WHAT TO DO IF YOU HAVE A COMPLAINT ABOUT OUR PLAN OR WANT TO APPEAL A DECISION ABOUT YOUR CARE

As a Dually-Eligible member of our plan, the way you make complaints and appeals about your services will depend on whether Healthfirst CompleteCare (HMO SNP) determines that the services are covered by Medicare or Medicaid.

- For complaints and appeals about a service that is covered only by Medicare (e.g. chiropractic services), you will follow the rules outlined in Chapter 9 of your Healthfirst CompleteCare (HMO SNP)’s Medicare Evidence of Coverage.
- For complaints and appeals about a service that is covered only by Medicaid (e.g. personal care services, private duty nursing, non-emergency transportation, dental services, etc.), you will follow the Medicaid rules listed below.
- For complaints and appeals about all other services covered by Healthfirst CompleteCare (HMO SNP) you may choose to follow either the Medicare rules outlined in Chapter 9 of your Healthfirst CompleteCare (HMO SNP) Evidence of Coverage or the Medicaid rules described below. If you choose to follow the Medicare rules, you cannot use your Medicaid complaint and appeal rights, including the right to a state Fair Hearing regarding the complaint or appeal. But if you choose to follow the Medicaid rules, you will have up to 60 days from the day of Healthfirst CompleteCare (HMO SNP) notice of denial of coverage to use your Medicare complaint and appeal rights.
Healthfirst CompleteCare (HMO SNP) will explain the complaints and appeals processes available to you depending on the complaint you have. Call member services at 1-888-260-1010 (TTY: 1-888-542-3821) to get more information on your rights and the options available to you.

MEDICAID RULES FOR APPEALS AND COMPLAINTS

Plan Appeals

There are some treatments and services that you need to get approval before you receive them or in order to be able to continue receiving them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an Initial Adverse Determination.

If you are not satisfied with our decisions about your Medicaid care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision about your service authorization request without talking to your doctor, your doctor may ask to speak with the plan’s Medical Director. The Medical Director will talk to your doctor within one workday.

You can file a Plan Appeal:

- If you are not satisfied with our decision about your service authorization request, you have 60 days after hearing from us to file a Plan appeal.
- You can do this yourself or ask someone you trust to file the Plan appeal for you. You can call Member Services 1-888-260-1010 (TTY: 1-888-542-3821) if you need help filing a Plan appeal.
- We will not treat you any differently or act badly toward you because you file a Plan appeal.
- The Plan appeal can be made by phone or in writing. If you make an appeal by phone, unless it is fast tracked, you must also send your Plan appeal to us in writing.

Your plan appeal will be reviewed under the fast track process:

- If you or your doctor asks to have your Plan appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided.
- Fast track appeals can be made by phone and do not have to be followed up in writing.
Aid to Continue while appealing a decision about your care

If we decide to reduce, suspend or stop services you are getting now, you may be able to continue receiving these services while you wait for your appeal to be decided. In order to do so, you must ask for an appeal:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

If we deny your appeal and you are not satisfied, you can appeal further using the External Appeals process or Fair Hearing process described below.

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan appeal. We will let you know if we need additional information to make our decision.
- We will send you a case file free of charge which includes a copy of the medical records and any other information and records we will use to decide the appeal. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom 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 Healthfirst with information to be used in deciding your appeal in person or in writing. You can call Healthfirst at 1-888-260-1010 (TTY: 1-888-542-3821) if you are not sure what information to provide.
- You will be given the reasons for our decision and our clinical rationale, if it applies.
- If your Plan Appeal is denied or is approved for an amount less than what was requested, you will receive a notice from Healthfirst called a Final Adverse Determination.
- If you think our Final Adverse Determination is wrong:
  - You can ask for a Fair Hearing. See the Fair Hearing section of this handbook.
  - For some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
  - You or someone you trust can file a complaint with the New York State Department of Health at 1-866-712-7197.

Timeframes for Action Appeals

- Standard appeals: If we have all the information we need, we will tell you our decision on your Plan Appeal no later than 30 days from the date you asked for your Plan Appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.
• Fast track appeals: If we have all the information we need, fast track Plan Appeal decisions will be made within 2 work days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
  o We will tell you within 72 hours if we need more information.
  o We will tell you our decision by phone and send a written notice later.

If we do not have the information we need to make either a standard or fast track decision about your Plan Appeal within the above timeframes we will:

• Write to tell you that we need more time to collect the information. If your request is in a fast track review, we will call you right away and send a written notice later.
• Tell you why the delay is in your best interest.
• Take no more than 14 additional days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time 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 1-888-260-1010 (TTY 1-888-542-3821) or writing.

