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NEW YORK STATE DEPARTMENT OF HEALTH, OFFICE OF HEALTH INSURANCE PROGRAMS

New York State Department of Health Instructions for the Provision of Medicaid Managed Care-Specific Information within Medicare Advantage Dual Special Needs Plan Marketing and Communications

I. Purpose

To provide Mainstream Managed Care Plans (MMC) and Health and Recovery Plans (HARP) that operate an Integrated Benefits for Dually Eligible Enrollees (IB-Dual) program, and Medicaid Advantage Plus (MAP) Plans, collectively referred to here as Medicaid Managed Care Plans (MMCP), who provide coverage of Medicare services for dually eligible enrollees through an aligned Medicare Advantage (MA) Dual Special Needs Plan (D-SNP), with guidance on Medicaid Managed Care-Specific Information for use on MA D-SNP Marketing and Communications.

This guidance is effective June 18, 2025.

II. Authority

- Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract; and
- Medicaid Advantage Plus Model Contract.

III. Definitions

For the purposes of this guidance, these terms have the following meanings:

a. “Centers for Medicare and Medicaid (CMS) Required Material” means a MA material that is required under 42 C.F.R. §422.2267(e).

b. “Medicare Advantage Marketing” means the CMS Required Materials, for D-SNPs, listed below:

i. Annual Notice of Change (ANOC);

ii. ANOC Errata;

iii. Evidence of Coverage Errata; and

iv. Summary of Benefits (SB).

c. “Medicare Advantage Communications” means the CMS Required Material, for D-SNPs, listed below:

   i. Evidence of Coverage (EOC).

d. “Medicaid Managed Care” means the Mainstream Managed Care, Health and Recovery Plan, and Medicaid Advantage Plus lines of business.

e. “Medicaid Managed Care-Specific Information” means Medicaid Managed Care contact information and enrollee rights.

f. “Plan Created Material” means any other member and/or public facing outreach, marketing, or communication created by an IB-Dual or MAP program aligned MA D-SNP, that is not a CMS Required Material, that contains Medicaid Managed Care-Specific Information or Medicaid Managed Care benefit information.

IV. Medicaid Managed Care-Specific Contact Information

MMCP must include the following contact information, where applicable, on MA Marketing and Communications described within this guidance and, as appropriate, on Plan Created Materials.

a. Medicaid Agency Contact Information

   i. MMCP must include the following contact information for the Medicaid Agency Contact:

      1. The name must reflect “New York State Medicaid Program”.

      2. The phone number must reflect “1-800-541-2831 Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM”.

      3. The TTY phone number must reflect “711”.

      4. The address must contain the following language:

         “You can write to your Local Department of Social Services (LDSS). Find the address for your LDSS at: www.health.ny.gov/health_care/medicaid/ldss”.

      5. The website must reflect “www.health.ny.gov/health_care/medicaid”.

b. State Specific Ombudsman Program Contact Information

   i. MMCP must include the following contact information for the Independent Consumer Advocacy Network (ICAN) ombudsman:

1. The name must reflect “Independent Consumer Advocacy Network (ICAN)”.
    A. MMCP operating the IB-Dual program must include the following additional language about ICAN:

    “This ombudsman can help enrollees in our Health and Recovery Plan (HARP), and enrollees in our Medicaid Managed Care (MMC) plan that get long term services and supports.”

2. The phone number must reflect “1-844-614-8800 Mon.-Fri. 9:00 AM - 5:00 PM”.

3. The TTY phone number must reflect “711”.

4. The address must reflect:

    “Independent Consumer Advocacy Network (ICAN)
    Community Service Society of New York
    633 Third Ave, 10th Floor
    New York, NY 10017
    EMAIL: ican@cssny.org”.

5. The website must reflect “www.icannys.org”.

ii. MMCP operating the IB-Dual program must include the following contact information for the Community Health Advocates (CHA) ombudsman:

1. The name must reflect “Community Health Advocates (CHA)”.

2. The phone number must reflect “1-888-614-5400 Mon.-Fri. 9:00 AM - 4:00 PM”.

3. The TTY phone number must reflect “711”.

4. The address must reflect:

    “Community Health Advocates (CHA)
    Community Service Society of New York
    633 Third Ave, 10th Floor
    New York, NY 10017
    EMAIL: cha@cssny.org”.

