GuildNet
LIGHTHOUSE GUILD
Vision+Health

GuildNet Gold Medicaid Advantage Plus

Member Handbook 2015

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GuildNet Gold
Medicaid Advantage Plus
Member Handbook

GuildNet Gold
Medicaid Advantage Plus (MAP) Member Handbook

WELCOME TO GUILDNET GOLD HMO-POS SNP PROGRAM
Medicaid Advantage Plus (MAP) Program

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

HELP FROM MEMBER SERVICES

You can call us at anytime at the Member Services number below.

There is someone to help you at Member Services:
Monday through Friday
8 am to 8 pm
Call 1-800-815-0000 (TTY users call 1-800-662-1220)

If you need help at other times, call us at
1-800-815-0000 (TTY users call 1-800-662-1220)

GuildNet Gold provides information in large print and alternate formats for the visually impaired. GuildNet Gold also provides information in other languages and has free language interpreter services available for non-English speakers.

ELIGIBILITY FOR ENROLLMENT IN THE MAP PROGRAM

GuildNet Gold is a program for people who have both Medicare and Medicaid. You are eligible to join the GuildNet Gold Program if you are also enrolled in GuildNet Gold for Medicare coverage and:

1) Are age 18 and older
2) Reside in the plan's service area: Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Queens or Suffolk

3) Have a chronic illness or disability that makes you eligible for services usually provided in a nursing home
4) Are able to stay safely at home at the time you join the plan
5) Require care management and are expected to need one or more of the following services for at least 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. Adult day health care, or
    f. Social day care if used instead of in-home personal care services: or
    g. Private Duty Nursing

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 Plan 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.

Your physician must agree to collaborate with GuildNet Gold or you must be willing to change to a physician who is willing to collaborate with the managed long-term care plan. Collaboration by a physician means the willingness to write orders for covered services that allow you to receive care from network providers upon enrollment.

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in the GuildNet Gold MAP Program. Enrollment in the MAP Program is voluntary.

Plan enrollment process and timeframes

- When you express an interest in enrolling in GuildNet Gold, you will be asked to sign a scope of appointment form or to give consent on the phone to have a licensed marketing representative call you to explain the Plan.

- If you are interested and are eligible for benefits under Medicare and Medicaid, a meeting will be set up with an Intake Nurse Manager either at your home or a nursing home to conduct a social and health assessment.

- A New York State Assessment Form will be completed by the Intake Nurse Manager to determine if you qualify for a nursing home level of care. The assessment will include a review of your home in terms of its safety and accessibility, and a plan of care for your

health needs will be developed. If you qualify and you are interested in enrolling you will be asked to sign an enrollment agreement, a medical release form and a privacy notice.

- The Intake Nurse Manager will contact your physician to notify him/her of your interest in enrolling and to explain the services provided by GuildNet Gold. We will discuss your plan of care. If your physician is unwilling to collaborate and you still wish to enroll, we can assist you in choosing another physician.

- The above information will be sent to the Medicaid office or their designee to confirm your enrollment.

- If you meet the established criteria and your Medicaid is currently active, your enrollment will usually be effective the 1st of the following month. If the enrollment application is incomplete it may delay the enrollment until a complete application has been secured for GuildNet Gold.

- If you do not meet the criteria to enroll in the MAP program, GuildNet will notify you by mail. If your enrollment is not approved by the Local Department of Social Services (LDSS) or their designee, you will also receive a letter from New York State.

- You will be visited again by the licensed marketing representative and asked to sign a Medicare enrollment form.

- Enrollments will be processed in the order in which they are received without restriction and without discrimination based on age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, health status, change in health status or cost for health services.

- During the enrollment process you will receive an explanation about how to access services and a list of GuildNet network providers. This list may be updated periodically and any changes will be published in the quarterly GuildNet newsletter sent to each member.

- You will receive a personal GuildNet identification card that will cover Medicare services and most Medicaid services. Remember, you need to keep your regular Medicaid card to get services that are not covered under GuildNet Gold.

