Montefiore
DIAMOND CARE

Member Handbook

1-855-55-MONTE (1-855-556-6683)
TTY/TDD: 711

Member Handbook

The Care Management Team

1-855-55-MONTE

(1-855-556-6683)

Approved by NYS DOH 10282020

Montefiore Diamond Care® Member Services

If you have questions or need help, you can call or write to us any time. Please contact us at the location listed below.

Montefiore Diamond Care
200 Corporate Boulevard South, Suite 200
Yonkers, NY 10701
1-855-55-MONTE (1-855-556-6683)
TTY 711

Call if you need to reach your Care Manager, ask about benefits and services, get help with referrals, replace a lost ID card, or ask any other questions you may have.

If you do not speak English, we can provide you with a written member handbook in other languages. We also use a translation service that can provide oral translation in multiple languages. All of these services can be received upon request at no charge. Please contact us at 1-855-55-MONTE (1-855-556-6683) for additional information.

Special services are available for people with special needs. If you have special needs, call us and we will provide extra help. We will help you find the services that will meet your needs from providers who understand and are prepared to meet your special needs. We can provide materials in large print upon request. To help make communication easier, you can reach us via TTY (Text Telephone Device) by dialing 711. This Member Handbook is also available in large print or on CD upon request.

About This Member Handbook

The Member Handbook is given to you at the time of enrollment to help you to learn about the program. It is designed to help you understand Montefiore Diamond Care's plan. Please read it carefully and refer to it when you need information about how the plan works, including:

- Which services are covered by Montefiore Diamond Care and how to receive them
- What to do in an emergency
- What to do when you are unhappy with services, or decisions about your health care

If you decide to enroll in Montefiore Diamond Care, this handbook becomes your guide to services and along with the enrollment agreement/attestation is your contract with Montefiore Diamond Care. You will receive an updated version of the Member Handbook whenever changes are made. You will also receive the Provider Directory upon enrollment. You may request one at any time.

To enroll in Montefiore Diamond Care, you must be Medicaid eligible.

Membership Card

Your Montefiore Diamond Care identification card (ID card), which will be provided upon enrollment, will let providers know that you are enrolled in the Montefiore Diamond Care Plan. It is important that you carry this card with you at all times.

Tips for New Members

- Keep this Member Handbook handy.
- Keep your Montefiore Diamond Care Member ID and any other health insurance cards in your wallet along with your Medicaid and Medicare cards, including your Medicare Prescription Drug Plan Card.
- Post Montefiore Diamond Care's contact telephone numbers near your telephone.

Contents

1. Welcome to Montefiore Diamond Care

Montefiore Diamond Care is pleased to introduce you to our Managed Long-Term Care program. Montefiore Diamond Care is offered by Montefiore HMO, LLC. We welcome you as a member and urge you to review this booklet carefully. Please feel free to ask questions about any of the sections. If you need help understanding the information in this handbook, please contact Montefiore Diamond Care at:

1-855-55-MONTE (1-855-556-6683)

TTY 711

Enrollment in Montefiore Diamond Care is voluntary. To enroll in our program, you must meet our eligibility criteria as outlined in Section 9, Eligibility. **Montefiore Diamond Care will help you remain as independent as possible.** Montefiore Diamond Care provides and coordinates services designed to keep you living in your own home for as long as possible. Montefiore Diamond Care does this by providing a comprehensive long-term care benefit package of covered services, and by coordinating the Medicaid and Medicare services that you need that we do not cover. Your Care Manager will work with you and your family to provide you with the care you need.

Montefiore Diamond Care provides access to services 24 hours a day, seven days a week, 365 days a year for information, emergency consultation services and response in the community, if necessary. To ensure that you receive the care you need and that your care needs are fully addressed, our staff is available to help you 24 hours a day, seven days a week, 365 days a year. To contact us at any time, call:

1-855-55-MONTE (1-855-556-6683)

TTY: 711

2. Special Features of Montefiore Diamond Care

Montefiore Diamond Care, a Managed Long-Term Care Plan (MLTCP), helps adults age 21 or older by providing and coordinating healthcare services so that they can continue to live at home for as long as possible. Should you decide to enroll in Montefiore Diamond Care, you will be participating in a Managed Long-Term Care Plan of New York State. Managed long-term care is a way to provide you with the healthcare and long-term care services you may need coordinated by one program, Montefiore Diamond Care. If you choose Montefiore Diamond Care, you agree to receive covered services only from Montefiore Diamond Care and its network of providers, as described in your Care Plan. The following elements are key to the Montefiore Diamond Care program:

A. The Montefiore Diamond Care Care Management Team

Upon your enrollment, you will be assigned a Care Manager. Your Care Manager, who will be a nurse or social worker, will help you manage and monitor your health, arrange appropriate care for you, and support your health and independence. Your Care Manger will be either a nurse or a social worker who will be available to help you. Your Care Manager will be supported by non-clinical staff in order to meet all of your care needs.

Your Care Manager is available to assist you with your health needs. These needs may include medical-related health needs such as medications, symptoms, coordinating with your doctor, etc. and non-medical-related health needs such as coordination of Medicaid, Medicare, other insurance, housing, community resources and programs, and/or individual or family counseling. Your Care Manager can also arrange for visits from professionals to your home for nursing, personal care assistance, physical therapy, occupational therapy, and nutrition counseling needs. You may also contact your Care Manager for help with scheduling medical appointments and non-emergent transportation to medical appointments.

In collaboration with you and your doctor, your Care Manager will develop a care plan (also known as a Person Centered Service Plan or PCSP for short) designed to meet your healthcare needs. The care plan will include your goals, objectives, and special needs. Your Care Manager will coordinate the services outlined in your care plan, communicate with your primary care providers on an ongoing basis and arrange for services covered by Montefiore Diamond Care as well as those not covered by Montefiore Diamond Care. To help decide what services are most important to help you remain at home, your Care Manager will continuously monitor and evaluate your health status. The care plan will change as your needs and condition change. Your care plan will be re-evaluated at least every 180 days by a nurse in your home.

You will receive a copy of your Person Centered Service Plan (PCSP) within fifteen (15) days of your enrollment/reassessment.