5. The website must reflect “www.communityhealthadvocates.org”.

iii. MMCP must include the following contact information for the Community Health Access to Addiction and Mental Health Project (CHAMP) ombudsman:

1. The name must reflect “Community Health Access to Addiction and Mental Healthcare Project (CHAMP)”.

2. The phone number must reflect “1-888-614-5400 Mon.-Wed. 9:00 AM – 7:00 PM, Thurs.-Fri. 9:00 AM – 4:00 PM”.

3. The TTY phone number must reflect “711”.

4. The address must reflect:

   “Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
   Community Service Society of New York
   633 Third Ave, 10th Floor
   New York, NY 10017
   EMAIL: ombuds@oasas.ny.gov”.

5. The website must reflect “www.champny.org”.

c. State Specific Long-Term Care Ombudsman Program Contact Information

i. MMCP must include the following contact information for the New York State Long Term Care ombudsman:

1. The name must reflect “The New York State Long Term Care Ombudsman Program”.

2. The phone number must reflect “1-855-582-6769 Mon.-Fri. 9:00 AM – 5:00 PM”.

3. The address must reflect:

   “2 Empire State Plaza, 5th Floor
   Albany, NY 12223
   EMAIL: ombudsman@aging.ny.gov”.

4. The website must reflect “www.aging.ny.gov/long-term-care-ombudsman-program”.

V. Medicaid Managed Care-Specific Appeal and Grievance Information

MMCP must include the following information on the MA Communications described within this guidance, as outlined in this section.

a. For MMCP operating the IB-Dual program where the aligned MA D-SNP **does not** meet CMS' definition of an Applicable Integrated Plan (AIP), the following sections within Chapter 9A of the EOC, titled *If you have a problem or complaint (coverage decisions, appeals, complaints),* should include the Medicaid Managed Care-Specific Information outlined below:

   i. In section 2, *Where to get more information and personalized help-You can get help and information from Medicaid*, MMCP must include the following information:

      - "You can call the Medicaid Helpline at 1-800-541-2831 (TTY 711) Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM.
      - You can write to your Local Department of Social Services (LDSS). Find the address for your LDSS at: www.health.ny.gov/health_care/medicaid/ldss
      - You can also visit the New York State Medicaid website: www.health.ny.gov/health_care/medicaid"

   ii. In section 12, *Handling problems about your Medicaid benefits*, MMCP must include the following information:

      "**The below information is for our members enrolled in the Integrated Benefits for Dually Eligible Enrollees (IB-Dual) Program.**

      Medicaid Appeals

      Because you get your Medicare and Medicaid benefits through <Insert Plan Name> [If health plan D-SNP name differs, health plan should also include "and <D-SNP Name>"], the way you make appeals about your services will depend on whether the services are covered by Medicare or Medicaid.

      When we deny a service or approve it for an amount that is less than requested, and the service is covered under Medicaid only, you will get an Initial Adverse Determination notice that tells you how to file a Medicaid appeal (also known as a Plan Appeal). Part II of your Medicaid member handbook also tells you how to file a Medicaid appeal.

      When we deny a service that is covered under **both** Medicare and Medicaid, you will get two notices, an Integrated Denial Notice about your Medicare decision and an Initial Adverse Determination notice about your Medicaid decision. In this case, you can file a Medicare appeal (also known as a Level 1 Appeal), a Medicaid appeal, or both.

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

- If you file a **Medicaid** appeal, you will still have **65 calendar days** from the day of <Insert Plan Name>'s Initial Adverse Determination notice to use your Medicare appeal rights instead.

You will have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Medicaid appeal.

You can call Member Services at <Insert Appropriate Health Plan Toll-Free Number> if you need help asking for a Medicaid appeal or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

You can ask for a Medicaid appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.

We will not treat you any differently or act badly toward you because you ask for a Medicaid appeal.

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 getting the service while you wait for an appeal determination.

You must ask for a Medicaid 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 appeal results in another denial, you may have to pay for the cost of any service(s) that you received.

To file a Medicaid appeal, you can call, write, or visit us. When you ask for a Medicaid appeal, or soon after, you will need to give us:

- Your name and address
- Your Member ID number
- The service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.

To help you prepare for your Medicaid appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Medicaid appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling <1-800 MCO number>.

Give us your information and materials by :

Phone ..... [1-800 MCO number]
Fax ..... [fax number]
[Optional: Email .....[email address]]
Mail .....[address], [city, state zip]
[Optional: Online ..... [web address]]
In Person .....[address], [city, state zip]

Standard Medicaid Appeals- We will give you a written decision as fast as your condition requires; by no later than 30 calendar days after we get your Medicaid appeal.

Fast Track Medicaid Appeals- We will give you a decision on a fast track Medicaid appeal within 72 hours after we get your Medicaid appeal.