- In order to improve our services and make sure you are satisfied with your care, a GuildNet staff member will contact you soon after enrolling to answer any questions you may have about GuildNet and to ask if you are satisfied with the service you are receiving through a new enrollee survey.

Network providers will be paid in full directly by GuildNet Gold for each service authorized

and provided to you with **no co-pay or cost to you**. If you receive a bill for covered services authorized by GuildNet Gold, you are not responsible to pay the bill. Please contact your Case Manager. You may be responsible for payment of covered services that were not authorized by GuildNet Gold, or for covered services that are obtained from providers outside of the GuildNet Gold network.

Transitional care procedures

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, agrees to follow GuildNet Gold quality assurance and other policies, and provides medical information about the care to the plan.

If a GuildNet provider you are using for an ongoing course of treatment no longer plans to participate in GuildNet Gold, we will inform you immediately and will assist you in choosing another provider from our network. The existing provider is required to continue providing services for a 90-day period until the transition to a new provider is in place.

MONTHLY SPEND-DOWN

Your payment responsibility to GuildNet will depend upon your eligibility for Medicaid, including any Medicaid spend-down.

When the Local Department of Social Services (LDSS) or their designee reviews your financial status for participation in GuildNet, it may determine that you must "spend-down" a portion of your monthly income in order to meet the income eligibility amount for Medicaid. If this happens, the LDSS or their designee will inform you and GuildNet of the exact amount of your "spend-down", which will be owed to GuildNet every month when you become a member.

You will be expected to pay your spend-down amount to GuildNet by the 15th of each month. If you have a problem meeting this responsibility, please discuss the situation with your Case Manager.

GuildNet will notify you in writing when you are 30 days in arrears of making your payment. If you do not pay your "spend-down" amount within 60 days after the date due, GuildNet has the right to involuntarily disenroll you from the plan.

If your eligibility for Medicaid, including any Medicaid spend-down, changes while you are a GuildNet member, the LDSS or their designee will notify you of the change and GuildNet will adjust your payment accordingly.

SERVICES COVERED BY THE GUILDNET GOLD HMO-POS SNP MAP 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 and prescription drugs are covered by Medicare and are described in GuildNet Gold's Medicare Evidence of Coverage. Sections 2 and 3 of GuildNet Gold's Medicare Evidence of Coverage explain the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some Medicare services have deductibles and copayments. These amounts are shown in the Benefit Chart in Section 4 of GuildNet Gold's Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". **Because you have joined GuildNet Gold, and you have Medicaid, GuildNet Gold will pay these amounts**. **You do not have to pay these deductibles and co-payments.** If there is a monthly premium for benefits (see Section 8 of the GuildNet Gold's 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.

Case Management Services

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

You will have a Care /Service Plan that addresses your short and long-term health needs and includes Medicare and Medicaid services you receive as well as services provided by your family or community organizations. The Care Plan will include the type of services you receive, the amount of services, the frequency of services and length of time the services are authorized for. It includes the goals that you, your family, your physician and Case Manager have discussed. Your Care/Service Plan is expected to change over time according to your needs. You may receive a copy of your Care/Service Plan from your Case Manager on request.

Your Intake Nurse Manager will begin to develop your Care/Service Plan with you during the initial assessment visit. This Care/Service Plan will be effective for the first four (4) months of your enrollment unless there is a significant change in your health status requiring a change in your Care/Service Plan. Once you are enrolled, you will be assigned to a Case Manager, Social Worker and a Member Services Representative. Your team will:

- Assist you with scheduling your medical appointments;
- Arrange non-emergency transportation to appointments and services;
- Assess your needs and modify your care plan;
- Identify and assist you in obtaining services;

- Coordinate your care with your physician;
- Arrange for medically necessary equipment;
- Arrange for modifications in your home if your Case Manager thinks they are needed;
- Remain available to answer your questions or discuss any aspect of your care; and
- Assist you in coordinating all covered and non-covered services.

