2022 Member Handbook

Senior Whole Health Managed Long Term Care Plan

MLTC_2022_15858

Senior Whole Health
BY MOLINA HEALTHCARE

How to contact Senior Whole Health of New York

Member Services	(877) 353-0185 (TTY/TDD: 711) Our hours are Monday through Friday, from 8 a.m. to 8 p.m. Call 911 or go to the nearest hospital or emergency facility if you think you need emergency care. We have free interpreter services for people who do not speak English.
Transportation	(855) 558-1638
Main Business Fax	(855) 818-4870
Address	15 MetroTech Center, 11th Floor Brooklyn, NY 11201
Website	www.SWHNYMembers.com

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Welcome to Senior Whole Health of New York Managed Long Term Care Plan

Welcome to Senior Whole Health of New York (SWH of NY) Managed Long Term Care (MLTC) plan. The MLTC plan is specially designed for people who have Medicaid and who need health and community based long-term care services like home and personal care to stay in their homes and communities as long as possible.

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

Help from Member Services

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

There is someone to help you at Member Services:

Monday through Friday from 8 a.m. to 8 p.m.

Call 1-877-353-0185 (TTY 711)

If you need help at other times, a Care Manager is available 24/7 at 1-877-353-0185 (TTY 711).

Our materials are available in alternative languages and formats free of charge. You may make a request by calling Member Services at the phone number above.

Eligibility for enrollment in the MLTC plan

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

1. Are age 21 and older;
2. Reside in the plan's service area which is Bronx, Kings, Nassau, New York, Queens, Suffolk or Westchester counties;
3. Have Medicaid;
4. Have Medicaid only and are eligible for nursing home level of care;
5. Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety; and
6. Are expected to require at least one of the following Community Based Long Term Care Services (CBLTCS) covered by the MLTC plan for a continuous period of more than 120 days from the date of enrollment:
    a. Nursing services in the home
    b. Therapies in the home
    c. Home health aide services
    d. Personal care services in the home
    e. Adult day health care,
    f. Private duty nursing; or

g. Consumer Directed Personal Assistance Services

The coverage explained in this handbook becomes effective on the date of your enrollment in (SWH of NY) MLTC plan. Enrollment in the MLTC plan is voluntary.

How to enroll

If you would like to enroll in SWH of NY you, must go through an eligibility process that will include an assessment from the Conflict Free Evaluation and Enrollment Center (CFEEC). The CFEEC is administered by NY Medicaid Choice (Maximus). The purpose of the evaluation is to verify your eligibility for 120 days of continuous Long Term Care services.

Once Maximus determines you qualify to enroll in an MLTC plan, you'll be given the opportunity to select an MLTC plan of your choice.

If you select SWH of NY, a nurse will visit you to complete an internal enrollment assessment. After we complete this assessment, you will be offered a Plan of Care based on your individual needs and goals. If accepted, you can enroll in SWH of NY.

- Completed assessments are submitted daily to Maximus. If assessments and documentation are completed by the 20th day of a current month, you'll be enrolled effective the 1st day of the following month.

What if I decide not to become a member after the enrollment process has started?

At any time before or during the enrollment process, you may change your mind and withdraw your application—even after you've completed the enrollment application process. You may withdraw an application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment. You may tell us you wish to withdraw either orally or in writing. After this point, you will still be able to leave SWH of NY by requesting disenrollment. For more information, please review the voluntary disenrollment section.

What happens if my enrollment is denied?

- If SHW of NY denies your enrollment in the plan, we will notify you by mail.
- If a denial of enrollment is determined by the Maximus, we will notify you of the denial of enrollment by email.