Your Medicaid appeal will be fast tracked if:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the appeal needs to be faster;
- You are asking for more of a service you are getting right now;
- You are asking for home care services after you leave the hospital;
- You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
- You are asking for mental health or substance abuse services that may be related to a court appearance.

If you ask for a Medicaid appeal, and you get another denial, you will get a Final Adverse Determination notice that tells you how to ask New York State (NYS) for a **Fair Hearing**. In some cases, you may also be able to ask for an **External Appeal.**

For more information about **Fair Hearings** and **External Appeals**, please refer to your Medicaid Managed Care or Health and Recovery Plan Member Handbook.

Medicaid 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.

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

To file a Medicaid complaint by phone, call Member Services at <Insert Member Services Toll-Free Number and Hours>. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

You can write us with your Medicaid complaint or call the Member Services number and request a complaint form. It should be mailed to <Insert Appropriate Health Plan Mailing Address>.

If you follow the Medicaid complaint process, and you disagree with the decision that we made about your complaint, you can file a complaint appeal with us.

If you need help filing a Medicaid complaint or following any steps of the complaint process, call Member Services at <Insert Appropriate Health Plan Toll-Free Number>. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

You also have the right to contact the New York State Department of Health about your complaint. Contact the Department of Health by:

- Phone: 1-800-206-8125
- Mail: New York State Department of Health
  Managed Care Complaint Unit
  OHIP DHPCO 1CP-1609
  Albany, New York 12237
- E-mail: managedcarecomplaint@health.ny.gov."

b. For MMCP operating the IB-Dual or MAP program where the aligned MA D-SNP **meets** CMS' definition of an AIP, the following sections within Chapter 9B of the EOC, titled *If you have a problem or complaint (coverage decisions, appeals, complaints),* should include the Medicaid Managed Care-Specific Information outlined within the following subparagraphs.

   i. In section 2, *Where to get more information and personalized help-You can get help and information from Medicaid*, MMCP must include the following information:

      - "You can call the Medicaid Helpline at 1-800-541-2831 (TTY 711) Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM.

- You can write to your Local Department of Social Services (LDSS). Find the address for your LDSS at: www.health.ny.gov/health_care/medicaid/ldss

- You can also visit the New York State Medicaid website: www.health.ny.gov/health_care/medicaid"

ii. In section 6.4, *The Level 2 appeal process-If your problem is about a service or item Medicaid usually covers*, MMCP must include the following information where the EOC instructs the MMCP to describe the Medicaid Level 2 appeals process:

"You can ask for a Fair Hearing with the state:

- By phone: 1-800-342-3334
  (TTY call 711 and ask operator to call 1-877-502-6155)

- By fax: 518-473-6735

- By internet: http://otda.ny.gov/oah/FHReq.asp

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

- In person: <u>For non-New York City residents:</u>
  Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  40 North Pearl Street
  Albany, New York 12243

  <u>For New York City residents:</u>
  Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  5 Beaver Street
  New York, New York 10004

After you ask for a Fair Hearing, the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong. If the State denies your request for a fast track Fair Hearing, they will call you and send you a letter. If your request for a fast track Fair Hearing is denied, the State will process your Fair Hearing in 90 days.

If the State approves your request for a fast track Fair Hearing, they will call you to give you the time and date of your hearing. All Fast Track Fair Hearings will be held by phone.

To prepare for the hearing:

- **We will send you a copy of the "evidence packet" before the hearing.** This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get the evidence packet by the week before your hearing, you can call [1-800 MCO-PLAN] to ask for it.

- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call [1-800 MCO-PLAN] to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.

- **You have a right to bring a person with you to help you at the hearing,** like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.

- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.

- **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow

Pages under "Lawyers" or go to www.LawhelpNY.org. In New York City, call 311.

External Appeal

You have other appeal rights if we said the service you asked for was:

1. not medically necessary;
2. experimental or investigational;
3. not different from care you can get in the plan's network; or
4. available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State (NYS) for an independent External Appeal. This is called an External Appeal because it is decided by reviewers who do not work for <Insert Plan Name> or NYS. These reviewers are qualified people approved by NYS. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

You have **4 months** from the date that we sent the decision letter on your Level 1 appeal to ask for an External Appeal. If you and <Insert Plan Name> agreed to skip our appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at <Insert Appropriate Health Plan Toll-Free Number> if you need help filing an External Appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an External Appeal application:

- Call the Department of Financial Services at 1-800-400-8882
- Go to the Department of Financial Services' web site at www.dfs.ny.gov.
- Contact us at <Insert Appropriate Health Plan Toll-Free Number>

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

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health; or

- You are in the hospital after an emergency room visit and the hospital care is denied by your plan.