The PCSP will be developed with your assistance and those individuals you select to participate in service planning and delivery including service providers and your chosen informal supports. The completed PCSP must be signed by you and returned to Montefiore Diamond Care. Montefiore Diamond Care will keep the signed PCSP on file. Should you refuse to sign the PCSP, a note will be placed in your record of your refusal to sign.

By staying in contact with you and your primary care providers and helping you manage all aspects of your care, your Care Manager can identify

problems early, prevent problems from getting worse, enable your access to appropriate care, and help you avoid trips to the hospital and emergency room.

B. Access to Care

For most covered services, your Care Manager must authorize the service before you can receive it. Some covered services require a doctor's order. However, your doctor or your Care Manager does not have to authorize services for you in an emergency or urgent situation, as described in Section 6.

You can also go to an audiologist, dentist, optometrist or apodiatrist for evaluation and routine services without prior authorization from your Care Manager.

C. Where You Will Receive Services

Most of your covered healthcare services are provided in your home and may be supplemented by a contracted day center in our provider network. You can access services in a medical office for dental, podiatry, audiology or optometry services, and if needed, you may receive inpatient nursing home services in an in-network nursing facility.

D. Primary Care Doctors and Other Non-Covered Service Providers

You can choose **your own doctor**. You can also change your doctor at any time.

If you do not have a doctor, your Care Manager can help you find a doctor.

If you need our assistance in finding or changing your doctor, contact your Care Manager at the telephone number listed in this Member Handbook and on your identification card.

You can choose any provider you wish for services not covered by Montefiore Diamond Care.

Your Care Manager will help you to identify providers of non-covered services if you do not already have a provider. See Section 4 for a listing of non-covered services.

Participating Providers and Covered Services You have the freedom to choose providers for covered services paid for by Medicare. However, when Medicare stops paying for these services, you must use a network provider in order for Montefiore Diamond Care to cover the service. Therefore, it may be better for you to choose one of our network providers

right from the start. Montefiore Diamond Care pays the Medicare co-pays for covered services if Medicare is the primary payor.

You will receive a Provider Directory upon enrollment. You may also request one at any time. You have the freedom to choose any provider from this list for covered services. Montefiore Diamond Care will assist you in choosing or changing a provider for covered or non-covered services.

Montefiore Diamond Care maintains an inclusive culturally competent provider network and promotes and ensures delivery of services in a culturally appropriate manner to all enrollees including but not limited to those with limited English skills and diverse cultural and ethnic backgrounds as well as enrollees with diverse faith communities.

You can switch to another network provider at any time. The provider will be changed as soon as possible, based upon the provider's availability.

Network providers will be paid in full directly by Montefiore Diamond Care for each service authorized and provided to you with no co-pay or cost to you. Although there is no cost to you for individual services, you are required to pay the Medicaid Spenddown, if you have one, to maintain your Medicaid benefit. See Section 13, Monthly Spenddown.

If you receive a bill for covered services authorized by Montefiore Diamond Care, please contact your Care Manager. You may be responsible for payment of covered services that were not authorized by Montefiore Diamond Care.

If you have questions about the qualifications of any provider, ask your Care Manager.

E. Flexibility of Care

Montefiore Diamond Care has flexibility in providing care according to your needs and can provide you with the services that are necessary to meet your needs.

F. Organizational Structure

Montefiore Diamond Care is offered by Montefiore HMO, LLC. Montefiore HMO is a managed long-term care company wholly owned by Montefiore Health Systems. Montefiore Diamond Care is a leader in coordinating the care needs of individuals age 21 or older who require more than a continuous 120 days of community-based services, with a focus on enabling them to live at home and in their communities.

3. Advantages of Enrolling in Montefiore Diamond Care

Montefiore Diamond Care was designed and developed specifically to promote independence among adults who need more than a continuous120 days of community-based services by offering comprehensive, coordinated long-term care services through a single organization. Montefiore Diamond Care's unique organizational and financing arrangements allow for providing the most flexible benefits. Other advantages of participating in the plan include:

- A Care Manager and other dedicated qualified health professionals who get to know you personally
- A Care Manager that is there to oversee and coordinate your care whether at home, in a hospital or in a nursing home
- Support for family and caregivers in their efforts to help you remain in your own home
- Enrollment that continues until death or disenrollment regardless of changes in health status; see Section 11, Disenrollment
- Ongoing health promotion and wellness initiatives to help you stay healthy.

4. Benefits and Coverage/Coordination of Other Medical Services

The following benefits are fully covered when specified in your service plan.

Montefiore Diamond Care Covered Services:

Covered Services	Definition
• Care Management	• Care management is a process that ensures consistent oversight, coordination and support to members and their families in accessing MLTCP covered services as well as non-covered services.
• Nursing Home Care (Residential Health Care Facility)	• Short- or long-term stays, including at least three months of permanent placement, provided in a New York State (NYS) licensed skilled care residential facility. Care is provided to members through Montefiore Diamond Care network facilities.
• Home Care a. Nursing	a. Intermittent, part-time nursing services. Nursing services must be provided by a registered nurse (RN) or a licensed practical nurse (LPN). Nursing services include care rendered directly to the member and instructions to a caregiver in the procedures necessary for the member's treatment or health maintenance.
b. Home Health Aide	b. Personal care services in addition to vital signs, administrating pre-drawn insulin, passive range of motion exercises, housekeeping services.
c. Medical Social Services	Information, referral and assistance obtaining or maintaining benefits to help the member remain in the community.
• Adult Day Health Care	Care and services provided in a healthcare facility, including medical, nursing, nutrition and social services; rehabilitation therapy; leisure time activities or other services.
• Personal Care	• Assistance with one or more activities of daily life, such as walking, cooking, cleaning, bathing, using the bathroom, personal hygiene, dressing, feeding, nutritional and environment support function tasks.