Conflict free evaluation and enrollment center (CFEEC)

In counties with mandatory enrollment into Managed Long Term Care (MLTC), a conflict-free evaluator or other designated entity will determine initial eligibility. CFEEC evaluations are conducted in your home, a hospital or nursing home by a registered nurse. A CFEEC evaluation is not required if you are transferring from another MLTC plan. If you live in one of these counties and are interested in joining, you should contact the conflict-free evaluator. When they determine eligibility, they will forward your information to the plan of your choice. To contact the CFEEC, call 1-855-222-8350 (TTY 1-888-329-1546) Monday through Friday from 8:30 a.m. to 8 p.m., or Saturday from 10 a.m. to 6 p.m. Counselors speak all languages.

Plan member (ID) card

You will receive your (SWH of NY) identification (ID) card within seven to ten (7-10) days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your identification card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Member Services at 1-877-353-0185 (TTY 711).

Transfers

If you want to transfer to another MLTC Medicaid plan

You can try us for 90 days. You may leave (SWH of NY) 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 (SWH of NY) 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 (SWH of NY) 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 1-800-505-5678. 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. SWH of NY 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 SWH of NY.

Services covered by the Senior Whole Health of New York MLTC plan

Care Management Services

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

transportation to those services.

Your care manager is a health care professional with experience in long term care, acute care and community care. Care Managers are also knowledgeable about in-home and community-based services and long-term support services and have experience in caring for seniors and people with chronic diseases. They work with you to help you to manage your care and conditions.

Your Care Manager will work with you to create a comprehensive Person-Centered Service Plan (PCSP) appropriate for your care and service needs. Care management helps you get the covered services identified in your PCSP as well as medical, social, educational, financial and other services that support your person centered service plan PCSP.

Your care manager will meet with you at least annually and as needed every six months to review your PCSP and service needs. Your care manager will also review your current health conditions and confirm your continued eligibility for the care and services authorized in your PCSP. You can call your Care Manager or a member of your Care Management team to ask for any service not previously authorized or included in your PCSP and to ask that these services be authorized in your PCSP. Your Care Manager and other members of your interdisciplinary care team will review your request and let you know if the request or service is approved and will be on your PCSP.

Care managers are available 24/7

You can call to speak with a care manager 24/7. We will respond to calls received on weekends, holidays and after hours on the same day they are received by the on-call Care Manager.

Flexible person-centered care planning

We understand your needs and services can change. We provide flexibility in developing a PCSP that meets your individual needs. Our benefits include a wide array of long-term support services and home- and community-based services that help you maintain your independence as you stay at home and in the community. Your Care Manager will work with you (and a caregiver or family member, if desired) and your doctor to develop your PCSP and to help you and your family determine appropriate medical and social services. You will receive your approved PCSP within 15 days of being enrolled in SWH of NY and again during your reassessment or annual assessment.

Additional covered services

Because you have Medicaid and qualify for MLTC, SWH of NY will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your Care Manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in the SWH of NY network. If you cannot find a provider in our plan with appropriate training or experience to meet your needs, you may obtain a referral to a health care provider outside the network. In the event you require an out-of-network provider, please contact your Care Manager to assist you in obtaining an authorization.

If you do not get authorization before receiving services, the out-of-network provider will not be paid. If you have questions regarding this process, please call Member Services at 1-877-353-0185 (TTY 711).

Additional Covered Services	
Adult Day Health Care	Care and services provided in a residential health care facility or approved extension site must be provided: • Under the medical direction of a physician • By Adult Day Health Care staff • Based on the member's comprehensive needs assessment and care plan • With ongoing coordination of the health care plan Includes transportation. **Prior authorization required.**
Audiology	Treatment and equipment to help you hear better. Hearing exams and hearing aids are provided by a network of local, independent audiologists in the SWH of NY service area. Every exam is performed by a fully licensed audiologist. If you think you need a hearing exam, we may ask you to see your doctor first to be sure that another health problem is not affecting your ability to hear. We also cover batteries for your hearing aids. **Prior authorization required.**
Consumer Directed Personal Assistance Services (CDPAS)	Services for members with chronic illnesses or physical disabilities who have a medical need for help with activities of daily living (ADL) or skilled nursing services. Includes any of the services provided by a personal care aide (home attendant), home health aide or nurse. You have flexibility and freedom in choosing your caregivers. You, or the person acting on your behalf, are responsible for hiring, firing, training, supervising and terminating, if necessary. **Prior authorization required.**
Dental	A service by a special type of provider that treats your teeth and gums. Dental services are provided by DentaQuest. You can contact them at 1-855-343-4272. Your coverage includes: • Annual oral examination and cleanings • Medically needed dentures, fitting and alignment (one full set every 4 years) • Dental implants, subject to medical necessity* ***Prior authorization required for dental implants.** Request must be accompanied by a physician's letter explaining how the implants will help with your medical problem. Additionally, a dentist's letter explaining why other alternatives will not correct your condition and why you require implants.

