Addendum to the New York State < Medicaid Managed Care/Health and Recovery Plan> Member Handbook for the Integrated Benefits for Dually Eligible Enrollees (IB-Dual) Program

Introduction

This member handbook addendum provides information for members of the Integrated Benefits for Dually Eligible Enrollees (IB-Dual) Program. The IB-Dual program allows Medicare-eligible members to be enrolled in <Medicaid managed care/Health and Recovery Plan (HARP)> health plan. Members will get their Medicare and Medicaid benefits through <Insert Plan Name> [If health plan D-SNP name differs, health plan should also include "and <D-SNP Name>"].

How to Use This Handbook Addendum

This addendum will tell you how your new integrated health care program works and how you can get the most from <Insert Plan Name>. It provides you with information that applies to an IB-Dual member (i.e., a member who has both Medicare and Medicaid coverage with the same health plan).

This includes information about enrollment, disenrollment, access to services, and how to file a complaint or appeal that may be different than what is included in your <Medicaid Managed Care/Health and Recovery Plan> member handbook.

When you have a question, check your handbook or call <Insert Plan Name> Member Services.

Enrollment

To be a member of the IB-Dual Program offered by <Insert Plan Name>, you must:

- Have both Medicare Part A and Medicare Part B and be enrolled in <Insert Plan Name or D-SNP Name if different> Medicare Advantage Dual Special Needs Plan (D-SNP) Part C,
- Live in the plan's service area [Health plan should describe the service area covered for enrollment into IB-Dual],
- Be a United States citizen or be lawfully present in the United States,
- Be enrolled in <Insert Plan Name> Medicaid managed care or Health and Recovery Plan (HARP), and
- Not be in receipt of community based long term care services (CBLTSS) for more than 120 days.

Your Health Plan Identification (ID) Card [Include this section to describe any differences in ID card (s) that an IB-Dual member must utilize to access services under this program, if applicable.]

After you enroll, you will be sent a welcome letter. Your new <Insert Plan Name> IB-Dual ID card should arrive within 14 days after your enrollment date. Your card has your primary care provider's (PCP's) name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong on your <Insert Plan Name> IB-Dual ID card, call us right away. Your IB-Dual ID card does not show that you have Medicaid or that <Insert Plan Name> is a special type of health plan.

Always carry your IB-Dual ID card and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need this card to get services that <Insert Plan Name> does not cover.

Disenrollment

You may disenroll from the IB-Dual program at any time. If you voluntarily disenroll from either the Medicare or Medicaid coverage with us, your coverage under this program will end.

You may be involuntarily disenrolled from your IB-Dual program if you:

- permanently move out of our service area for the IB-Dual program,
- lose your Medicaid coverage and don't regain it within 90 days (see below under "Loss of Medicaid Eligibility" for more information),
- are in receipt of long term care services for more than 120 days (if <Insert Plan Name> finds that you require long term care services for more than 120 days, you will be offered the option to enroll in a Managed Long Term Care (MLTC) plan, or
- become eligible for a long term nursing home stay.

Medicare Coverage

If you disenroll from the <Insert Plan Name> IB-Dual program, you can enroll in a Medicare Advantage plan. If you do not enroll in a Medicare Advantage plan, the federal government will enroll you in Original Medicare for your medical care and in a Prescription Drug Plan (PDP) for your prescription drug coverage.

Medicaid Coverage

If you disenroll from the <Insert Plan Name> IB-Dual program, New York Medicaid Choice will enroll you in regular Medicaid.

Note: If you disenroll from the IB-Dual program in error, please contact the plan as soon as possible.

Loss of Medicaid Eligibility

If you lose Medicaid eligibility, your coverage in the IB-Dual program will end. However, you will have a 90-day grace period when your Medicare coverage will continue with the <insert Plan Name or D-SNP Name if different> D-SNP. If you regain Medicaid eligibility during the 90-day grace period, your coverage in the IB-Dual program will be reinstated. If you do not regain Medicaid eligibility during the 90-day grace period, you will be responsible for any copayments, coinsurance, premiums, and/or deductibles for which Medicaid would otherwise cover had you not lost your Medicaid eligibility.

Coordinating your Benefits

<Insert Plan Name> will coordinate both your Medicare and Medicaid benefits through the IB-Dual program. Your cost-sharing for Medicare-covered services will be $0 because Medicaid will cover your Medicare cost-sharing amounts.

Some services not covered by <Insert Plan Name> are available through regular Medicaid or Original Medicare (for example, non-emergency transportation and hospice services). Additionally, the Medicaid Pharmacy Program (NYRx) will cover select over the counter (OTC) drugs, prescription vitamins, and cough suppressants that are not covered by Medicare Part D. You will continue to have access to regular Medicaid services during your enrollment in the IB-Dual plan.

Service Authorization, Appeals, and Complaints

Service Authorization

For services that are covered by Medicare or by both Medicare and Medicaid, <Insert Plan Name> will make decisions about your care as described in Chapter 9 of your Medicare Advantage D-SNP Evidence of Coverage (EOC). These are also known as Coverage Decisions.

For services covered only by Medicaid, <Insert Plan Name> will make decisions about your care following our Service Authorization rules described in Part II of your member handbook.

[***The following language should be included by plans that do not meet the definition of Applicable Integrated Plan***]

Appeals

Because you have both Medicare and Medicaid, the way you make appeals about your services will depend on whether the services are covered by Medicare or Medicaid.

Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file an appeal (also known as a Level 1 appeal) or complaint on a decision <Insert Plan Name> makes about a service that is covered only by Medicare (such as chiropractic services) using the Medicare process.