Covered Services	Definition
• Consumer Directed Personal Assistance Service (CDPAS)	• Allows the member or person acting on the member's behalf to assume full responsibility for hiring, training, supervising, arranging backup coverage when necessary, keeping payroll records and, if necessary, terminating the employment of the person providing personal care services.
• Durable Medical Equipment (DME) a. Medical/Surgical Supplies b. Medical Equipment c. Enteral and Parenteral Nutritional Supplements* d. Prosthetics e. Orthotics f. Orthotic Footwear	 a. Items for medical use, other than drugs, used to treat a specific medical condition, such as diabetic supplies, wound dressings and other prescribed therapeutic supplies. b. Adaptive devices and equipment prescribed by a medical provider. c. Liquid nutritional supplements as prescribed. d. Artificial substitute or replacement of a limb. e. Appliances and devices used to support or correct the function of a movable part of the body. f. Prescription footwear and inserts. *Limitations apply.*
• Personal Emergency Response System	• An electronic device that enables members to secure help in the event of a physical, emotional or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.
• Non-emergency Medical-Related Transportation	• Travel by ambulance, ambulette, taxi or livery service to obtain necessary covered medical care and services.
• Podiatry	• Services by a podiatrist, which include routine foot care performed as a necessary and integral part of medical care, such as in the diagnosis and treatment of diabetes, ulcers and infections.
• Dentistry	• Includes but not limited to routine exams, preventive and therapeutic dental care, dentures and supplies.
• Optometry/Eyeglasses	• Includes the services of an optometrist and an ophthalmic dispenser, eyeglasses, medically necessary contact lenses and other low-vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the member's condition.

Covered Services	Definition
• Outpatient Rehabilitation Therapies: a. Physical Therapy (PT)* b. Occupational Therapy (OT)* c. Speech Therapy (ST)*	 a. Rehabilitative healthcare that uses specially designed exercises and equipment to help patients regain or improve their physical abilities. b. Rehabilitative healthcare that uses specially designed exercises and equipment to help patients regain or improve their abilities to perform activities of daily living. c. Rehabilitation services for the restoration of the member to his or her functional level in speech or language. * Montefiore Diamond Care Plan will cover medically necessary PT, OT and ST visits that are ordered by a physician or other licensed healthcare professional.
• Audiology • Hearing aids and batteries	• Audiology services include examination, testing, hearing aid evaluation and prescription. • Hearing aid services include selecting, fitting, repairs, replacement, special fittings and batteries.
• Respiratory Therapy	• The provision of preventive, maintenance and rehabilitative airway-related techniques and procedures, including oxygen and other inhalation therapies prescribed by a physician and provided by a qualified company/respiratory therapist.
• Nutrition	• Provided by a Montefiore Diamond Care registered dietician (RD) or diet technician (DT). The RD or DT makes specific recommendations for service to the Care Manager and the member.
• Private Duty Nursing	• Part-time or continuous care from a nurse in the member's place of residence, based on medical needs.
• Home Delivered or Congregate Meals	• Meals delivered for members without cooking facilities or other special circumstances.
• Social Day Care	• Care and services provided in a facility that provides socialization, supervision, monitoring and nutrition.

Covered Services	Definition
• Social and Environmental Supports	• Services and items include, but are not limited to, home maintenance tasks, homemaker/care services, housing improvement and respite care.

Effective January 1, 2016, covered services may be delivered by telehealth. Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver covered services.

Benefits cannot be transferred from you to any other person or organization.

The following services are not covered by Montefiore Diamond Care.

Montefiore Diamond Care Non-Covered Services:[1]

Non-Covered Services	Definition
• Inpatient Hospital Care Services	• A hospital or other institutional bed for receiving care, including room, board and general nursing.
• Outpatient Hospital Care Services	• Care received in a clinic, medical office or other site affiliated with a hospital but not occupying a regular hospital bed.
• Physician Services	• Preventive care, primary medical care and specialty services that fall within a physician's scope of practice.
• Laboratory and Radioisotope Services	• Tests and procedures ordered by a qualified medical professional.
• Emergency Transportation	• Transportation by ambulance as a result of an emergency condition.
• Rural Health Clinic Services	• Federally Qualified Health Centers providing affordable, quality primary care services.
• Chronic Renal Dialysis	• Method used to treat advanced and permanent kidney failure, provided by a renal dialysis center.
• Mental Health Services	• Medical specialty concerned with the prevention, diagnosis and treatment of mental illness.
• Alcohol and Substance Abuse Services	• Treatment to end the excessive use of a substance such as alcohol or drugs.
• Office for People With Developmental Disabilities (OPWDD) Services	• Long-term therapy services provided by treatment facilities certified by OPWDD, comprehensive Medicaid Case Management services, and home- and community-based waiver program services for the developmentally disabled.
• Family Planning Services	• Contraceptive and birth control services.
• Prescription and Nonprescription Drugs; Compounded Prescriptions	• Medications prescribed and/or recommended by a physician. Prescriptions prepared by a pharmacist.
• Hospice	• Home and inpatient care that provides non-curative medical and support services for persons certified by a physician to be terminally-ill with a life expectancy of twelve (12) months or less.
• All other services listed in the Title XIX State Plan	• Services paid by Medicaid fee-for-service.

[1] Non-covered services will be paid for by Medicare, Medicaid fee-for-service or third party insurance, if applicable. We will coordinate these services for all members.

Nursing Home Care

There may be times when your doctor, your Care Manager, and you and your family decide that the best short- or long-term care for you is placement in a nursing home. This is because your home is no longer the best place for you to be taken care of safely and comfortably. The Montefiore Diamond Care plan Care Manager will carefully supervise this placement, and you will continue to receive care through the plan. Nursing Home Care is covered for individuals who are considered permanently placed for at least three months. Following that time period, your Nursing Home Care may be covered through regular Medicaid.

When nursing home care is required, a semiprivate room will be provided in a network facility. If your doctor determines it to be medically necessary, a private room will be covered. The Montefiore Diamond Care plan does not cover personal conveniences such as telephone, radio or television rental.

If you are a veteran, spouse of a veteran or Gold Star parent and need nursing home care, you have the right to get this care in a veteran's home. Montefiore Diamond Care will tell you and your family during enrollment about the availability of a veteran's home in its provider network. If you are eligible and would like to get nursing home care from a veteran's home, and Montefiore Diamond Care does not have an in-network veteran's home, it will arrange this service for you on an out-of-network basis. Montefiore Diamond Care will also work with you, your family and the New York Enrollment Broker to transition you to another Managed Long Term Care (MLTC) Plan in your area with an in-network veteran's home.

