2023 Member Handbook

Learn about your health care benefits

AetnaBetterHealth.com/NewYork

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Aetna Better Health® of New York

1376310-NY-EN

Personal Information

Care Manager name and telephone number

Care Manager Associate name and telephone number

Member Services telephone number: **1-855-456-9126**

Aetna Better Health of New York

Managed Long-Term Care (MLTC) Program

Member Handbook

Contents

Helpful Information		
Name	**Phone, Fax, Email**	**Address**
Aetna Better Health of New York Member Services	Ph: **1-855-456-9126** Fax: **1-855-863-6421** Website: **AetnaBetterHealth.com/NewYork**	Aetna Better Health 101 Park Avenue 15th Floor New York, NY 10178
Services for the Hearing Impaired	New York Relay **7-1-1**	
Non-Emergency Transportation	Call your care management team or Aetna Better Health of New York Member Services at **1-855-456-9126**	
Emergency Medical Services	**9-1-1**	
Dental Services Provided by LIBERTY Dental Plan	**1-855-225-1727** **(TTY 877-855-8039)**	
Vision Services Provided by EyeQuest	**1-855-873-1282** Monday – Friday 8 AM – 8 PM	
Language Interpretation Services	Call Aetna Better Health of New York Member Services **1-855-456-9126**	
Grievance and Appeals	Call Aetna Better Health of New York Member Services **1-855-456-9126** Fax: **1- 855-264-3822**	Aetna Better Health of New York Grievance & Appeals Department PO Box 81040 5801 Postal Road Cleveland, OH 44181

Name	Phone, Fax, Email	Address
Fraud and Abuse Hotline	**1-855-456-9126**	
Nassau County Department of Social Services (DSS)	**516- 227-7474**	
Suffolk County Department of Social Services (DSS)	**631-854-9935**	
New York City Human Resource Administration (HRA)	**1-877-422-8411**	
NY Department of Aging	**518-474-7012**	
NYS Department of Financial Services	**1-800-400-8882**	New York State Department of Financial Services PO Box 7209 Albany NY, 12224-0209
New York State Department of Health Bureau of Managed Long-term Care New York State Department of Health (Complaints)	**1-866-712-7197**	
New York Medicaid Choice (Maximus)	**1-888-401-6582**	

Welcome to Aetna Better Health of New York Managed Long-Term Care (MLTC) plan. The MLTC plan is especially designed for people who have Medicaid and who need health and Community Based Long Term Services and Supports (CBLTSS) like home care and personal care to stay in their homes and communities if possible.

This handbook tells you about the added benefits Aetna Better Health of New York covers since you are enrolled in the plan. It also tells you how to request a service, file a complaint, or disenroll from Aetna Better Health of New York. Please keep this handbook as a reference, it includes important information regarding Aetna Better Health of New York and the advantages of our plan. You need this handbook to learn what services are covered and how to get these services.

HELP FROM MEMBER SERVICES

You can call us at any time, 24 hours a day seven days a week, at the Member Services number below.

There is someone to help you at Member Services:
1-855-456-9126 24 hours a day, 7 days a week
Call **1-855-456-9126 (NY Relay: 711)** for the hearing impaired

Members can receive information in another language or if they are hearing or vision impaired by contacting their case manager or a member service representative.

ELIGIBILITY FOR ENROLLMENT IN THE MLTC PLAN

The MLTC plan is for people who have Medicaid. You are eligible to join the MLTC plan if you:

1. Are age 21 and older,
2. Reside in the plan's service area, which is Manhattan, Brooklyn, Queens, Bronx, Nassau and Suffolk,
3. Have Medicaid,
4. Have Medicaid only **and** are eligible for nursing home level of care
5. Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, ***and***
6. Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the MLTC Plan for a continuous period of more than 120 days from the 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

The coverage explained in this Handbook becomes effective on the date of your enrollment in Aetna Better Health of New York MLTC plan. Enrollment in the MLTC plan is voluntary.

NEW YORK INDEPENDENT ASSESSOR - INITIAL ASSESSMENT PROCESS

Effective May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) is now known as the New York Independent Assessor (NYIA). The NYIA will manage the initial assessment process. NYIA will start the expedited initial assessments at a later date. The initial assessment process includes completing the:

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

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

Aetna Better Health of New York will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIA Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care, and any other medical documentation. If more information is needed, someone on the panel may examine you or discuss your needs with you. The IRP will make a recommendation to Aetna Better Health of New York about whether the plan of care meets your needs.