You or someone you trust can file a complaint with us if you don’t agree with our decision to take more time to review your action appeal. 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.

If you do not receive a response to your Plan Appeal or we do not decide your Plan Appeal within the required time, including extensions, you can ask for a Fair Hearing. See Fair Hearing section of this handbook. If we do not decide your Plan Appeal on time, and we said the service was not medically necessary, was experimental or investigational, 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, the original denial will be reversed. This means your service authorization request will be approved.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary or because it is experimental or investigational, 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, you can ask New York State for an independent external appeal. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. 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:

1. You must file a Plan Appeal with the plan and get the plan’s Final Adverse Determination; or
2. If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an
expedited External Appeal at the same time. Your doctor will have to say an expedited Appeal is necessary; or

3. You and the plan may agree to skip the plan’s appeals process and go directly to External Appeal; or

4. You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have 4 months after you receive 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 1-888-260-1010 (TTY: 1-888-542-3821) 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 for an External Appeal:

- 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 1-888-260-1010 (TTY: 1-888-542-3821)

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

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, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends or stops your service, you can ask for a Fair Hearing, and External Appeal or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.
Fair Hearings

You must first ask for a Plan Appeal and receive a Final Adverse Determination prior to requesting a Fair Hearing. Once you receive a Final Adverse Determination, you will then have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

You may ask for a Fair Hearing from New York State if:

- You are not happy with a decision your local department of social services or the State Department of Health made about your staying or leaving the Medicaid Advantage Plus Program.
- You are not happy with a decision that your doctor would not order one of the services listed under the list of Prior Authorization that you wanted. You feel that the doctor’s decision stops or limits your Medicaid benefits. You must file a complaint and an appeal with Healthfirst CompleteCare (HMO SNP). If Healthfirst CompleteCare (HMO SNP) agrees with your doctor, you may ask for a State Fair Hearing.
- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.
- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
  - reduce, suspend or stop care you were getting; or
  - deny care you wanted; or
  - deny payment for care you received

If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you are getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a Fair Hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later.

However, if you choose to ask for services to be continued, and lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

The decision you receive from the Fair Hearing will be final.

If you filed a complaint or appeal under Medicare rules, you may not then request a state Fair Hearing about the same complaint or appeal.

You can use one of the following ways to request a Fair Hearing:

- By phone. Call toll free 1-800-342-3334
- By fax at 518-473-6735
- By Internet at www.otda.state.ny.us/oah/forms.asp
- By mail:
  NYS Office of Temporary and Disability Assistance Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 122023
  Albany, New York 12201-2023
When you ask for a Fair Hearing about a decision Healthfirst CompleteCare (HMO SNP) made, we must send you a copy of the evidence packet. This includes information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before the hearing, you can call 1-888-260-1010 (TTY: 1- 888-542-3821) to ask for it.

Remember, you can file a complaint anytime to the New York State Department of Health by calling 1-866-712-7197. Call Member Services at 1-888-260-1010 (TTY: 1- 888-542-3821) if you have any questions.

Complaints

We hope our plan serves you well. If you have a problem with the care or treatment you receive from our staff or providers or you do not like the quality of care or services you receive from us, call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) or write to Member Services. Please remember that complaints about services that are only a benefit under Medicare should be handled through the Healthfirst CompleteCare (HMO SNP) Medicare complaint process. Complaints about services only covered by Medicaid should be handled through the Healthfirst CompleteCare (HMO SNP) Medicaid complaint process. You can choose to use either the Medicare or Medicaid complaints process for complaints about services that Healthfirst CompleteCare (HMO SNP) determines are a benefit under both Medicare and Medicaid.

Most problems can be solved right away. Problems that are not solved over the phone and any complaint that comes in about a Medicaid service will be handled according to the procedures described below. 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 with the Plan:

To file by phone, call Member Services at 1-888-260-1010 (TTY 1-888-542-3821), 7 days a week, 8:00 am to 8:00 pm. 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.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

Healthfirst Medicare Plan
Appeals and Grievances Unit
P.O. Box 5166
New York, NY 10274-5166
What happens next?
If we don’t solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters it will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don’t have enough information, we will send a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, 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 60 business days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The complaint appeal must be made in writing. If you make an appeal by phone, it must be followed up in writing. After your call, we will send you a form which is a summary of 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 working days. The letter will tell you:

- who is working on your complaint appeal
- how to contact this person
- if we need more information
Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

We will let you know our decision within 30 working 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. You will be given 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.