Additional Covered Services	
Durable Medical Equipment (DME)	Items to help with your health care and to take care of yourself. DME includes medical/surgical supplies, enteral and parenteral formula, hearing aid batteries, prosthetics, orthotics and orthopedic footwear, canes, hospital bed, wheelchairs, oxygen, and walkers. **Prior authorization may be required for some equipment.**
Home Delivered or Congregate Meals	Meals provided at home or in congregate settings, such as senior centers for individuals unable to prepare meals or have them prepared. **Prior authorization required.**
Home Health Care Services (not covered by Medicare)	Services provided in your home. These services may be provided by licensed staff or unlicensed staff. Includes nursing, home health aide, occupational, physical and speech therapies. **Prior authorization required.**
Medical Social Services	Checking, setting up and giving help for social problems to keep you in your home. Services are performed by a qualified social worker and provided within a plan of care. **Prior authorization required.**
Medical Supplies	Products needed to take care of a medical condition. Usually these products are not re-usable by other people. New York Medicaid allows us to pay for compression and support stockings only when they are used to treat venous stasis ulcers. **Prior authorization required.**
Non-emergency Transportation	Includes non-emergency transportation to and from a medical appointment. To schedule transportation, call 1-855-558-1638 and follow the prompts. Transportation must be scheduled at least 3 (three) days before your appointment. You can schedule your transportation up to 30 days in advance. **Prior authorization required.**
Nutrition	Includes assessment of nutritional needs, development and evaluation of treatment plans, nutrition education and counseling. Includes cultural considerations. **Prior authorization required.**

Additional Covered Services	
Nursing Home Care (not covered by Medicare)	A nursing home is a place for people who don't need to be in a hospital but can't be cared for at home. Most nursing homes have nursing aides and skilled nurses on hand 24 hours a day. Some nursing homes are set up like a hospital. The staff provides medical care, as well as physical, speech and occupational therapy. There might be a nurses' station on each floor. Other nursing homes try to be more like home. They try to have a neighborhood feel. Often, they don't have a fixed day-to-day schedule, and kitchens might be open to residents. Staff members are encouraged to develop relationships with residents. Some nursing homes have special care units for people with serious memory problems such as Alzheimer's disease. Nursing homes are not only for the elderly, but for anyone who requires 24-hour care. For SWH of NY to pay for nursing home care, you must be eligible to receive the nursing home care from Medicaid in New York. **Prior authorization required.**
Optometry	Vision services include: • Annual preventive eye exams • Medically necessary eye exams • Eyeglasses provided by network optometrists (must be medically necessary) - Limited to one pair of glasses every 2 (two) years unless your prescription changes For members who require both distance and reading correction, you may get one pair of each every 2 (two) years **Prior authorization required.**
Outpatient Rehabilitation	Covered services include: • Physical and occupational therapy • Speech language therapy • Cardiac rehabilitative therapy • Social and psychological therapy • Comprehensive Outpatient Rehabilitation Facility (CORF) services **Prior authorization required.**
Personal Care	Service to help you stay at home instead of going to a nursing home. Personal care includes services such as housekeeping, meal preparation, bathing, toileting, and grooming. **Prior authorization required.**
Personal Emergency Response System (PERS)	An electronic device that sends an alert if you are not safe or have fallen and cannot get up by yourself. **Prior authorization required.**