Once NYIA completes the initial assessment steps and determines that you are eligible for Medicaid Managed Long Term Care, you then choose which Managed Long Term Care plan to enroll with.

1. If you are new to Managed Long Term Care or you are currently enrolled with another long-term care plan and wishes to transfer, you may also call our Member Services at **1-855-456-9126** and a member service representative will be available to take down your information.

2. Your information will be sent to our enrollment intake specialists, who will contact you to confirm your interest for MLTC services with Aetna Better Health of New York and to review that your Medicaid is eligible to receive MLTC services.

3. The enrollment intake specialist will schedule a registered assessment nurse to call you and review with you the outcome of the initial assessment (CHA and PO) completed by NYIA and develop a Person-Centered Service Plan (PCSP). If applicable, you might be scheduled with a registered assessment nurse at a time that is agreed upon by you for an in-person or for a virtual initial assessment in order to develop a Person-Centered Service Plan (PCSP).

   The assessment lets us know the type of care you need based on your health and ability to do everyday activities. During the review or assessment, we will:
   - Determine if you are eligible to join the program.
   - Assist you with completing the enrollment application and the Medicaid application, if needed. Your application for Aetna Better Health will be held until your Medicaid application is approved.
   - If you are applying for Medicaid while you enroll in Aetna Better Health of New York, the Enrollment may take at least one or two months longer than if you already have active Medicaid.
   - Review this member handbook in detail, this handbook includes information on policies and procedures and is an import part of your agreement to enroll in this program. Including member rights and responsibilities.
   - Review the provider directory.
   - Develop a proposed care plan with you and anyone else involved in your care, such as family members.

4. The CHA and PO review or an initial assessment by Aetna Better Health of New York must be conducted within thirty (30) days of first contact by an individual requesting enrollment or of receiving a referral for the Enrollment Broker.

5. Enrollment into Aetna Better Health of New York is voluntary, if you are interested in enrolling and you qualify to become an Aetna Better Health member, you or your representative must sign:

- An enrollment agreement.
- A Privacy request form. This allows the care manager to speak to your primary care provider (your physician) about your care plan.
- Authorization for nursing assessment. This allows our nurse to complete your assessment.
- Your Person-Centered Service Plan (PCSP)
- Member Contingency/Back-Up Plan
- Memorandum of Understanding for Consumer Directed Personal Assistance Services (if applicable)
- Healthix Consent Form (optional)

Before or after signing if you choose to choose not to enroll, you may withdraw your application or enrollment agreement by noon on the day 20 of the month prior to the effective date of enrollment by indicating your wishes verbally or in writing and a written acknowledgment of your withdrawal will be sent to you.

If choose to enroll with Aetna Better Health of New York, we will submit your application to New York Medicaid Choice. Your application for enrollment will be reviewed and determined by New York Medicaid Choice. The coverage explained in this member handbook becomes effective on the effective date of your enrollment in the Aetna Better Health Plan. Enrollment in Aetna Better Health is voluntary. If you have questions about our plan or enrollment you can call Member Services at **1-855-456-9126**, whether you are already an Aetna Better Health member or not.

You may be denied enrollment into Aetna Better Health of New York MLTC plan if at the time of enrollment:

- Do not meet the eligibility criteria as mentioned above.
- Do not require Community Based Long Term Care Services (CBLTC) for more than 120 days.
- Is receiving Hospice services.
- Is receiving care in a state Office of Mental Health (OMH) facility, Office for People with Developmental Disabilities (OPWDD) facility/treatment center, an assisted living facility (ALP) or in an alcohol/substance abuse long term residential treatment program.
- Is in the OPWDD Home and Community Based Services or Traumatic Brain Injury, and Nursing Home Transition & Diversion; section 191S(c) waiver program.
- Is under sixty-five (65) years of age in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer and are not otherwise covered under creditable health coverage.
- Is expected to have Medicaid for less than 6 months, have Emergency

Medicaid, in the Foster Family Care Demonstration or is in the family planning expansion program.

If you are new to Aetna Better Health and are getting an ongoing course of treatment from a provider who is not in our network, you may continue the treatment for up to 90 days from the day you enroll with Aetna Better Health. In order continue the treatment your provider must:

- Accept Aetna Better Health's payment rate.
- Adhere to Aetna Better Health's policies including quality assurance.
- Provider medical information about the care to Aetna Better Health.