**DISENROLLMENT FROM HEALTHFIRST COMPLETECARE (HMO SNP) MEDICAID ADVANTAGE PLUS PROGRAM**

We will treat you with fairness and respect at all times. Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on age, sex (including gender identity or status of being transgender), race, creed, physical or mental disability (including gender dysphoria), developmental disability, national origin, sexual orientation, type of illness or condition, or the need for health services.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call member services at 1-888-260-1010 (TTY 1-888-542-3821). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

**You Can Choose to Disenroll**

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

To request disenrollment, call:

- Healthfirst CompleteCare (HMO SNP) Member Services at 1-888-260-1010 (TTY 1-888-542-3821). It could take up to six weeks to process, depending on when your request is received.

- You can also call New York Medicaid Choice at 1-888-401-6582 (TTY 1-888-329-1541) or the local LDSS.

If you disenroll from Healthfirst CompleteCare (HMO SNP), but are still in need of long-term care services, New York State may require you to join a managed long-term care plan (MLTCP) to continue to receive these services, as long-term care services are no longer covered by New York’s Fee-For-Service Medicaid Program.
You Will Have to Leave Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program if you:

- No longer are in Healthfirst CompleteCare (HMO SNP) for your Medicare coverage
- Need nursing home care, but are not eligible for institutional Medicaid
- Are out of the plan’s service area for more than 90 consecutive days
- Permanently move out of the Healthfirst service area
- If you are no longer eligible for nursing home level of care as determined at any comprehensive assessment for the calendar year using the assessment tool prescribed by the New York State Department of Health. However, you will not be disenrolled if we (or the local department of social services) agree that the termination of services would result in you being eligible for nursing home level of care within the succeeding six-month period.
- Join a Long-Term Home Health Care Program, 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.
- Are incarcerated
- Are ineligible for Medicaid

We Can Ask You to Leave the Plan

We will ask that you leave Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Program for the following reasons:

- If you intentionally give us incorrect information when you are enrolling in Healthfirst CompleteCare (HMO SNP) and that information affects your eligibility for our plan.
- If you, your family members, or other caregivers or other persons in the household continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other Healthfirst CompleteCare (HMO SNP) members even after we make and document our efforts to resolve any problems you may have.
- If you knowingly fail to complete and submit any necessary consent or release form allowing Healthfirst CompleteCare (HMO SNP) and providers to access health care and service information that is necessary for us to deliver care to you.
- If you let someone else use your ID card to get medical care.
- If you do not pay your Medicaid spend down. This means you will be disenrolled if
  - you do not pay the excess income you owe to remain eligible for Medicaid within thirty (30) days of its original due date,
  - a reasonable effort has been made by Healthfirst CompleteCare (HMO SNP) to collect the spend down from you, and
  - you are alerted by Healthfirst CompleteCare (HMO SNP) before you are disenrolled.

Re-Enrollment Provisions

If you voluntarily disenroll, you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled, for any reason, you may complete a new application for re-enrollment at any time. If you are eligible for enrollment described earlier in this Handbook, you will be re-enrolled.
RIGHTS AND RESPONSIBILITIES

As a member in Healthfirst CompleteCare (HMO SNP), you have the Right:

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

Responsibilities of Members

To have the greatest benefit from enrollment in Healthfirst CompleteCare (HMO SNP), you have the following responsibilities:

1. To Participate Actively in Your Care and Care Decisions
   - To communicate openly and honestly with your doctor and Care Team about health and care.
   - To ask questions to be sure you understand your service plan and to consider consequences of not following your service plan. Your care plan and changes to your Care Plan will be discussed and documented as part of our monthly care management call.
   - To share in care decisions and continue to be in charge of your own health.
   - To complete self-care as planned.
   - To keep appointments or inform the Team of needs to change appointments
   - To use the Healthfirst CompleteCare (HMO SNP) Network Providers for care except in emergency situations.
• To notify Healthfirst CompleteCare (HMO SNP) if you receive health services from other health care providers.
• To participate in policy development by writing to us, or calling us.