Money Follows the Person (MFP)/Open Doors

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

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

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

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

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

5. Care Planning

Care Planning and Care Management

When you enroll, you, your doctor and your Montefiore Diamond Care Plan Care Manager will work together to develop a care plan that meets your needs and is medically necessary. Medically necessary services are services that are necessary to prevent, diagnose, correct or cure conditions that cause you acute suffering, endanger your life, result in illness or infirmity, interfere with your capacity for normal activity or threaten some significant handicap.

The care plan is a written description of your goals, objectives, and special needs as well as all the services that you need. Your care plan is based on input from you and your family or caregivers, your care manager's assessment of your healthcare needs, and the recommendations of your doctor.

Your Care Manager will arrange for the services that you need. This includes arranging for home care services, providing you with home-delivered meals if needed, setting up transportation to and from all non-emergent medically related appointments as needed, and pursuing hospice care if desired.

Your Care Manager will continuously monitor and evaluate your health status and care needs. If your needs change, your care plan will be changed to make sure that it includes all of the services you currently need. This will include increasing or decreasing services and/or changing the services provided. (Please see Requesting Additional Services or Changes to the Care Plan Service and Authorization for Services later in this section.) A formal reassessment of your care needs will occur at least once every 180 days.

These services coordinated by your Care Manager can include non-covered services if you need them as well. If needed your Care Manager will help you schedule appointments with providers of non-covered services and arrange for non-emergent transportation to and from these appointments.

To make monitoring your care and evaluating your needs easier, it is important that you talk with your Care Manager to let them know what you need. It is also important to let your Care Manager know when you have used a non-covered

service. See Section 4, Benefits and Coverage/Coordination of Other Medical Services. By doing so, your care manager will be able to manage your care in the best way possible.

A member of your Montefiore Diamond Care Team is available 24 hours a day, seven days a week, to answer questions about your care plan, and to assist you in accessing both covered and non-covered services.

Authorization for Services

Most of the covered services that you receive must be authorized by your Care Manager. Some of the services also require a doctor's order: home health care, nursing home care, rehabilitative therapies, respiratory therapy, durable medical equipment, prosthetics and orthotics. Environmental supports and home-delivered meals must be authorized by your Care Manager, but do not require a doctor's order. You can go to an audiologist, dentist, optometrist or a podiatrist for evaluation and routine services without prior authorization from your Care Manager.

If you access these services on your own, Montefiore Diamond Care recommends that you contact your Care Manager at your earliest convenience to better manage your healthcare needs.

If you need help to access any covered service, you should talk to your Care Manager. Your Care Manager can schedule an appointment and transportation with the provider.

Emergency or urgent care services do not have to be ordered by your doctor or authorized by your Care Manager.

Requesting Additional Services or Changes to the Care Plan

If you or your doctor feels that you need a covered service or would like to change your service plan, you should contact your Care Manager. Your Care Manager will review the request and reassess your needs to determine if they are medically necessary. Your Care Manager may consult with your doctor about the services and other changes you have requested.

If your Care Manager determines that your request is medically necessary, the service will be provided and your service plan will be modified. If your request is denied, you will receive a Notice of Action regarding the denial.

Montefiore Diamond Care will provide you with a Notice of Action any time we deny or limit services requested by you or a provider on your behalf. See Section 14, Resolving Member Problems and Complaints.

There are specific types of requests called Prior Authorization or Concurrent Review, which can be handled as either standard or expedited. The following are the definitions for each of these:

SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS

Definitions:

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee's behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such service is provided to the Enrollee.

Concurrent Review: review of a request by an Enrollee, or provider on Enrollee's behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

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

There are specific timeframes that Montefiore Diamond Care must adhere to for reviewing your requests, based on whether the request is a Prior Authorization or a Concurrent Review.

Timeframes for Service Authorization Determination and Notification

For Prior Authorization requests, Montefiore Diamond Care Plan must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request

Standard: Fourteen (14) days after receipt of request for Service Authorization Request.

For Concurrent Review Requests, Montefiore Diamond Care Plan must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request

Standard: Fourteen (14) days of receipt of the Service Authorization Request

In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

Up to 14 calendar day extension: Extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.

The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination and help the enrollee by listing potential sources of the requested information.

Enrollee or provider may appeal decision – see Appeal Procedures.

If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.

Montefiore Diamond Care Plan must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee's service request will be reviewed in the standard timeframe.

You have the right to file an appeal if the request is denied.

6. Emergency Services

An emergency[2] is a sudden change in medical condition or behavior that is so severe that if you do not get medical attention it would place your health in serious jeopardy.

A medical emergency can include severe pain, an injury or sudden illness.

When you have a medical emergency, you or your caregiver should call **911**. This is probably the best way for you to receive the care you need as quickly as possible. However, you can always call us. Someone will be able to assist you 24 hours a day. If you need to reach us in an emergency, call:

1-855-55-MONTE (1-855-556-6683)

TTY: 711

You are not required to obtain prior approval from Montefiore Diamond Care to receive emergency services and/or emergency care. You are also not required to notify us in advance that you are seeking emergency care or services.

After you receive emergency care, we ask that you or your caregiver notify us as soon as possible. This will help us to manage your care in the best way.

7. Care Received Outside the Montefiore Diamond Care Service Area

Planned Services

Before you leave Montefiore Diamond Care's service area for an extended period, you must be sure to notify your Care Manager. You can contact us 24 hours a day at:

1-855-55-MONTE (1-855-556-6683)

TTY 711

If you notify us before you leave, we will be better able to assist you in making care arrangements like making sure you have enough medications before you leave. We will also be able to coordinate your care for up to 30 days while you are

[2] An emergency is a medical or behavioral condition, the onset of which is sudden and so severe that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in placing your health or another's in serious jeopardy.

away. During that time, we will be able to help you with any issues or concerns that you have about your care, and with accessing other services.