Plan Member (ID) Card

You will receive your Aetna Better Health of New York identification (ID) card within 10 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to always carry your ID card with you along with your Medicaid card. If your card becomes lost or is stolen, please contact Member Services at **1-855-456-9126**.

SERVICES COVERED BY THE Aetna Better Health of New York MLTC PLAN
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. Other assistance you can receive from your Care Manager include referring you or helping you coordinate your medical, social, educational, psychosocial, financial, or other services that support your PCSP. Your Care Manager will help you whether or not the needed services are included as a part of your benefit.

Once you agree to become a member of Aetna Better Health, your care manager will talk to the nurse who made your home visit. The information from your home visit will be reviewed. Your care manager will then contact you to talk with you more about your needs. Together, you will develop your Person-Centered Service Plan (PCSP).

Your plan of care is based on your health status and health care needs. Your primary care provider may give us information, talk with you and your care manager, and help develop your care plan. We also get input from your family, caregivers, and others that you think are important for us to talk with. The care plan will describe the

personal care hours you need. The care plan will list other services you will get from Aetna Better Health. The care plan will describe the services that Aetna Better Health will cover and the schedule for delivering the services. Your care plan is important. It shows that we have all worked together to decide how we will help you. It includes the services we will pay for to help you get and stay as healthy as you can be.

After your Person-Centered Service Plan (PCSP) is developed, your care team will help you get all the care and services you need. The care management team will work with you to make appointments for any health care services you need. The care management team will also set up the transportation you need to receive those services.

Your care manager will call you at least once a month to check on you. Aetna Better Health's care management team will provide a minimum of one care management home visit every six (6) months for each enrollee, which can be included as part of any re-assessment.

a. Ensure that the type of care management and the Plan of Care you as an enrollee receives is based on the degree of seriousness of your illness and it addresses both your body and your mind.
b. Identify the number of care managers to the number of members according to the degree of seriousness with their health issues which involves both the body and the mind. If care management is provided in a "team approach," then the Care Management Guidance must address how the team operates.
c. The member will be educated about the Consumer Directed Personal Assistance Services (CDPAS) and other service options when creating their Care Plan after a home visit with our nurse.
d. Your care manager will communicate with you regarding all your requests. You will always have your care manager's phone number.

Services will begin the first day of the month after your enrollment application is approved. Your care management team will help to coordinate your care such as physician visits, prescription drugs, and hospital admissions with other health providers. You can participate in your care by sharing with your care management team your needs and concerns so that you may continue to live independently in your community. You and your care management team will review your care plan at least twice every year. The care team may also review your care plan if your condition changes to make sure you receive the services you need.

Additional Covered Services

Because you have Medicaid and qualify for MLTC, 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 Aetna Better Health of New York network. If you cannot find a provider in our plan, you must get covered services from providers in the Aetna Better Health network. You may obtain a referral to a health care provider outside the network in the event Aetna Better Health does not have a provider with appropriate training or experience to meet your needs. If you require an out of network provider, please contact your care management team to assist you in obtaining an authorization.

When using a provider outside of the Aetna Better Health network for covered services, you must get an authorization from Aetna Better Health before seeing the provider.
Without first obtaining the required authorization, the provider will not be paid for services. If you have questions regarding this process, please contact your care management team or call Member Services at **1-855-456-9126**.

If you want a service and your provider will not give you that service because of moral or religious reasons, please call your care management team or Member Services toll free **1-855-456-9126**. They will help you find a provider for the covered service.

You should not get a bill or must pay for covered services. Please call your care management team or Member Services toll free **1-855-456-9126** if you do.

- 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)*
- Audiology
- DME
- Medical Supplies
- Prosthetics and Orthotics
- Optometry
- Consumer Directed Personal Assistance Services
- Podiatry
- Respiratory Therapy

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 for at least three months. Following that time period, your Nursing Home Care may be covered through regular Medicaid, and you will be disenrolled from Aetna Better Health of New York.

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 manager 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

Aetna Better Health of New York within 24 hours of the emergency. You may be in need of long-term care services that can only be provided through Aetna Better Health of New York. If you are hospitalized, a family member or other caregiver should contact Aetna Better Health of New York 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 Aetna Better Health of New York so that we may work with them to plan your care upon discharge from the hospital.