2. To Support the Healthfirst CompleteCare (HMO SNP)
• To appropriately express opinions, concerns and suggestions in the following ways including, but not limited to, expressing your opinions or concerns to your Care Team, or through the Healthfirst CompleteCare (HMO SNP) Appeals and Grievances Process.
• To review the Member Handbook and follow procedures to receive services.
• To respect the rights and safety of all those involved in your care and to assist Healthfirst CompleteCare (HMO SNP) in maintaining a safe home environment.
• To notify your Care Team at Healthfirst CompleteCare (HMO SNP) of any of the following;
  • if you are leaving the service area
  • if you have moved or have a new telephone number
  • if you have changed doctors
  • any changes in condition that may affect our ability to provide care
ADVANCED DIRECTIVES

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, we have outlined your rights, which include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in one of these situations. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.
If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

**Remember, it is your choice whether you want to fill out an advance directive** (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

**What if your instructions are not followed?**

If you have signed an advance directive, and you believe that a doctor or hospital hasn’t followed the instructions in it, you may file a complaint with The New York State Department of Health:

The New York State Department of Health Bureau of Managed Long-Term Care (MLTC)
One Commerce Plaza, Room 1620
Albany, NY 12210
1-866-712-7197
NOTICE OF INFORMATION AVAILABLE ON REQUEST

The following information is available upon request by the member:

- A list of names, business addresses and official positions of the members of Healthfirst CompleteCare (HMO SNP)’s Board of Directors, officers, controlling partners, and owners or partners.
- A copy of the most recent annual certified financial statement of Healthfirst CompleteCare (HMO SNP) including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant.
- Information related to member complaints and aggregated information about grievances and appeals.
- Healthfirst CompleteCare (HMO SNP) procedures for protecting confidentiality of medical records and other member information.
- A written description of the organizational arrangement and ongoing procedures of Healthfirst CompleteCare (HMO SNP)’s Quality Assurance Program.
- A description of the procedures followed by Healthfirst CompleteCare (HMO SNP) in making decisions about the experimental, or investigational nature of individual drugs, medical devices or treatments in clinical trials.
- Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which Healthfirst CompleteCare (HMO SNP) might consider in its utilization review and how it is used in the utilization review process, provided, however, that to the extent that such information is proprietary to Healthfirst CompleteCare (HMO SNP), the member or prospective member shall only use the information for the purpose of assisting the member/prospective member in evaluating the covered services provided by Healthfirst CompleteCare (HMO SNP):
  - Individual health practitioner affiliations with participating hospitals and other facilities.
  - Licensure, certification and accreditation status of participating providers.
  - Written application, procedures and minimum qualification requirements for health care providers to be considered by Healthfirst CompleteCare (HMO SNP); and/or
  - Information concerning the education, facility affiliation, and participation in clinical performance reviews conducted by the Department of Health, of health care professionals who are licensed, registered, or certified under Article 8 of the State Education Law.
Disclaimer Information:

Healthfirst Health Plan, Inc., is an HMO plan with a Medicare contract and a contract with the New York Medicaid program. Enrollment in Healthfirst Medicare Plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. Medicare Part B premium is covered for dual-eligible members with full Medicaid coverage. This plan is available to anyone who has full Medicaid benefits from the State and Medicare.

Eligible beneficiaries can enroll at any time. Contact Healthfirst CompleteCare (HMO SNP) for additional information.

This information is available for free in other languages. Please call our Member Services number at 1-888-260-1010, TTY/TDD number 1-888-542-3821, 7 days a week, from 8am-8pm.

Esta información está disponible de forma gratuita en otros idiomas. Por favor, llame a nuestro número de Servicios a los Miembros al 1-888-260-1010, o al 1-888-867-4132 para los usuarios de TTY, los 7 días de la semana de 8:00 a.m. a 8:00 p.m.

日本語版は無料で提供されています。詳細は1-888-260-1010、聴覚障害者専用のTTY/TDD 1-888-542-3821に連絡してください。サービス時間は毎週7日間、8am-8pmです。
Notice of Non-Discrimination

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

Healthfirst 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 first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Healthfirst at 1-866-305-0408. For TTY services, call 1-888-542-3821.