If you have notified us that you are leaving the service area, you must return within 30 days in order for us to keep you as a member of Montefiore Diamond Care. If you do not return by then, we will unfortunately have to begin the disenrollment process at the end of the 30-day period.

Urgent Services

If you need urgent services and you are in the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa or the Northern Mariana Islands, you or your designee must notify your Care Manager. You can contact us 24 hours a day at:

1-855-55-MONTE (1-855-556-6683)

TTY: 711

When you notify us, we will be able to assist you in making care arrangements and will work with your doctor to ensure you get the services you need.

8. Transitional and Specialty Care

In mandatory counties, if you are transitioning from a Medicaid community-based long-term care program or from a Mainstream Managed Care program and are being treated by a non-network provider for an ongoing course of treatment, we will pay the provider after you are enrolled, for a period of up to 90 days or until your Montefiore Diamond Care care plan is in place (whichever is later), for any covered service that you receive as part of the treatment. In order for us to do this, however, the provider must agree to accept Montefiore Diamond Care's payment rate as payment in full, must agree to abide by Montefiore Diamond Care's policies and procedures, and must agree to provide medical information about your plan of care.

If an enrollee is being disenrolled from another MLTC Plan to Montefiore Diamond Care's MLTC Plan due to an approved service area reduction, closure, acquisition, merger, or other approved arrangement, Montefiore Diamond Care must continue to provide services under the Enrollee's existing Person Centered Service Plan for a continuous period of 120 days after enrollment or until Montefiore Diamond Care has conducted an assessment and the Enrollee has agreed to the new Person Centered Service Plan.

If you are being treated by a network provider for an ongoing course of treatment while you are enrolled, and the provider leaves the network, we will continue to pay the provider for any covered service that you receive for a period of up to 90 days if the provider continues to treat you after he or she leaves the network. In

order for us to do this, however, the provider must agree to accept Montefiore Diamond Care's payment rate as payment in full, must agree to abide by Montefiore Diamond Care's policies and procedures, and must agree to provide medical information about your plan of care.

Your Care Manager may authorize an out-of-network care provider of a covered service. Montefiore Diamond Care will authorize an out-of-network service if the network expertise or the service is not available or accessible in our network. Under these circumstances, we will pay for this covered service.

9. Eligibility

You may be eligible to enroll in Montefiore Diamond Care if you are:

- At least 21 years old.
- Living in the Bronx or Westchester, which are Montefiore Diamond Care's service areas.
- Requiring long-term care services offered by Montefiore Diamond Care for a continuous120 days from the effective date of enrollment. These services are:
    a. nursing services
    b. therapies in the home
    c. home health aide services
    d. personal care services in the home
    e. adult day health care or
    f. private during nursing
    g. Consumer Directed Personal Assistance Services
- Disenrolled from another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, or OPWDD Day Treatment Program at time of enrollment.
- Qualified for Medicaid.
- You are able to return to or remain at home and in your community without jeopardy to your health and safety at the time of enrollment.

In addition to meeting these criteria, you must also sign an Enrollment Agreement and agree to abide by the conditions of Montefiore Diamond Care, as explained in this Member Handbook.

Enrollment is subject to approval by the New York Enrollment Broker, Local Department of Social Services or an entity designated by the New York State Department of Health (DOH).

Conditions for Denial of Enrollment

You will be denied enrollment if any of the following conditions apply:

- You do not meet one of our eligibility criteria.

- You were previously a member of Montefiore Diamond Care and do not meet our requirements for re-enrollment. See Section 12, Re-enrollment Provisions, page 21.

If you are denied enrollment for any reason, the New York Enrollment Broker, LDSS or an entity designated by the NYS DOH will send you a notice advising you of your right to a Fair Hearing.

10. Enrollment and Effective Dates of Coverage

Enrolling in Montefiore Diamond Care is voluntary. If you are interested in joining Montefiore Diamond Care, you or anyone you wish can call Montefiore Diamond Care to find out more about our program.

If you are new to managed long term care, you must first have a Uniform Assessment System (UAS) evaluation conducted by the Conflict-Free Evaluation and Enrollment Center (CFEEC). The CFEEC evaluation which will be performed in your home (including a hospital or nursing home) by a Registered Nurse and will determine if you are community-based long term care eligible. New York State has partnered with New York Medicaid Choice as the independent and conflict-free entity to provide evaluation, education and enrollment services.

To schedule an evaluation or to learn more information about long term care eligiblity and enrollment, please contact the CFEEC at 1-855-222-8350.

As long as you are 21 years of age or older, and live in our service area, an Enrollment Specialist will come to your home to share more information about our program, including providing a copy of this Member Handbook. A Montefiore Diamond Care Provider Directory will be provided to you upon enrollment. In addition, we will collect more information about you and your healthcare needs. You may have a family member, or anyone else you wish present, when the Enrollment Specialist comes to your home. If you are still interested in joining Montefiore Diamond Care after our Enrollment Specialist has described the program to you, our Enrollment Specialist will check your Medicaid eligibility.

- Medicaid eligibility must be reviewed and established for potential enrollees by the New York City Human Resources Administration (NYC HRA) or LDSS.
- If you do not currently have Medicaid, we will help you apply for Medicaid coverage.

Our Enrollment Specialists will:

- Ask you to sign an authorization for intake and nurse assessment, which allows the Intake Nurse to assess your healthcare needs and clinical eligibility.
- Ask you to sign a consent form that allows your healthcare providers to release your medical information to us.
- Review this Member Handbook with you.
- Give you a Provider Directory.

Our Intake Nurse will come to your home, usually within a week of our Enrollment Specialist's visit, to:

- Do an initial assessment which must be conducted within thirty (30) days of your first contact with Montefiore Diamond Care.
- Determine if you require long-term care services offered by Montefiore Diamond Care for more than 120 days.
- Provide you with information and the form regarding the Health Care Proxy.
- Discuss your service needs with you.

After completing the initial assessment, our Intake Nurse will ask you to sign the Enrollment Agreement. By signing the Enrollment Agreement, you agree to:

- Receive all covered services from Montefiore Diamond Care and our network providers.
- Participate in Montefiore Diamond Care according to the terms and conditions described in this Member Handbook.