If you need a new service or a change in an existing service, call your Case Manager to request this service. Your Case Manager will follow the service authorization process described in the Handbook.

If your service request is approved, you will be notified verbally. If the requested service is expected to continue for an extended amount of time you will also receive a written notification of approval. If we deny your request, you will receive a written notification of that decision which also describes how you may appeal our decision.

Your Care/Service Plan will be reviewed with you periodically and during the semi-annual assessment process. If a service is reduced, stopped or suspended or denied by GuildNet Gold during an authorization period, you will receive written notification of that decision which also describes how you may appeal our decision.

Additional Covered Services

Because you have Medicaid and qualify for the MAP 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 Case 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 GuildNet Gold Long Term Care Network.

There may be times when you might need to use a provider outside of the GuildNet Gold Long Term Care Network to provide a covered service. If GuildNet does not have a provider with the training and expertise to meet a specialized health care need included in your Care/Service Plan, you can review the service with your Case Manager. In this instance, GuildNet will authorize a provider who is not in the Long Term Care Network

The following services require authorization from your GuildNet Gold Case Manager **and** a physician's order.

Adult Day Health Care	Includes medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure activities, dental, pharmaceutical, and other ancillary services. Services furnished in approved SNF or extension site.
Home Health Care Services Not Covered by Medicare including	Medicaid covered home health services include the provision of skilled services not covered by Medicare

nursing, home health aide, occupational, physical and speech therapies	(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.
Medical and Surgical Supplies	These items are generally considered to be one-time only use, consumable items routinely paid for under the Durable Medical Equipment category of fee-for–service Medicaid**.**
Medical Social Services	Assessment, arranging and providing aid for social problems related to maintaining individual at home.
Parental and Enteral Formulas and Nutritional Supplements	Coverage of enteral formula and nutritional supplements is limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding.

Outpatient Rehabilitation	Medicaid covered occupational therapy, physical therapy and speech and language therapy is limited to twenty (20) visits per therapy per calendar year except for children under age 21 and the developmentally disabled.
Personal Care (such as assistance with bathing, eating, dressing, toileting and walking)	Medically necessary assistance with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks.
Private Duty Nursing	Private duty nursing services in your home provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse. Private duty nursing services are covered when determined by the attending physician to be medically necessary. Nursing services may be intermittent, part-time or continuous and provided in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan.

The following services must be authorized by your Case Manager; however, they do not require a physician's order.

Nutrition	Assessment of nutritional status/needs, development and evaluation of treatment plans, nutritional education, in-service education, includes cultural

	considerations.
Home Delivered Meals and/or meals in a group setting such as a day care	Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or have them prepared.
Social Day Care	Structured comprehensive program providing socialization, supervision, monitoring, personal care and nutrition in a protective setting.
Non-Emergency Transportation	Transportation essential for an enrollee to obtain necessary medical care and services under the plan's benefits or Medicaid fee-for-service. Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee's medical condition and a transportation attendant to accompany the enrollee, if necessary.
Social/Environmental Supports (such as chore services, home modifications or respite)	Services and items to support member's medical need. May include home maintenance tasks, homemaker/chore services, housing improvement, and respite care.
Personal Emergency Response System	Electronic device that enables individuals to secure help in a physical, emotional or environmental emergency.
Nursing Home Care not covered by Medicare	Skilled nursing facility days provided by a licensed facility in excess of the first 100 days in the Medicare Advantage benefit period.
Hearing Aid Batteries	Services include hearing aid replacement parts such as batteries.

You can access the following services yourself from GuildNet network providers without an authorization from the Case Manager:

Dental	Dental services include, but shall not be limited to, Medicaid-covered preventive, prophylactic and other dental care services, supplies, routine exams, prophylaxis, oral surgery (when not covered by Medicare), and dental prosthetic and orthotic appliances required to alleviate a serious health condition, including one which affects employability.

The following service is authorized as part of your medical benefit.

Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit	All inpatient mental health services, including voluntary or involuntary admissions for mental health services over the Medicare 190-Day Lifetime Limit.