TRANSITIONAL CARE PROCEDURES

New members in Aetna Better Health of New York 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 Aetna Better Health of New York quality assurance and other policies, and provides medical information about the care to your 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/Open Doors 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 Aetna Better Health of New York does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at **1-855-456-9126** if you have a question about whether a benefit is covered by Aetna Better Health of New York or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription and non-prescription drugs, as well as compounded prescriptions are covered by regular Medicaid or Medicare Part D if you have 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 Intellectual 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 including:

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

Certain medically necessary ovulation enhancing drugs when criteria are met.

SERVICES NOT COVERED BY AETNA BETTER HEALTH OF NEW YORK OR MEDICAID

You must pay for services that are not covered by Aetna Better Health of New York or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them are:

Examples of services not covered by Aetna Better Health of New York or Medicaid:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a Provider that is not part of the plan (unless Aetna Better Health of New York sends you to that provider)

If you have any questions, call Member Services at **1-855-456-9126**.

SERVICE AUTHORIZATIONS, ACTIONS AND ACTION APPEALS

When you ask for approval of a treatment or service, it is called a **service authorization request**. To submit a service authorization request, you must

Service authorization steps

Following are the steps for pre-approval:

- Your provider gives Aetna Better Health information about the services he or she thinks you need.
- Aetna Better Health reviews the information.
- If the request cannot be approved, a different Aetna Better Health provider will review the information.
- Aetna Better Health will let you know when we make a decision. We will send you and your provider a letter to tell you about our decision. You and your provider will get a letter when a service is approved or denied.
- If the request is denied, the letter will say why.
- If a service is denied, you or your provider can file an appeal.

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

Prior Authorization

Some covered services require prior authorization (approval in advance) from our Prior Authorization staff 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:

- Medical / Adult Day Health Care
- Attendant Care
- Audiology and Hearing Aids
- Dentistry
- Dietary Supplements and Nutritional Counseling
- Durable Medical Equipment includes Medical/Surgical Supplies, Prosthetics, Orthotics and Orthopedic footwear, Canes, Hospital Bed, Wheelchairs, Oxygen and Walkers
- Home Care- Skilled/Licensed Nursing (RN or LPN) Physical Therapy, Occupational Therapy, Speech Pathology, Medical Social Services
- Home Care- Non-licensed Home Health Aides (HHA)
- Home Delivered or Congregate Meals
- Medical Supplies
- Non-Emergency Transportation
- Nursing Home Care
- Personal Care-includes housekeeping, meal prep, bathing, toileting
- Personal Emergency Response System (PERS)
- Podiatry
- Prosthetics and Orthotics
- Respiratory Therapy- medical equipment, supplies, respiratory therapy, and oxygen
- Social and Environmental Supports
- Social Day Care
- Speech Therapy
- Vision
- Telehealth
- Consumer Directed Personal Assistance Services (CDPAS)

Concurrent Review

You can also ask your Care Manager to get more of a service than you are getting now. This is called **concurrent review**.

Retrospective Review

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

What happens after we get your service authorization request?

The 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 indicated below.

Timeframes for prior authorization requests

- **Standard review**: We will make a decision about your request within 3 workdays 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 14 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 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- **Fast track review**: We will make a decision within 1 workday 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 workday 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.
- Decide 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 **1-855-456-9126** 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 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. See ***How do I File an Appeal of an Action?*** which explains how to make an appeal if you do not agree with our decision.

What is an Action?

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

Timing of Notice of Action

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

Contents of the Notice of Action

Any notice we send to you about an action will:

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

The notice will also tell you about your right to an appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing.
- It will say that that you must file an appeal before asking for a Fair Hearing; ***and***
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on the notice. If we are reducing, suspending, or terminating and authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling **1-855-456-9126** or writing to PO Box 81040, 5801 Postal Road, Cleveland, OH 44181. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

If you are appealing a restriction, reduction, suspension, or termination of services you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a plan appeal, and to ask for aid to continue, see ***"How do I File an Appeal of an Action?"*** above.

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

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

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

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

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend, or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health

condition requires. In some cases, you may request a "*fast track*" appeal. (See "**Fast Track Appeal Process"** section below.)