This is called an Expedited External Appeal. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- you ask for a fast track Level 1 appeal within 24 hours, **AND**
- you ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track Level 1 appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing **and** an External Appeal, the decision of the fair hearing officer will be the one that counts."

c. In section 10.2, *Additional Medicaid Appeals,* MMCP should **not** include additional language where the EOC instructs the MMCP to insert a description of procedures and instructions about filing additional appeals in the state.

d. In section 11.4, *You can also tell Medicare [insert as applicable: and Medicaid] about your complaint:*

i. MMCP should insert "and Medicaid" in the title of this section.

ii. MMCP operating the MAP program should include the following Medicaid agency complaint contact information:

"You also have a right to contact the New York State Department of Health about your complaint. Contact the Department of Health by:

- Phone: 1-866-712-7197
- Mail: New York State Department of Health
  Bureau of Managed Long Term Care
  Technical Assistance Center
  99 Washington Ave/ One Commerce Plaza 16th Fl
  Albany, NY 12210
- E-mail: mltctac@health.ny.gov"

iii. MMCP operating the IB-Dual program should include the following Medicaid agency complaint contact information:

"You also have the right to contact the New York State Department of Health about your complaint. Contact the Department of Health by:

- Phone: 1-800-206-8125
- Mail: New York State Department of Health
  Managed Care Complaint Unit
  OHIP DHPCO 1CP-1609
  Albany, New York 12237
- E-mail: managedcarecomplaint@health.ny.gov"

VI. Submission of Medicare Advantage Materials to the Department of Health

a. MMCP are required to submit MA Marketing, Communications, and Plan Created Materials described in Appendix A of this guidance to the Department of Health (the Department) for approval prior to use, and in accordance with the submission frequency and deadlines described in Appendix A.

   i. NOTE: Appendix A indicates bifurcated submission deadlines for the ANOC, EOC, and SB materials. MMCP must submit these materials to the Department, incorporating only Medicaid Managed Care-Specific Information, by August 1st of each year to ensure Department approval prior to the submission of these materials to CMS. MMCP are required to submit a final copy of these materials to the Department, incorporating all Medicare information, no later than the CMS submission deadline indicated in Appendix A.

b. MMCP must submit these materials to the following Department mailboxes:

   i. For MMCP operating the IB-Dual program, materials must be sent to bigaplans@health.ny.gov.

   ii. For MMCP operating the MAP program, materials must be sent to mltc.docs@health.ny.gov.

c. MMCP that receive Department feedback requesting revisions to these materials must return the revised materials to the Department no later than **1 week** from the receipt of the request.

Appendix A- Medicare Advantage D-SNP Marketing and Communications Materials Requiring Department of Health Review

Material Name:	CMS or Department Model:	Submission Frequency to the Department:	Submission Deadline to the Department:
Annual Notice of Change (ANOC)	CMS	Yearly	August 1 with Medicaid Managed Care-Specific Information only *AND* September 30 with Medicare information incorporated*****
ANOC Errata	CMS	Only when a correction to Medicaid Managed Care-Specific Information is needed	Prior to October 15
Evidence of Coverage (EOC)	CMS	Yearly	August 1 with Medicaid Managed Care-Specific Information only *AND* October 15 with Medicare information incorporated*****
EOC Errata	CMS	Only when a correction to Medicaid Managed Care-Specific Information is needed	Prior to November 15
Integrated Member ID Card	N/A	<u>New MAP/IB-Dual Plans</u> Prior to Department approval to operate MAP or the IB-Dual program	Prior to Department approval to operate MAP or the IB-Dual program
		<u>Current IB-Dual Plans Who Have Not Previously Used an Integrated Member ID Card</u> Prior to use	At least 60 days prior to use
		<u>MAP/IB-Dual Plans Currently Using a Department-Approved Integrated Member ID Card</u> Only when information on the existing ID card is changing	At least 60 days prior to use

Appendix A-Continued

Material Name:	CMS or Department Model:	Submission Frequency to the Department:	Submission Deadline to the Department:
Summary of Benefits (SB)	CMS	<u>MAP Plans</u> Yearly	August 1 with Medicaid Managed Care-Specific Information only *AND* October 15 with Medicare information incorporated*****
		<u>IB-Dual Plans</u> Yearly when Medicaid Managed Care-Specific Information is included	
Any plan-created outreach, marketing material, or communication that is member and/or public facing that contains Medicaid Managed Care-Specific Information	N/A	<u>New Materials</u> Prior to use	At least 60 days prior to use
		<u>Materials Previously Approved by the Department</u> When Medicaid Managed Care-Specific Information is changing	

***Submission required for Department records only**