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.
- Orthopedic footwear and inserts coverage is limited to individuals when used as an integral part of a lower limb orthotic appliance or as part of a diabetic treatment plan.
- Compression and support stockings are limited to treatment of venous stasis ulcers or pregnancy.
- Nursing Home Care for long term residential care is covered only for individuals who are eligible for institutional Medicaid coverage. Long term residential care is covered only in facilities that are participating in GuildNet Gold's Long Term Care Network.

Getting Care Outside the Service Area

Please call Member Services or your Case Manager if you are planning to spend time outside of the GuildNet Gold service area so that we may arrange for the provision of covered services. We want to make sure your health care needs are addressed and we want to maintain continuity of care.

Emergency Service

An emergency condition manifests itself by acute symptoms of sufficient severity, for example severe pain, that a prudent lay-person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, to the unborn child; serious impairment to bodily functions; or serious dysfunction of any body organ or part.

You are not required to get prior authorization from GuildNet Gold for treatment of emergency medical conditions. In the event of an emergency medical condition, call 911 or go to the nearest emergency room. You may receive emergency care anywhere in the world without prior authorization. Wherever you are, it is important that you call your GuildNet Case Manager as soon as you, a family member or a friend is able to allow GuildNet Gold to better coordinate your follow up care.

MEDICAID SERVICES <u>NOT</u> COVERED BY OUR PLAN

There are some Medicaid services that GuildNet Gold does not cover. You can get these

services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-800-815-000 (TTY users call 1-800-662-1220) if you have a question about whether a benefit is covered by GuildNet Gold or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription drugs are covered by GuildNet Gold Medicare Part D as described in section 6 of GuildNet Gold's Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Medicare.

Certain Mental Health Services, including:

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

Certain Mental Retardation and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services:

- Methadone Treatment
- 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 GUILDNET GOLD OR MEDICAID

You must pay for services that are not covered by GuildNet Gold 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 GuildNet Gold or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Services of a Provider that is not part of the plan (unless GuildNet Gold sends you to that provider)

If you have any questions, call Member Services at 1-800-815-0000 (TTY users call 1-800-662-1220).

Service Authorizations and Actions

When GuildNet Gold 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 your GuildNet Gold Case Manager before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. When you ask for approval of a treatment or service, it is called a **service request**. To make a service request, you or your doctor may call your Case Manager at our toll-free number at 1-800-815-0000 (TTY users call 1-800-662-1220) or send your request in writing to GuildNet Gold, 15 West 65th St, NY, NY 10023.

Your Case Manager will discuss your need for services with your physician and if necessary with a GuildNet physician reviewer, to determine if the services are appropriate and in what amount and frequency. Once a decision is made, the Case Manager will provide an authorization for these services to the assigned provider who will be responsible for obtaining the medical order from your physician.

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

What happens after we get your service authorization request

The health plan has a review team to be sure you get the services we cover. 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.

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

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).

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 3 work days. We will tell you by the third work day 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 received your request.

- Fast track 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 3 work days after we received your request.

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 **end of** original timeframe.

If you are not satisfied with our answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

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 1-800-815-0000 (TTY users call 1-800-662-1220) 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.

Other Decisions About Your Care

Sometimes we will do a concurrent review on 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 terminate 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.**

Action Appeals

When GuildNet Gold 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; reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal.

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

You can file an action appeal**:**

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 45 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. You can call Member Services 1-800-815-0000 (TTY users call 1-800-662-1220) if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you file an appeal.
- The appeal can be made by phone or 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 should sign and return the form to us. You can make any needed changes before sending the form back to us.

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.

What happens after we get your appeal

- Within 15 days, we will send you a letter to let you know we are working on your appeal. We will let you know if we need additional information to make our decision.
- Action 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.
- Before and during the appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.

- You can also provide information to be used in making the decision in person or in writing.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained or you or someone you trust can file a complaint with the New York State Department of Health at 1-866-712-7197.