Additional Covered Services	
Podiatry	Care for your feet by a podiatrist (foot doctor). Foot care including initial examination, nail trimming and callous removal when medically necessary. **Prior authorization required.**
Private Duty Nursing	Must be provided by a registered professional nurse (RN) or licensed practical nurse (LPN) possessing a license and current registration from the NYS Education Department. Services may be provided through an approved certified home health agency, licensed home care agency or private practitioner. **Prior authorization required.**
Prosthetics and Orthotics	Prosthetics are man-made body parts (other than dental) used to replace your missing body part(s). Orthotics are special inserts for your shoes. • Prescription footwear is limited to treatment of diabetics or when shoe is part of a leg brace (orthotic). **Prior authorization required.**
Respiratory Therapy	We will coordinate with your health care professionals on required medical equipment, supplies, respiratory therapy, and oxygen. **Prior authorization required.**
Social Day Care	Social day care is set up as a safe place you can go to receive care and meet with others. Social day care services include time with other adults, supervision, personal care, and help with your nutrition. Some social day care facilities have more services and may include help for your caregiver, help with living skills, care coordination, and transportation. **Prior authorization required.**
Social/ Environmental Supports	Social supports are people and tools that help keep you in touch with other people. Environmental supports are changes to your home that increase your ability to do things on your own or increase your ability to help with your care. Social and environmental supports include services such as home maintenance tasks, homemaker/chore services, housing improvement, and respite care. **Prior authorization required.**

How to obtain covered services

For covered services listed on the chart above, you may need a physician's order and/or prior approval from SWH of NY.

For others, you may access the service directly. Contact the Member Services department by calling 1-877-353-0185 (TTY 711). The Member Services representative will gladly assist you with your needs or transfer your request to your Care Manager.

Authorization is the process by which a covered service in SWH of NY is determined to be medically necessary for the member's condition, illness or ailment by the member's physician and/or SWH of NY.

Covered services: Outpatient rehabilitation

Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)

SWH of NY has removed service limits on physical therapy (PT), occupational therapy (OT), and speech therapy (ST). Instead, SWH of NY will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional. Prior authorization is required.

To learn more about these services, call Member Services at 1-877-353-0185 (TTY 711).

Limitations

- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
- Nursing Home Care is covered for 3 (three) months for individuals who are considered a permanent placement for at least three months. Following that time period, your Nursing Home Care may be covered through regular Medicaid.

Getting care outside the service area

You must inform your Care Manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your Care Manager should be contacted to assist you in arranging services.

Emergency service

Emergency Service means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial 911. As noted above, prior authorization is not needed for emergency service. However, you should notify SWH of NY within 24 hours of the emergency. You may be in need of long-term care services that can only be provided through SWH of NY.

If you are hospitalized, a family member or other caregiver should contact SWH of NY within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact SWH of NY so that we may work with them to plan your care upon discharge from the hospital.

Transitional care procedures

New members in SWH of NY may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider if the provider accepts payment at the plan rate, adheres to SWH of NY quality assurance and other policies, and provides medical information about the care to the plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

Money Follows the Person (MFP)/Open Doors

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

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

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

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

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

Medicaid services not covered by our plan

There are some Medicaid services that (SWH of NY) does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-877-353-0185 (TTY 711) if you have a question about whether a benefit is covered by (SWH of NY) or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

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

Certain Mental Health Services, including: Intensive Psychiatric Rehabilitation Treatment

- Day Treatment
- Case Management for seriously and persistently mentally ill (sponsored by state or local mental health units)
- Partial hospital care not covered by Medicare
- Rehabilitation services to those in community homes or in family-based treatment
- Continuing day treatment
- Assertive community treatment
- Personalized recovery oriented services