Fast Track Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for a *fast-tracked* review of your appeal. of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

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

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

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

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice. If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under ***"How Long Will It Take the Plan to Decide My Appeal of an Action?"*** *above*, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice. If we are reducing, suspending, or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your

Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

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

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

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

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

Online Request Form: Request Hearing | Fair Hearings | OTDA (ny.gov)
Mail a Printable Request Form:

NYS Office of Temporary and Disability Assistance Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

Fax a Printable Request Form: **518-473-6735**
Request by Telephone:
Standard Fair Hearing line – **1-800-342-3334**
Emergency Fair Hearing line – **1-800-205-0110**
TTY line – **711** (request that the operator call **1-877-502-6155**

Request in Person:
New York City
14 Boerum Place, 1st Floor Brooklyn, New York 11201

Albany
40 North Pearl Street, 15th Floor Albany, New York 12243

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

State External Appeals

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

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

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

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called a fast-track external appeal. The external appeal reviewer will decide a fast-track appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

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

COMPLAINTS AND COMPLAINT APPEALS

Aetna Better Health of New York will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by Aetna Better Health of New York staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint, please call: (855) 456-9126 or write to: PO Box 81040 5801 Postal Road Cleveland, OH 44181. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

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

The Complaint Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process must be completed within 7 days of the receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

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

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision, we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal orally or in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address, and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial compliant decision.

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

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 MLTC plan like Aetna Better Health of New York. This support includes unbiased health plan choice counseling and general plan 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 AETNA BETTER HEALTH OF NEW YORK MLTC PLAN

You will not be disenrolled from the MLTC Plan based on any of the following reasons:

- high utilization of covered medical services
- an existing condition or a change in your health
- diminished mental capacity or uncooperative or disruptive behavior resulting from your special needs unless the behavior results in your becoming ineligible for MLTC.

Voluntary Disenrollment

You can ask to leave the Aetna Better Health of New York at any time for any reason. To request disenrollment, call **1-855-456-9126** or you can write to us. The plan will provide you with written confirmation of your request. We will include a voluntary disenrollment form for you to sign and send back to us. 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 CBLTSS, like personal care, you must join another MLTC plan, Medicaid Managed Care plan or Home and Community Based Waiver program, in order to receive CBLTSS.

Transfers

You can try our plan for 90 days. You may leave Aetna Better Health of New York and transfer and join another plan at any time during that time. If you do not leave in the first 90 days, you must stay in Aetna Better Health of New York for nine more months, unless you have good reason (good cause.)

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving Aetna Better Health of New York is best for you.
- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the State

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

To change plans: Call New York Medicaid Choice at **1-888-401-6582**. The New York Medicaid Choice counselors can help you change health plans.

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

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

Involuntary Disenrollment

An involuntary disenrollment is a disenrollment initiated by Aetna Better Health of New York. If you do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) business days from the date we know you meet any of involuntary disenrollment reasons.

You Will Have to Leave Aetna Better Health of New York if you are:

- No longer are Medicaid eligible.
- Permanently move out of Aetna Better Health of New York service area.
- Out of the plan's service area for more than 30 consecutive days.
- Needing nursing home care but are not eligible for institutional Medicaid.
- Hospitalized or enter an Office of Mental Health, Office for People with Developmental Disability or Office of Alcoholism and Substance Abuse Services residential program for forty-five (45) consecutive days or longer.
- Assessed as no longer having a functional or clinical need for (CBLTSS) on a monthly basis.
- Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- Receiving Social Day Care as your only service.
- No longer require, and receive, at least one CBLTSS in each calendar month.
- At the point of any reassessment, while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- Incarcerated.
- Providing the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

We Can Ask You to Leave Aetna Better Health of New York 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
- fail to pay or make arrangements to pay the amount money, as determined by the Local Department 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, Aetna Better Health of New York will obtain the approval of New York Medicaid Choice (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 you become ineligible for enrollment. If you continue to need CBLTSS you will be required to choose another plan, or you will be automatically assigned (auto assigned) to another plan.

CULTURAL AND LINGUISTIC COMPETENCY

Aetna Better Health of New York 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

members. 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

Aetna Better Health of New York 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.
- You have 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 Aetna Better Health of New York.
- Using Aetna Better Health of New York 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 Aetna Better Health of New York 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 Aetna Better Health of New York staff (with your input).
- Cooperating with and being respectful with the Aetna Better Health of New York staff and not discriminating against Aetna Better Health of New York staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation, or marital status.
- Notifying Aetna Better Health of New York within two business days of receiving non-covered or non-pre-approved services.
- Notifying your Aetna Better Health of New York health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- Informing Aetna Better Health of New York 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 Aetna Better Health of New York.
- Specific clinical review criteria relating to a particular health condition and other information that Aetna Better Health of New York 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 Aetna Better Health of New York certified financial statement; policies and procedures used by Aetna Better Health of New York to determine eligibility of a provider.

Notes:

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