During the time prior to your enrollment, the Care Manager will maintain contact with you to answer any of your questions, develop your service plan and help you with any service needs prior to your enrollment date.

Your enrollment becomes effective the first of the month. You will receive your membership letter and a Montefiore Diamond Care membership identification card.

Within a few days of joining our program, your Care Manager will contact you to present your service plan and discuss any concerns you may have.

Withdrawal of Enrollment

You may ask Montefiore Diamond Care to stop the enrollment process by noon on the 20th day of the month before the effective date of your enrollment. Montefiore

Diamond Care will confirm your withdrawal in writing. After the effective date of your enrollment, you must disenroll from the program if you no longer wish to participate in Montefiore Diamond Care. See Section 11, Disenrollment and Termination of Benefits.

Transfers

If you want to transfer to another MLTC Medicaid Plan (and have enrolled after December 1, 2020):

You can try us for 90 days. You may leave Montefiore Diamond Care and join another health plan at any time during that time. If you do not leave in the first 90 days, you must stay in Montefiore Diamond Care for nine more months, unless you have a good reason (good cause). Some examples of Good Cause include:

- 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 Montefiore Diamond Care 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. Montefiore Diamond Care 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 Montefiore Diamond Care

11. Disenrollment and Termination of Benefits

Voluntary Disenrollment

Enrollment in Montefiore Diamond Care is voluntary, and you can initiate disenrollment at any time. We will make every effort to resolve your concerns. To initiate disenrollment from the program, you or your designee must make an oral or written request. You can make the request to your Care Manager, who will help you with the process. You will receive written acknowledgment of receipt of request for disenrollment. Disenrollment is effective on the last day of the month following the month in which it is processed by NYMC, LDSS or an entity designated by the NYS DOH. Written confirmation of disenrollment will be mailed to you after disenrollment becomes effective.

Please note that if you are enrolled in Montefiore Diamond Care and you apply to receive services from another managed care plan capitated by Medicaid, an OPWDD Day Treatment program or a program such as the Traumatic Brain Injury Program, you are considered to have initiated disenrollment from Montefiore Diamond Care.

Involuntary Disenrollment

There are certain circumstances under which Montefiore Diamond Care will disenroll you, even though this is not what you wish. Prior to taking this step, we will make every effort to resolve the issues/concerns if possible. You will receive a written notice of our decision to initiate involuntary disenrollment. Once your disenrollment is approved by NYMC, LDSS or an entity designated by the NYS DOH, then NYMC, LDSS or an entity designated by the NYS DOH will send you a notice of your right to a Fair Hearing. Montefiore Diamond Care will send you written confirmation of disenrollment.

Montefiore Diamond Care must disenroll you if:

- You move out of the Bronx or Westchester County, our service area;
- You leave the Bronx or Westchester County for any reason for more than 30 consecutive days;
- You lose your right to receive benefits from the Medicaid program;
- You no longer demonstrate functional or clinical need on a monthly basis for a community-based long-term care services, or for non-dual eligible members, in addition you no longer meet the nursing home level of care requirement;

- You are hospitalized or enter an Office of Mental Health, Office for People With Developmental Disabilities or Office of Alchohol Substance Abuse Services residential program for 45 days or longer
- Your only/sole service is Social Day Care;
- You no longer require and receive at least one CBLTCS in each calendar month;
- Montefiore Diamond Care will provide the LDSS or entity designated by the Department the results of its assessment and recommendations regarding disenrollment within five (5) business days of the assessment making such determination.
- You provide Montefiore Diamond Care with false information, otherwise deceive Montefiore Diamond Care, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

Montefiore Diamond Care may choose to disenroll you if:

- You or your family members or caregivers engage in conduct or behavior that seriously impairs our ability to furnish services to you or others. We must demonstrate and document reasonable efforts to resolve the problems presented by you.

  Montefiore Diamond Care may not disenroll you because of an adverse change in your health status, or because of your utilization of medical services, your diminished mental capacity, or uncooperative or disruptive behaviors resulting from your medical condition or special needs.

- You fail to pay or make arrangements to pay any amount owed as Medicaid spend-down/surplus within 30 days after the amount first became due, provided that during that 30-day period Montefiore Diamond Care made a reasonable effort to collect the amount, including making a written demand for payment and advising you in writing of prospective disenrollment.

Termination of Enrollment for Other Reasons

Your enrollment in Montefiore Diamond Care will be ended if Montefiore Diamond Care loses its contract with New York State allowing it to offer healthcare services. Montefiore Diamond Care has a contract with New York State that is subject to renewal on a periodic basis. Failure of Montefiore Diamond Care to maintain this contract will result in termination of enrollment in the program

Effective Date of Disenrollment and Coordination of Transfer to Other Service Providers

Your disenrollment will become effective on the first day of the month following the month in which the event occurred that resulted in you being ineligible for enrollment. Until your disenrollment becomes effective, Montefiore Diamond Care will continue to provide covered services according to your care plan. During that time, if you wish, your Care Manager will help you identify other service providers who can meet your care needs. Montefiore Diamond Care will assist you in contacting these providers and will coordinate the transfer of your care to them.

12. 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 be allowed to re-enroll in the program if the circumstances that were the basis for disenrollment have been resolved.

13. Monthly Spenddown

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

If you are eligible for:	**You will pay:**
Medicaid (no monthly spenddown)	Nothing to Montefiore Diamond Care
Medicaid (with monthly spend-down)	A monthly spend-down to Montefiore Diamond Care as determined by New York City HRA or LDSS

If you are eligible for Medicaid with a spend-down and your spend-down changes while you are a Montefiore Diamond Care member, your monthly payment will be adjusted.

14. Resolving Member Problems and Complaints

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

To file a complaint or to appeal a plan action, please call: **1-855-556-6683 (TTY 711) Monday-Friday 8:30am-5:00pm** or write to:

Montefiore Diamond Care
Grievance and Appeals Department
Box 500
200 Corporate Blvd. South, Suite 200
Yonkers, NY 10701

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

What is a Complaint?

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

The Complaint Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.