Certain mental retardation and developmental disabilities services, including:

- Long-term therapies
- Day treatment
- Medicaid service coordination
- Services received under the home and community based services waiver

Other Medicaid services including:

- Methadone treatment
- Directly observed therapy for TB (Tuberculosis)
- HIV COBRA case management
- Conversion or reparative therapy
- Family planning

Services not covered by SWH of NY or Medicaid

You must pay for services that are not covered by SWH of NY or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by SWH of NY or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Infertility treatment
- Services of a provider that is not part of the plan (unless SWH of NY sends you to that provider)

If you have any questions, call Member Services at 1-877-353-0185 (TTY 711).

Service authorizations, actions and action appeals

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

To submit a service authorization request, you or your provider may call our toll-free Member Services number at 1-877-353-0185 (TTY 711) or send your request in writing to:

Senior Whole Health of New York
15 MetroTech Center, 11th Floor
Brooklyn, New York 11201

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

Prior authorization

Some covered services require prior authorization (approval in advance) from the SWH of NY Utilization Management (UM) team before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

To obtain prior authorization, please call Member Services at 1-877-353-0185 (TTY 711) Monday through Friday, 8 a.m. to 8 p.m.

Concurrent review

You can also ask SWH of NY to get more of a service than you are getting now. This is called concurrent review.

Retrospective review

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

What happens after we get your service authorization request?

The plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

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

After we get your request, we will review it under a standard or fast track process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than indicated below.

Timeframes for prior authorization requests

- Standard review: We will make a decision about your request within 3 workdays of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- Fast track review: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

- Standard review: We will make a decision within 1 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- Fast track review: We will make a decision within 1 workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 workday if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. We will:

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-877-353-0185 (TTY 711) or writing.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

If our answer is yes to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

If our answer is no to part or all of what you asked for, we will send you a written notice that explains why we said no. See How do I File an Appeal of an Action? that explains how to make an appeal if you do not agree with our decision.

What is an action?

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

Timing of notice of action

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

Contents of the notice of action

Any notice we send to you about an action will:

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

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

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

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

How do I file an appeal of an action?

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

How do I contact my plan to file an appeal?

We can be reached by calling 1-877-353-0185 (TTY 711). Or writing to:

Senior Whole Health of New York
15 MetroTech Center, 11th Floor
Brooklyn, New York 11201

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For some actions you may request to continue service during the Appeal process

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

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

How long will it take the plan to decide my appeal of an action?

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

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

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

Expedited appeal process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than

72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for 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 deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under ***How long will it take the plan to decide my Appeal of an Action?*** above, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice.

If we are reducing, suspending or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 (ten) days of the date on the Final Adverse Determination notice.

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

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

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

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

- **Online request form:** https://errswebnet.otda.ny.gov/errswebnet/erequestform.aspx
- **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**: 1-518-473-6735
- **Request by telephone:**

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

- **Request in Person:**

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

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

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

State external appeals

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

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

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

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

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

Complaints and complaint appeals

SWH of NY 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 SWH of NY staff or a health

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

To file a complaint, please call: 1-877-353-0185 (TTY 711) or write to:

Senior Whole Health of New York
15 MetroTech Center, 11th Floor
Brooklyn, New York 11201

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 must be completed within 7 days of the receipt of the complaint.

2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

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

How do I appeal a complaint decision?

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

Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MLTC plan like (SWH of NY). This support includes unbiased health plan choice counseling and general plan related information. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)
Web: www.icannys.org | Email: ican@cssny.org

Disenrollment From SWH of NY MLTC plan

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

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

Voluntary disenrollment

You can ask to leave the (SWH of NY) at any time for any reason.

To request disenrollment, call 1-877-353-0185 (TTY 711) or you can write to us. The plan will provide you with written confirmation of your request. We will include a voluntary disenrollment form for you to sign and send back to us. It could take up to six weeks to process, depending on when your request is received.