Part II of your <Medicaid Managed Care/Health and Recovery Plan> member handbook tells you how to file an appeal (also known as a Plan Appeal) on a decision <Insert Plan Name> makes about a service that is covered only by Medicaid (such as personal care services) using the Medicaid process.

For services covered by **both** Medicare and Medicaid, you can file an appeal using the Medicare process, the Medicaid process, or both processes.

- If you follow the Medicare process to appeal, you cannot use your Medicaid appeal rights, which includes the right to a state Fair Hearing and may also include the right to an External Appeal.

- If you follow the Medicaid process to appeal, you will still have 60 days from the day of <Insert Plan Name>'s notice of action to use your Medicare appeal rights instead.

Aid to continue while appealing a decision about your care

If <Insert Plan Name> reduces, suspends, or stops a service, and the service is covered by Medicaid, you may be able to continue the service while you wait for an appeal determination.

You must ask for a Medicaid Plan Appeal:

- **Within ten (10) days from being told that your care is changing, or**
- **By the date the change in service is scheduled to occur, whichever is later.**

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

If you are unhappy with your appeal decision, you can appeal again.

- If the appeal is for a service covered only by Medicare, <Insert Plan Name> will automatically forward your case to the Medicare Independent Review Entity

(IRE). See Chapter 9 of your Medicare Advantage D-SNP EOC about Level 2 appeals.

- If the appeal is for a service covered only by Medicaid, see Part II of the <Medicaid Managed Care/Health and Recovery Plan> member handbook about how to file a Fair Hearing. In some cases, you may also be able to file an External Appeal.
    - If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.
- If the appeal is for a service covered by **both** Medicare and Medicaid, <Insert Plan Name> will forward your case to the IRE. You may also file a Fair Hearing. In some cases, you may also be able to file an External Appeal. See Part II of the <Medicaid Managed Care/Health and Recovery Plan> member handbook on how to file a Fair Hearing and External Appeal.
    - If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Aid to continue while waiting for a Medicaid Fair Hearing decision

You may be able to continue your services while you wait for a Fair Hearing determination. Continuation of benefits is only available if <Insert Plan Name> reduces, suspends, or stops a service, and the service is covered by Medicaid.

You must ask for a Fair Hearing:

- **Within ten (10) days from the date of the Final Adverse Determination, or**
- **By the date the change in services is scheduled to occur, whichever is later.**

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

If you are unhappy with the Level 2 appeal decision for a service covered by Medicare, you may have other appeal rights options. For more information about these appeal rights options, see Chapter 9 of your Medicare Advantage D-SNP EOC or call Member Services.

Complaints

Because you have both Medicare and Medicaid, the way you make a complaint about your services will depend on whether the benefit is covered by Medicare or Medicaid.

Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a complaint about Medicare benefits.

Part II of your <Medicaid Managed Care/Health and Recovery Plan> member handbook tells you how to file a complaint about Medicaid benefits.

For complaints about your Medicare and Medicaid benefits, you can file a complaint using the Medicare process, the Medicaid process, or both.

- If you follow the Medicaid process to complain, and you disagree with the decision <Insert Plan Name> made about your complaint, you can file a complaint appeal with <Insert Plan Name>.

[The following language should be included by plans that meet the definition of Applicable Integrated Plan]

Appeals

If you are unhappy with a decision <Insert Plan Name> makes, you can file an appeal. This is called a Level 1 appeal.

Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a Level 1 appeal on any decision <Insert Plan Name> makes.

Aid to continue while appealing a decision about your care

If <Insert Plan Name> reduces, suspends, or stops a service you are getting now, you may be able to continue the service while you wait for a Level 1 appeal determination.

You must ask for a Level 1 appeal:

- **Within ten (10) days from being told that your care is changing, or**
- **By the date the change in service is scheduled to occur, whichever is later.**

If your Level 1 appeal results in another denial, you will not have to pay for the cost of any continued benefits that you receive.

If you are unhappy with your Level 1 appeal decision, you can appeal again. This is called a Level 2 appeal. Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a Level 2 appeal on any decision <Insert Plan Name> makes.

Aid to continue while waiting for a Fair Hearing decision

You may be able to continue your services while you wait for a Fair Hearing determination. Continuation of benefits is only available if <Insert Plan Name> reduces, suspends, or stops a service, and the service is covered by Medicaid.

You must ask for a Fair Hearing:

- **Within ten (10) days from the date of the Final Adverse Determination, or**
- **By the date the change in services is scheduled to occur, whichever is later.**

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

If you are unhappy with the Level 2 appeal decision for a service covered by Medicare, you may have other appeal rights options. For more information about additional appeals rights options, see Chapter 9 of your Medicare Advantage D-SNP EOC or call Member Services.

Complaint

If you have a problem with your care or services, you can contact Member Services at [Health Plan to provide contact information and availability here].

If you send a complaint in writing, <Insert Plan Name> will respond to you in writing. Your complaint will be answered as quickly as your case requires based on your health status, either in writing, by telephone, or both, within 30 calendar days from the day your complaint is received.

See Chapter 9 of your Medicare Advantage D-SNP EOC for more information on complaints.

Benefits and Services

As an IB-Dual enrollee, you receive both your Medicare benefits and Medicaid benefits from the same health plan. Most of your health benefits and services are covered through your Medicare Advantage D-SNP. The <Medicaid managed care/HARP> part of your plan provides a number of Medicaid services in addition to those you get with regular Medicaid.

See your Medicare Advantage D-SNP EOC for details on your Medicare benefits and services. For additional benefits and services covered through Medicaid managed care, see Part II of your <Medicaid Managed Care/Health and Recovery Plan> member handbook.

<Insert Plan Name> will arrange for most services that you will need. You can get some services without going through your PCP. Please call Member Services at <Insert Member Services Toll-Free Number> if you have any questions or need help with any of these services.