2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

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

How do I Appeal a Complaint Decision?

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

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

What is an Action?

When Montefiore Diamond Care 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.)

Timeframes for Action Notices

When Montefiore Diamond Care Plan intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:

- the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or
- Montefiore Diamond Care may mail notice not later than date of the Action for the following:

  - the death of the Enrollee;
  - a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);
  - the Enrollee's admission to an institution where the Enrollee is ineligible for further services;
  - the Enrollee's address is unknown, and mail directed to the Enrollee is returned stating that there is no forwarding address;
  - the Enrollee has been accepted for Medicaid services by another jurisdiction; or
  - the Enrollee's physician prescribes a change in the level of medical care.

For CBLTCS and ILTSS, when the Montefiore Diamond Care Plan intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)-(b).

For CBLTCS and ILTSS, when Montefiore Diamond Care Plan intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, Montefiore Diamond Care will not set the effective date of the Action to fall on a non-business day, unless Montefiore Diamond Care provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals

Montefiore Diamond Care Plan must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,

When Montefiore Diamond Care Plan does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and Montefiore Diamond Care must send notice of Action to the Enrollee on the date the timeframes expire.

Contents of Action Notices

Montefiore Diamond Care Plan must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.

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

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

How do I File an Appeal of an Action?

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

How do I Contact my Plan to file an Appeal?

We can be reached by calling **1-855-556-6683 Monday-Friday 8:30am-5:00pm. (TTY/TDD 711)** or writing to:

Montefiore Diamond Care
Grievance and Appeals Department
Box 500
200 Corporate Blvd. South, Suite 200
Yonkers, NY 10701

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

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

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless

you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

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

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

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

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

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

Expedited Appeal Process

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

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

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

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

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

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

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

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

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

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

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

- Online Request Form: http://otda.ny.gov/oah/FHReq.asp

- Mail a Printable Request Form:

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

- Fax a Printable Request Form: (518) 473-6735

- Request by Telephone:

  Standard Fair Hearing line – 1 (800) 342-3334
  Emergency Fair Hearing line – 1 (800) 205-0110
  TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:

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

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

State External Appeals

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

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

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

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

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

Contacting the Participant Ombudsman

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. 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

15. Your Rights and Responsibilities as a Montefiore Diamond Care Member

As a member of Montefiore Diamond Care, you have the right:

1. To receive medically necessary care.
2. To timely access to care and services.
3. To privacy about your medical record and when you get treatment.
4. To get information on available treatment options and alternatives presented in a manner and language you understand.
5. To get information in a language you understand. You can get oral translation services free of charge.
6. To get information necessary to give informed consent before the start of treatment.
7. To be treated with respect and dignity.

8. To get a copy of your medical records and ask that the records be amended or corrected.
9. To take part in decisions about your healthcare, including the right to refuse treatment.
10. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
11. To get care without regard of age, sex, race, gender identity including status of being transgender, creed, religion, physical or mental disability including gender dysphoria, sexual orientation, source of payment, type of illness or condition, need for health services, place of origin, or with regard to the Capitation Rate the Plan will receive.
12. To be told where, when and how to get the services you need from Montefiore Diamond Care, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
13. To complain to the New York State Department of Health.
14. To complain to your local department of social services and the right to use the New York State Fair Hearing system.
15. To appoint someone to speak for you about your care and treatment.
16. To make advance directives and plans about your care.
17. To seek assistance from the Participant Ombudsman program.
18. To receive information in a manner which does not disclose your participation in the Montefiore Diamond Care Plan (provided that inclusion of the Plan's name is not considered a violoation of this right).

Responsibilities of Members

To have the greatest benefit from enrollment in Montefiore Diamond Care, you have the following responsibilities:

1. To Participate Actively in Your Care and Care Decisions

- To communicate openly and honestly with your doctor and Care Manager about your health and care.
- To ask questions to be sure you understand your service plan and to consider consequences of not following your service plan. Your Care Plan and changes to your Care Plan will be discussed and documented as part of our monthly care management call.
- To share in care decisions and continue to be in charge of your own health.
- To complete self-care as planned.
- To keep appointments or inform the Care Manager of needs to change appointments.

- To use Montefiore Diamond Care network providers for care except in emergency situations.
- To notify Montefiore Diamond Care if you receive health services from other healthcare providers.
- To participate in policy development by writing to us, or calling us, or being part of the member advisory council.

2. To Support the Montefiore Diamond Care Program

- To appropriately express opinions, concerns and suggestions in the following ways, including, but not limited to, expressing your opinions or concerns to your Care Manager, or through the Montefiore Diamond Care complaint and appeals process.
- To review the Member Handbook and follow procedures to receive services.
- To respect the rights and safety of all those involved in your care and to assist Montefiore Diamond Care in maintaining a safe home environment.
- To notify your Care Manager at Montefiore Diamond Care if you:
    - are leaving the service area
    - have moved or have a new telephone number
    - have changed doctors
    - have any changes in your condition that may affect our ability to provide care

You can call us at **1-855-556-6683 (TTY 711)** or write to us at:

Montefiore Diamond Care
Box 800
200 Corporate Boulevard South, Suite 200
Yonkers, NY 10701

Notice of Information Available on Request

The following information is available upon request by the member:

- Montefiore Diamond Care procedures for protecting confidentiality of medical records and other member information.
- Information related to member complaints and aggregated information about complaints and appeals.
- A written description of the organizational arrangement and ongoing procedures of Montefiore Diamond Care's Quality Assurance Program.
- Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information that Montefiore Diamond Care might consider in its utilization review and how it is used in the utilization review process, provided, however, that to the extent that such information is proprietary to Montefiore Diamond Care, the member or prospective member shall use the information only for the purpose of assisting the member/prospective member in evaluating the covered services provided by Montefiore Diamond Care.
- Individual health practitioner affiliations with participating hospitals and other facilities.
- Licensure, certification and accreditation status of participating providers.