Your action appeal will be reviewed under the fast track or expedited appeals process if:

- If you or your doctor asks to have your 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.

Timeframes for Action Appeals

- Standard appeals: If we have all the information we need, we will tell you our decision in 30 days from your appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.

- Fast track/expedited appeals: If we have all the information we need, fast track appeal decisions will be made in 2 working days from your appeal. We will tell you in 3 work days after giving us your appeal, if we need more information. 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 action 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 to make a decision.

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 1-800-815-0000 (TTY users call 1-800-662-1220) 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 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 your original denial was because we said the service was not medically necessary or was experimental or investigational, and we do not tell you our decision about your appeal, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care

In some cases you may be able to continue receiving the services while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you 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 process Fair Hearing process or External Appeals described below.

Fair Hearings

In some cases you may ask for a Fair Hearing from New York State.

- 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 GuildNet Gold made about one of the services that you were getting. You feel the decision limits your Medicaid benefits or that the plan did not make the decision in a reasonable amount of time.

- You are not happy with a decision that GuildNet Gold made that denied services. You feel that the decision limits your Medicaid benefits or that GuildNet Gold did not make the decision in a reasonable amount of time.

- You are not happy with a decision that your doctor would not order one of the services listed above 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 GuildNet Gold. If GuildNet Gold agrees with your doctor, you may ask for a State Fair Hearing.

- In some cases, you may be able to keep getting care the same way while waiting for your Fair Hearing.

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:

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

NOTE: 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.

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 1-800-815-0000 (TTY users call 1-800-662-1220) if you have any questions.

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, 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:

- You must file an action appeal with the plan and get the plan's final adverse determination; **or**
- If you have not gotten the service, and you ask for a fast track action appeal with the plan, you may ask for an expedited external appeal at the same time. Your doctor will have to say an expedited external appeal is necessary; **or**
- You and the plan may agree to skip the plan's appeals process and go directly to external appeal; **or**
- You can prove the plan did follow the rules correctly when reviewing your action 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.

If you had a fast track action appeal and are not satisfied with the plan's decision you can choose to file a standard action appeal with the plan or ask for an external appeal. If you choose to file a standard action appeal with the plan, and the plan upholds its decision, you will receive a new final determination and have another chance to ask for an external appeal.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the State Department of Financial Services within 4 months from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the State Department of Financial Services. You can call Member Services at 1-800-815-0000 (TTY users call 1-800-815-0000) if you need help filing an appeal. You and your doctors will have to give information about your medical problem.

Here are some ways to get an application:

- Call the State Department of Financial Services, 1-800-400-8882
- Go to the State Department of Financial Services website at www.dfs.ny.gov
- Contact the health plan at 1-800-815-0000 (TTY users call 1-800-662-1220)

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.

You may also ask for a Fair Hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for 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.

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 GuildNet Gold 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 Sections 10 and 11 of GuildNet Gold'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 GuildNet Gold you may choose to follow either the Medicare rules outlined in Sections10 and 11of GuildNet Gold's 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 GuildNet Gold's notice of denial of coverage to use your Medicare complaint and appeal rights.

GuildNet Gold will explain the complaints and appeals processes available to you depending on the complaint you have. Call member services at 1-800-815-0000 (TTY users call 1-800-662-1220) to get more information on your rights and the options available to you.

MEDICAID RULES FOR COMPLAINTS AND APPEALS

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 your receive from us, call Member Services at 1-800-815-0000 (TTY users call 1-800-662-1220) or write to Member Services. Please remember that complaints about services that are only a benefit under Medicare should be handled through the GuildNet Gold Medicare complaint process. Complaints about services only covered by Medicaid should be handled through the GuildNet Gold Medicaid complaint process. You can choose to use either the Medicare or Medicaid complaints process for complaints about services that GuildNet Gold 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 1-800-815-0000 (TTY users call 1-800-662-1220) Monday through Friday 8 am to 8 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 GuildNet Quality Assurance and Performance Improvement Department (QAPI), 15 West 65th Street, New York, NY 10023.