If you believe that Healthfirst 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 Healthfirst by:

- Mail: Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- Phone: 1-866-305-0408 (for TTY services, call 1-888-542-3821)
- Fax: 1-212-801-3250
- In person: 100 Church Street, New York, NY 10007
- Email: http://healthfirst.org/members/contact/

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 http://www.hhs.gov/ocr/office/file/index.html
- Phone: 1-800-368-1019 (TTY 800-537-7697)
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).</td>
</tr>
<tr>
<td>Arabic</td>
<td>ملاحظة: إذا كنت تتحدث العربية، سوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408. (TTY: 1-888-542-3821)</td>
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<tr>
<td>Yiddish</td>
<td>אָטְנַשון: דַעְעַת אָסיר אָראָדְט אָידיש, געָן פָּטְסייבע פָּאָר איַוְר שに入った פּוּדְפּוּד ייִדיש סעַרְפּרֶר. (TTY: 1-888-542-3821) 1-866-305-0408</td>
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<tr>
<td>Bengali</td>
<td>লক্ষ্য করুনঃ যদি আপনি বাংলা, কন্ন বলতে পারেন, তাহলে নিঃসন্ধান ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৬৬-৩০৫-০৪০৮ (TTY: 1-888-542-3821).</td>
</tr>
<tr>
<td>Urdu</td>
<td>خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب بھی کے کریں. (TTY: 1-888-542-3821) 1-866-305-0408</td>
</tr>
</tbody>
</table>
IMPORTANT Phone Numbers

Healthfirst Corporate Office: 100 Church Street, New York, NY 10007

Member Services can help you:
- change your PCP
- with questions about benefits and services
- replace an ID card
- report a birth
- with referrals
- enroll in a medical management program

Healthfirst Network Providers

DentaQuest
Dental
- select a primary care dentist
- enquire about services covered
- find a dentist’s location
1-800-508-2047
Monday to Friday, 8am–8pm

Davis Vision
Vision
- enquire about benefit coverage
- locate participating eye doctors (optometrists and opticians)
1-800-753-3311
Monday to Friday, 8am–11pm
Saturday, 9am–4pm
Sunday, 12pm–4pm

Pharmacy
Prescriptions
- submit a pharmacy claim
- enquire about drug coverage and prescription-related issues
1-888-260-1010
24 hours a day, 7 days a week

Government Offices

Medicare
1-800-MEDICARE (1-800-633-4227)
(TTY 1-877-486-2048)
24 hours a day, 7 days a week

Elderly Pharmaceutical Insurance Coverage Program
1-800-332-3742
(TTY 1-800-290-9138)
Monday to Friday, 8am–5pm

Local Department of Social Services (please fill in)
Use this space to fill out you and your family’s provider information.

Member Name:  
PCP Name:  
Phone Number:  
Address:  

Member Name:  
PCP Name:  
Phone Number:  
Address:  

Member Name:  
PCP Name:  
Phone Number:  
Address:  

Member Name:  
PCP Name:  
Phone Number:  
Address:  

For medical emergencies, please call 911, or go to the nearest emergency room, an urgent care center, or a medical center. You will be asked to present your Healthfirst Member ID card when you receive emergency care.
Community Offices in Your Neighborhood

**BRONX**

Fordham
412 E. Fordham Road
Monday to Saturday,
8:30am–5:30pm

East Tremont
774 E. Tremont Avenue
Monday to Saturday,
9am–5:30pm

**BROOKLYN**

Bensonhurst
2236 86th Street
Monday to Sunday,
8:30am–5:30pm

Flatbush
2166 Nostrand Avenue
Monday to Saturday,
8:30am–5:30pm

Sunset Park
5324 7th Avenue
Monday to Sunday,
9am–5:30pm

**QUEENS**

Elmhurst
40-08 81st Street
Monday to Sunday,
9am–5:30pm

Flushing
41-60 Main Street
Rooms 201 & 311
Monday to Sunday,
9am–5:30pm

Main Plaza Mall
37-02 Main Street
Monday to Sunday,
10am–6:30pm

Jackson Heights
93-14 Roosevelt Avenue
Monday to Saturday,
8:30am–5:30pm

**LONG ISLAND**

NASSAU COUNTY

Hempstead
242 Fulton Avenue
Monday to Saturday,
8:30am–5pm

Valley Stream
Green Acres Mall
2034 Green Acres Mall
Sunrise Highway, Level 1
Monday to Saturday,
10am–7pm,
Sunday, 11am–7pm

**SUFFOLK COUNTY**

Bay Shore
Westfield South Shore Mall
1701 Sunrise Highway
Monday to Saturday,
10:30am–7pm
Sunday, 11am–5:30pm

Lake Grove
Smith Haven Mall
313 Smith Haven Mall
Monday to Saturday,
10am–7pm,
Sunday, 11am–7pm

Patchogue
99 West Main Street
Monday to Saturday,
8:30am–5pm

Shirley
La Placita
58 D Surrey Circle
Monday to Saturday,
8:30am–5pm

For questions about your benefits, call Member Services at:

**1-888-260-1010 (TTY 1-888-542-3821)**

7 days a week, 8am–8pm