16. Important Information About Advance Directives

You have a right to make your own health care decisions. State and federal laws give adults in New York State the right to accept or refuse medical treatment, including life-sustaining treatment, in the event of a serious illness or injury. Your instructions can be stated in a document called an ***Advance Directive***. Montefiore Diamond Care encourages you to think about this now before a serious situation occurs.
Preparing Advance Directives will help ensure that your health care wishes are followed. There are many different types of Advance Directives:

- Living will
- Power of Attorney
- Durable Power of Attorney for Health
- Health Care Proxy
- Do Not Resuscitate Orders

It is your choice whether you wish to complete an Advance Directive and which type of Advance Directive is best for you. The law forbids any discrimination against you in medical care based on your Advance Directive decisions.

For more information regarding Advance Directives, please speak with your Care Manager by calling 1-855-55-MONTE (1-855-556-6683) Monday through Friday 8:30 am to 5:00 pm. Your primary care provider can also tell you more about Advance Directives.

17. Protection of Member Confidentiality

It is the policy of Montefiore Diamond Care to protect your confidentiality and that of your family. To protect this confidentiality:

- All information in your medical record is confidential. Staff protect against accidental release of information by safeguarding records and reports from unauthorized use.
- All requests for information will be reviewed by the Montefiore HMO Compliance Officer to protect your right to privacy. Only necessary information will be released to community agencies, hospitals and long-term care facilities to ensure the continuity of your care. Information will be copied or shared with these agencies only if you or your designee has signed a release to authorize Montefiore HMO to provide medical, nursing and psychosocial information to that facility.
- Montefiore HMO will permit only legally authorized representatives of Montefiore HMO to inspect and request copies of your medical record and other records of the covered services provided to you according to the written consent that you will have been asked to execute authorizing Montefiore Diamond Care to release such information.
- Montefiore Diamond Care will follow all federal and New York State laws regarding confidentiality, including those that relate to HIV testing results.
- Montefiore Diamond Care will maintain all records relating to you for a period of not less than seven years after your disenrollment. Montefiore Diamond Care's medical and financial records are, and will remain, the property of Montefiore Diamond Care except in accordance with applicable state and federal law, regulations and Montefiore Diamond Care policy and procedures.
- Any requests for information regarding your care received from law enforcement agencies, such as the police or district attorney's office, will be brought to the attention of the Compliance Officer of the Montefiore HMO prior to providing any information to ensure that the proper authorization is obtained.

18. Quality Assurance and Improvement Program

Montefiore Diamond Care has a Quality Management System to systematically monitor and evaluate the quality and appropriateness of care and service. This comprehensive Quality Management System must meet the New York State health and long-term care quality assurance standards.

Our Quality Management System identifies opportunities for improving:

- The quality of service provided;
- The management of care, including availability, access and continuity;
- The identification and correction of operational and care management practices;
- The outcomes in clinical, nonclinical and functional areas.

The Quality Management System includes a plan to look for areas where improvement is needed, a process for the continuous improvement of performance, a review of the credentials of all providers providing care or service, maintenance of health information records and review of service utilization.
We welcome your suggestions and input regarding quality improvement.

Definitions

Backup Care Plan means a plan that is in place to ensure that needed assistance will be provided when the regular services and supports in the Enrollee's Person Centered Service Plan are temporarily unavailable. The Backup Care Plan may include other individuals, services, or settings and must be included in the PCSP. Individuals available to provide temporary assistance include informal caregivers such as the Enrollee's family member, friend or other responsible adult.

Personal Care Services – medically necessary assistance with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Includes medically necessary assistance with Activities of Daily Living (ADL's), Instrumental Activities of Daily Living (IADL's) and health-related tasks through hands-on assistance, supervision, and/or cueing.

Home Health Aide Services – health care tasks, personal hygiene services, housekeeping tasks and other related supportive services essential to the patient's health.

Personal Emergency Response Services (PERS) – Electronic device that enables individuals to secure help in a physical, emotional or environmental emergency.

Home Delivered and/or Congregate Meals – Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or to have them prepared.

Conflict Free Evaluation and Enrollment Center (CFEEC) is the entity that contracts with the Department to provide initial evaluations to determine if an Applicant is eligible for Community Based Long Term Care (CBLTC) for a continuous period of more than 120 days. The CFEEC will be responsible for providing conflict-free determinations by completing the Uniform Assessment System (UAS) for Applicants in need of care. CFEEC evaluations are conducted in the Applicant's home (includes hospital or nursing home) by a Registered Nurse.

Consumer Directed Personal Assistance Services (CDPAS) means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of an Enrollee or the Enrollee's designated representative. Personal assistants are hired, trained and if necessary, fired by the Enrollee or their designated representatives. Personal assistants are paid through a Fiscal Intermediary, which is an entity that has a subcontract with Montefiore Diamond Care to provide wage and benefit processing and other fiscal intermediary responsibilities specified in subdivision (i) of Section 505.28 of Title 18 of the NYCRR. If you are not self directing a designated

representative will be identified to assume your responsibities for CDPAS. This representative may not act as your personal assistant.

Long Term Services and Supports or (LTSS) means health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS is comprised of community-based services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, Personal Care Services, and institutional services including Long Term Placement in Residential Health Care Facilities.

Money Follows the Person (MFP) means a demonstration that is part of Federal and State initiatives designed to rebalance long term care services and promote consumer choice. As New York State continues to shift the focus of its long term care systems away from institutional care and towards integrated home and community-based care, support from the MFP program becomes valuable to all Managed Care Organizations (MCO's). MFP is designed to streamline the process of deinstitutionalization for vulnerable populations. Under the name Open Doors, the MFP program funds Transition Specialists and Peer Support to assist these individuals to transition out of institutions such as nursing homes and intermediate care facilities, and into qualifying community settings. A qualified setting may be a house, an apartment, or a group home (with a maximum of four unrelated people).

Non-Emergency Medical Transportation shall mean transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the Enrollee's condition for the Enrollee to obtain necessary medical care and services reimbursed under the New York State Plan for Medical Assistance or the Medicare Program. Montefiore Diamond Care is required to use only approved Medicaid ambulette vendors to provide ambulette transportation services to Enrollees.

Telehealth means the use of electronic information and communication technologies by telehealth providers to deliver healthcare services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee. Telehealth shall not include delivery of health care services by means of audio-only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring.