



Welcome to Senior Whole Health by Molina Healthcare's Managed Long-Term Care plan



Welcome to Senior Whole Health by Molina Healthcare (SWH of NY)'s Managed Long-Term Care (MLTC) plan. The MLTC plan is especially designed for people who have Medicaid and who need health and Community-Based Long-Term Services and Supports (CBLTSS) like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits 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 any time, 24 hours a day, 7 days a week at the Member Services number below:



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

1. Are age 18 and older,
2. Reside in the plan's service area which are the following counties:
 - a. Westchester
 - b. Bronx
 - c. New York
 - d. Kings
 - e. Queens
 - f. Nassau
 - g. Suffolk
3. Have Medicaid,
4. Have Medicaid only or are aged 18-20 with both Medicaid and Medicare and are eligible for nursing home level of care,
5. 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 Services and Supports (CBLTSS) 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.

New York Independent Assessor Program (NYIAP) – initial assessment process

Effective December 1, 2022, NYIAP started conducting the expedited initial assessments based on an immediate need for PCS and/or CDPAS.

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
- Your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIAP 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 NYIAP will complete a clinical appointment and PO a few days later.

SWH of NY 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 NYIAP 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 SWH of NY about whether the plan of care meets your needs.

Once NYIAP completes the initial assessment steps and determines that you are eligible for Medicaid Managed Long-Term Care, you then choose which Managed Long-Term Care plan to enroll with.

How to enroll

If you would like to enroll in SWH of NY, you must go through an eligibility process with NYIAP that will include an assessment from the NYIAP. For plan-to-plan transfers, a new NYIAP assessment is not required.

The purpose of the evaluation is to verify your eligibility for more than 120 days of continuous long-term care services.

Once NYIAP determines that 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 contact you to schedule an in-person or telehealth visit to review the CHA and complete a plan of care based on the NYIAP assessment. We will also do a home visit to review the CHA and develop your plan of care, as needed. During the CHA review, you will be offered a plan of care based on your person-centered service plan, individualized goals and needs. If you accept the SWH of NY plan of care based on NYIAP CHA, and you choose SWH of NY then SWH of NY will complete your enrollment documentation. Your enrollment documentation will be sent to New York Medicaid Choice so you can enroll in SWH of NY. You can enroll in SWH of NY:

- If the NYIAP assessment and enrollment documentation are completed by the 20th day of the current month, you'll be enrolled effective the first day of the following month.
- If the NYIAP assessment and documentation is not completed by the 20th day of the current month, you will be enrolled no later than the first day of the second month.

How to withdraw enrollment

You may change your mind and withdraw your enrollment — even after you have completed the enrollment documentation process. You or someone on your behalf can tell us either orally or in writing that you wish to withdraw your SWH of NY enrollment by noon on the 20th day of the month before the first day of the month you would be enrolled with SWH of NY. After the 20th day of the month, and you are enrolled you will still be able to leave SWH of NY by requesting a voluntary disenrollment. SWH of NY will process a request to withdraw an enrollment by you or someone on your behalf as soon as the request is received any time before or during the enrollment process, and even after you have completed your enrollment.

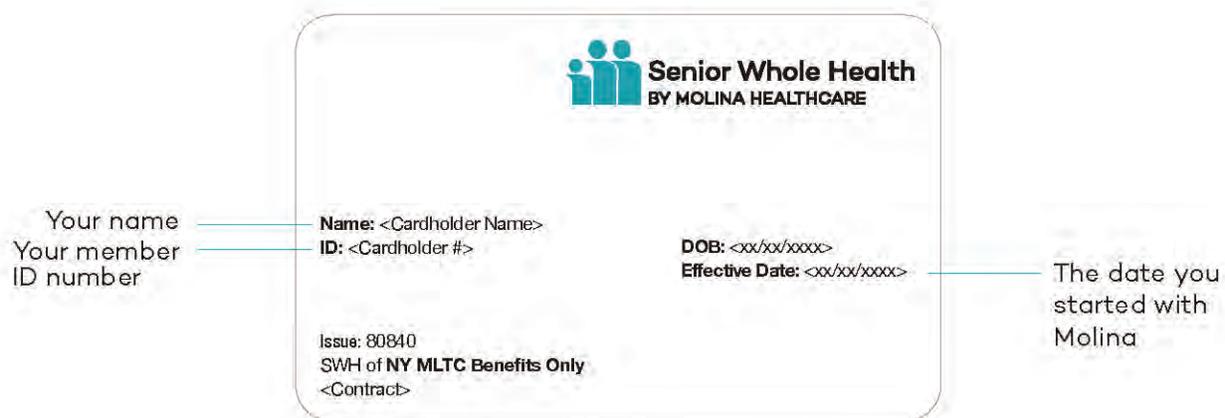
What happens if my enrollment is denied?

If SWH of NY recommends a denial of enrollment, the plan will inform New York Medicaid Choice (NYMC) and if NYMC agrees, they will send you a letter to notify you of the decision.

Plan member (ID) card

You will receive your SWH of NY identification (ID) card within 7-10 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your ID card with you at all times along with your Medicaid card.

If your card becomes lost or is stolen, please contact Member Services at **(877) 353-0185 (TTY: 711)**.



Services covered by SWH of NY

Care Management Services

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

The care manager is a clinician with experience in long-term care, acute care, community care and knowledge of in-home and community-based services and long-term supportive services. The care manager has knowledge and experience with elderly care, frail and chronic diseases and understands conditions such as dementia, Alzheimer's disease, behavioral health and other cognitive impairments. Care managers work with you to help you 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 PCSP.

Your care manager will meet with you at least once a month and as needed to review your PCSP and service needs. They 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 added to 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. Call your manager at (877) 353-0185 (TTY:711).

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, your doctor (and a caregiver or family member, if desired) to develop your PCSP and to help you and your family determine the 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, our plan will arrange and pay for the extra health and social services described below. You may get these services if 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, the SWH of NY care management and utilization management team will coordinate and request the medically necessary services from an out-of-network provider for as long as you medically need these usually covered services, and the services are not available from an in-network provider.

As part of the person-centered service process, your care management team will work with you and your primary care provider (PCP) to evaluate the covered services and care you need to be authorized and included in your person-centered service plan. Services covered and authorized in your care plan need to be approved by your care manager and the utilization management team before they can be

authorized. Your care management team will work with your PCP and or specialist to get the prescription note for these services:

- Outpatient rehabilitation.
- Personal care (such as assistance with bathing, eating, dressing, walking and going to the bathroom).
- Home health care services not covered by Medicare including nursing, home health aide, occupational, physical and speech therapies.
- Nutrition.
- Medical social services.
- Home delivered meals and/or meals in a group setting such as a day care.
- Social day care.
- Private duty nursing.
- Dental.
- Social/environmental supports (such as chore services, home modifications or respite)
- Personal emergency response system.
- Adult day health care.
- Nursing home care not covered by Medicare (provided you are eligible for institutional Medicaid).
- Audiology.
- DME.
- Medical supplies.
- Prosthetics and orthotics.
- Optometry.
- Consumer Directed Personal Assistance Services.
- Podiatry.
- Respiratory therapy.



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 healthcare plan.

Includes transportation.

Prior authorization is 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 is required.

Consumer Directed Personal Assistance Services (CDPAS)

Services for members with chronic illnesses or physical disabilities who have a medical need for help with daily living activities (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, training, supervising and terminating, if necessary.

Prior authorization is required.

Additional covered services

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

(855) 343-4272.

Your coverage includes:

- Annual oral examination and cleanings.
- Medically needed dentures, fitting and alignment (one full set every four years).
- Dental implants, subject to medical necessity.*

*Prior authorization is 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.

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 is required.

Home health care services (not covered by Medicare)

Services provided in your home. These services may be provided by licensed or unlicensed staff. Includes nursing, home health aide, occupational, physical and speech therapies.

Prior authorization is required.

Additional covered services

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 is 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 is required.

Nutrition

Includes assessment of nutritional needs, development and evaluation of treatment plans, nutrition education and counseling. Includes cultural considerations.

Prior authorization is required.

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 hospitals. 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.

Additional covered services

Limitations:

Nursing Home Care is covered 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, and you will be disenrolled from SWH of NY

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 nursing home care from Medicaid in New York.

Prior authorization is 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 two years unless your prescription changes. For members who require both distance and reading correction, you may get one pair of every two years.

Prior authorization is 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 is 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 is required.

Additional covered services

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 is required.

Podiatry

Care for your feet by a podiatrist (foot doctor). Foot care might include initial examination, nail trimming and callous removal when medically necessary.

Prior authorization is required.

Private Duty Nursing

Must be provided by a registered 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 is required.

Prosthetics and Orthotics

Prosthetics are man-made body parts (other than dental) used to replace 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 is required.

Respiratory Therapy

We will coordinate with your health care professionals on required medical equipment, supplies, respiratory therapy and oxygen.

Prior authorization is required.

Additional covered services

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 is 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 is required.

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 individuals who are considered permanent placement for at least three months. Following that time period, your nursing home care may be covered through regular Medicaid, and you will be disenrolled from SWH of NY.

Getting care outside the service area

You must inform your care manager when you travel outside your coverage area. If you need services outside your coverage area, your care manager should be contacted to help you arrange 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. Prior authorization is not needed for emergency service. However, you should notify SWH of NY within 24 hours of the emergency. You may need 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 of 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 your 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 support 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/Open Doors 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 **(844) 545-7108**, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at health.ny.gov/mfp or 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 **(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 Intellectual 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 tuberculosis (TB).
- HIV COBRA case management.
- Family planning.
- Certain medically necessary ovulation enhancing drugs, when criteria are met.

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.
- 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 **(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 **(877) 353-0185 (TTY: 711)** or send your request in writing to 15 MetroTech Center, 11th Floor, Brooklyn, NY 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:

- Adult day health care.
- Audiology.
- CDPAS.
- Dental (prior authorization required for dental implants).
- DME (prior authorization may be required for some equipment).
- Home delivered meals and/or meals in a group setting such as a day care.
- Home health care services not covered by Medicare include nursing, home health aide, occupational, physical and speech therapies.
- Medical social services.
- Medical supplies.
- Nursing home care not covered by Medicare (provided you are eligible for institutional Medicaid).
- Nutrition.
- Optometry.
- Outpatient rehabilitation.
- Personal care (such as assistance with bathing, eating, dressing, going to the bathroom and walking).
- PERS.
- Podiatry.
- Private duty nursing.
- Prosthetics and orthotics.
- Respiratory therapy.
- Social day care.
- Social/environmental supports (such as chore services, home modifications or respite).

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:	Fast-track review:
We will make a decision about your request within three (3) workdays from 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.	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.

Time frames for concurrent review requests

Standard review:	Fast-track review:
We will make a decision within one (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.	We will make a decision within one (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 one (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 time frames 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 **(877) 353-0185 (TTY: 711)**.

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 **(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?* on page 22 which 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 time frames, those are considered plan "actions." An action is subject to appeal. (See How do I file an appeal of an action? on page 22 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 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; and
- 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:
- Explain the difference between an appeal and a State Fair Hearing;
- Say that that you must file an appeal before asking for a State Fair Hearing; and
- 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 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 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 **(877) 353-0185 (TTY: 711)** or writing to 15 MetroTech Center, 11th Floor, Brooklyn, NY 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 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 fast tracked, 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 a “*fast-track*” appeal. (See the *Fast Track Appeal* Process section below.)

Fast-Track 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 a fast-tracked review of your appeal of the action. We will respond to you with our decision within two (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 a fast-track 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 a fast-track appeal within two (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 State Fair Hearing, who can appear at the State 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 State 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 time frames under “*How Long Will It Take the Plan to Decide My Appeal of an Action?*” above, you may request a State Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a State 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 State Fair Hearing, you must make your State Fair Hearing request within 10 days of the date on the Final Adverse Determination Notice.

Your benefits will continue until you withdraw the State 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 State Fair Hearing Officer.

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

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



Online request form: otda.ny.gov/hearings/request



Mail a printable request form:

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings Managed Care Hearing Unit
PO Box 22023
Albany, NY 12201-2023



Fax a printable request form: (518) 473-6735



Request by telephone:

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



Request in person:

New York City
5 Beaver Street
New York, NY 10004

Albany
40 North Pearl Street, 15th Floor
Albany, NY 12243

For more information on how to request a State Fair Hearing, please visit:

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 a fast-track external appeal. The external appeal reviewer will decide a fast-track 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 State Fair Hearing and an external appeal. If you ask for a State 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: (877) 353-0185 (TTY: 711) or write to: 15 MetroTech Center, 11th Floor Brooklyn, NY 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, didn't show up 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 time frames.

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 made concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal orally or 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 complaint decision.

For standard complaint 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 fast-track complaint appeal process. For fast-track complaint appeals, we will make our appeal decision within two (2) business days of receipt of necessary information. For both standard and fast-track complaint appeals, we will provide you with written notice of our decision of your complaint appeal. 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

an 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:
(844) 614-8800
(TTY: 711)

 Web:
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 your becoming ineligible for MLTC.

Voluntary Disenrollment

You can ask to leave SWH of NY at any time for any reason. To request disenrollment, call **(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 CBLTSS, like personal care, you must join another MLTC plan, Medicaid managed care plan or Home- and Community-Based Waiver program in order to receive CBLTSS.

Transfers

You can try our plan for 90 days. You may leave SWH of NY and transfer and join another 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 good reason (good cause.)

- 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 (888) 401-6582. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. 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.

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 Medicaid eligible.
- Permanently move out of the SWH of NY service area.
- Out of the plan's service area for more than 30 consecutive days.
- Needing nursing home care but are not eligible for institutional Medicaid.
- 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.
- Assessed as no longer having a functional or clinical need for CBLTSS on a monthly basis.
- Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- Receiving social day care as your only service.
- No longer require, and receive, at least one CBLTSS in each calendar month.
- At the point of any reassessment while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- Incarcerated.
- Providing 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 spend-down/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, SWH of NY 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 CBLTSS 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.
- You have 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; policies and procedures used by SWH of NY to determine eligibility of a provider.