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 within 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 day 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 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 business 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 working 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 GUILDNET GOLD MAP PROGRAM

GuildNet Gold will not disenroll based on age, sex, race, creed, physical or mental handicap/developmental disability, national origin, sexual orientation, type of illness or condition, health status, change in health status or cost for health services.

You Can Choose to Disenroll

You can ask to leave the GuildNet Gold MAP Program at any time for any reason.

To request disenrollment, call Member Services or call your Case Manager. 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.

You Will Have to Leave GuildNet Gold's MAP Program if you:

- Are no longer in GuildNet Gold 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 GuildNet Gold service area
- No longer require a nursing home level of care
- 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.

We Can Ask You to Leave the Plan

We will ask that you leave GuildNet Gold if

- You or family member or caregiver behaves in a way that prevents the plan from providing the care you need
- You knowingly provide false information or behave in a deceptive or fraudulent way.
- You fail to complete or submit any consent form or other document that is needed to obtain services for you
- You fail to pay or make arrangements to pay money owed to the plan (spenddown/surplus/NAMI)

GuildNet will notify you in writing if you are at risk of being disenrolled and we will make every attempt to work with you to resolve the matters that are putting you at risk for disenrollment. In all instances we must obtain the approval of the LDSS or their designee before a member can be involuntarily disenrolled.

GuildNet will continue to provide or arrange for your long term care services until your disenrollment is effective. We will also assist you in finding and referring you to alternative service providers.
To prevent a lapse in care, services from the new provider will be effective on the day after your disenrollment from GuildNet. Involuntary disenrollments can only become effective on the first day of a calendar month and follow the same time frames as voluntary disenrollments.

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, you will need to go through the application process again to reenroll. You would need to address the issue that caused the initial disenrollment prior to re-enrolling.

Rights and Responsibilities

Your rights as a minimum include the right to:

- Receive medically necessary care;
- Privacy about your medical record and when you get treatment;
- Timely access to care and services;
- Get information on available treatment options and alternatives presented in a manner and language you can understand;
- Get information in a language you understand; oral translation services are free of charge;
- Get information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get a copy of your medical records and ask that the records be amended or corrected;
- Take part in decisions about your health care including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Get care without regard to sex, race, health status, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to get the services you need from GuildNet, including how you can get covered benefits from out-of-network providers if services are not available in the plan network;
- Complain to GuildNet, the New York State Department of Health or the LDSS or designee office, to use the New York State Fair Hearing System or in some instances request an external appeal, concerning issues of services and quality of care, without retaliation or change in your care from GuildNet;
- Appoint someone to speak for your about your care and treatment; and
- Make advance directives and plans about your care if you are no longer able to decide yourself.

GuildNet offers members opportunities to participate in program policy and development by:

- Giving feedback to us about your experiences with the plan through surveys; and
- Giving suggestions, recommendations and opinions to Member Services, your Case Manager or leadership staff at GuildNet.

You have responsibilities to:

- Use Medicaid providers who are in-network;
- Get approval (prior authorization) from your physician and Case Manager before receiving a covered service requiring such approval;

- Tell GuildNet about your care needs and concerns and work with your Case Manager in addressing them;
- Notify GuildNet when you go away or out of town;
- Make all required payments to GuildNet; and
- Cooperate with any requests for documentation related to maintaining your Medicaid eligibility.

Advanced Directives

The New York Health Care Proxy Law allows you to appoint someone you trust - for example, a family member or close friend - to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. You will need a health care agent if you are temporarily or permanently unable to make health care decisions.

You can request the New York State forms from your Case Manager or from Member Services. You should discuss your wishes with your health care agent. Once your Health Care Proxy has been signed, it's important to ensure that a copy is given to your agent, primary care provider and other family members as well as GuildNet. It is also a good idea to consider carrying a copy in your wallet or purse, in case of unexpected emergencies.

Information Upon Request

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

GuildNet

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