You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require Community Based Long Term Care (CBLTC) services, like personal care, you must join another MLTC plan, Medicaid Managed Care plan or Home and Community Based Waiver program, in order to receive CBLTC services.

Involuntary disenrollment

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

You will have to leave SWH of NY, if you:

- Are no longer are Medicaid eligible;
- Permanently move out of (SWH of NY) service area;
- Are out of the plan's service area for more than 30 consecutive days;
- Need nursing home care, but are not eligible for institutional Medicaid;
- Are hospitalized or enter an Office of Mental Health, Office for People with Developmental Disability or Office of Alcoholism and Substance Abuse Services residential program for forty-five (45) consecutive days or longer;
- Are assessed as no longer having a functional or clinical need for community-based long term care (CBLTC) services on a monthly basis;
- Have Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool;
- Are receiving Social Day Care as your only service;
- No longer require, and receive, at least one CBLTC services in each calendar month;
- At point of any reassessment while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTC services;
- Have been incarcerated; or
- Provide the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership

We can ask you to leave SWH of NY if you:

- Or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs the plan's ability to furnish services
- Fail to pay or make arrangements to pay the amount of money, as determined by the Local Department of Social Services, owed to the plan as spenddown/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, SHW of NY NHC will obtain the approval of New York Medicaid Choice (NYMC) or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which you become ineligible for enrollment. If you continue to need community based long term care services, you will be required to choose another plan or you will be automatically assigned (auto-assigned) to another plan.

Cultural and linguistic competency

SWH of NY honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all members. This includes but is not limited to those with limited English

skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

Member rights and responsibilities

SWH of NY will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

Member rights

- You have the right to receive medically necessary care.
- You have the right to timely access to care and services.
- You have the right to privacy about your medical record and when you get treatment.
- You have the right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the right to get information in a language you understand; you can get oral translation services free of charge.
- You have the right to get information necessary to give informed consent before the start of treatment.
- You have the right to be treated with respect and dignity.
- You have the right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the right to take part in decisions about your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the right to complain to the New York State Department of Health or your Local Department of Social Services; and, the right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the right to appoint someone to speak for you about your care and treatment.
- You have the right to seek assistance from the Participant Ombudsman program.

Member responsibilities

- Receiving covered services through SWH of NY;
- Using SWH of NY network providers for covered services to the extent network providers are available;
- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies; Being seen by your physician, if a change in your health status occurs;
- Sharing complete and accurate health information with your health care providers;
- Informing SWH of NY staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions;
- Following the plan of care recommended by the SWH of NY staff (with your input);
- Cooperating with and being respectful with the (SWH of NY) staff and not discriminating against SWH of NY staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status;
- Notifying SWH of NY within two business days of receiving non-covered or non-pre-approved services;
- Notifying your SWH of NY health care team in advance whenever you will not be home to receive services or care that has been arranged for you;
- Informing SWH of NY before permanently moving out of the service area, or of any lengthy absence from the service area;
- Your actions if you refuse treatment or do not follow the instructions of your caregiver;
- Meeting your financial obligations.

Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf.

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents. If you already have an advanced directive, please share a copy with your Care Manager.

Information available on request

- Information regarding the structure and operation of SWH of NY;
- Specific clinical review criteria relating to a particular health condition and other information

that SWH of NY considers when authorizing services;

- Policies and procedures on protected health information;
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program;
- Provider credentialing policies;
- A recent copy of the SWH of NY certified financial statement; and policies and procedures used by SWH of NY to determine eligibility of a provider

New York Independent Assessor – Initial Assessment Process

Starting May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) will become the New York Independent Assessor (NYIA). The NYIA will manage the initial assessment process, except for expedited initial assessments, which will begin on July 1, 2022. The initial assessment process includes completing the:

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

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

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

Senior Whole Health
BY MOLINA HEALTHCARE