2022 Member Handbook

Senior Whole Health Medicaid Advantage Plus (MAP)

Senior Whole Health
BY MOLINA HEALTHCARE

MAP_2022

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Chapter 1: Getting started as a member

Welcome to Senior Whole Health of New York NHC program. SWH of NY NHC is for people who have both Medicare and Medicaid and who need long-term support services, like home and personal care, to stay in their homes and communities.

This handbook tells you about the added benefits SWH of NY NHC covers for people enrolled in the Medicaid Advantage Plus plan. It also tells you how to request a service, file a complaint or disenroll from our plan. The benefits listed in this handbook are in addition to the Medicare benefits in the Evidence of Coverage. You need both to know what services are covered and how to get them.

The coverage explained in this Handbook starts on the effective date of your enrollment in SWH of NY NHC plan. Enrollment in SWH of NY NHC is voluntary.

Getting help from Member Services

If you have questions about your benefits or our plan, you can call Member Services to get help. We can help with referrals, replacing a lost ID card, changes that might affect your benefits and more. You can reach us at (833) 671-0440 (TTY: 711) Monday through Friday from 8 a.m. to 8 p.m. (from October 1 – March 31, 7 days a week).

If you have health questions and need to speak with a nurse, call (833) 671-0440 (TTY: 711) anytime, day or night.

If you have a special hearing or vision need, we're happy to help you. We'll make arrangements on an individual basis as necessary. This is a free service to all our members.

Getting help from the Independent Consumer Advocacy Network (ICAN)

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 MAP plan like Senior Whole Health of New York NHC. This support includes unbiased health plan choice counseling and general program related information. Contact ICAN to learn more about their services:

Chapter 2: Eligibility requirements

Senior Whole Health of New York NHC is a plan for people who have both Medicare and Medicaid. You're eligible to join SWH of NY NHC's plan if you have Medicare Parts A and B and:

1. Are age 65 and older;
2. Live in the plan's service area: Bronx, Queens, Kings, New York, Westchester & Nassau counties;
3. Are medically eligible for nursing home level of care at of the time of enrollment;
4. Are capable at the time of enrollment of returning or remaining in your home and community without jeopardy to your health and safety, AND

5. Have been assessed and require care management. You also need at least one of these services for more than 120 days from the start date of enrollment:
    - Nursing services in the home
    - Therapies in the home
    - Health aide services in the home
    - Personal care services in the home
    - Adult day health care
    - Private duty nursing
    - Consumer Directed Personal Assistance Services (CDPAS);
6. Have been determined eligible for Medicaid benefits by the New York City Human Resources Administration (HRA)/ Local District of Social Services (LDSS) Medicaid office.

Individuals in one of these may be enrolled into Medicaid Advantage Plus upon discharge or termination:

- Hospital inpatient
- Inpatient or resident of a facility licensed by:
    - State Office of Mental Health (OMH)
    - Office of Alcoholism and Substance Abuse Services (OASAS)
    - State Office for People with Developmental Disabilities (OPWDD)
- Enrolled in:
    - A Medicaid managed care plan
    - A Home and community-based services waiver program
    - An OPWDD day treatment program
- Receiving hospice services

These documents are required for enrollment:

- A signed Enrollment Agreement. This includes a release of information to Senior Whole Health of New York.
- A signed Authorization to Release Personal Health Information to a Friend or Family Member form. This gives Senior Whole Health of New York consent to release medical information. (If you refuse consent to the medical release portion of the Enrollment Agreement, we'll consider, on a case-by-case basis, whether the release is necessary)
- If you're joining a long-term care plan for the first time or have not been in a plan for 45 or more days, you need an evaluation to see if you're eligible for community-based long-term care. The New York State Department of Health has a contract with New York Medicaid Choice to provide assessments for eligibility. It's called the Conflict-Free Evaluation and Enrollment

Center (CFEEC). The evaluation must be completed and recorded before enrollment.

If you're not eligible, you'll get notice saying you're ineligible and have fair hearing rights.

SWH of NY NHC will not discriminate against anyone based on health status, need for services or cost of covered services.

Enrollment denial

You will be ineligible for enrollment in SWH of NY NHC if:

- You cannot be maintained safely in your home
- You don't need community-based long-term care services for more than 120 days
- You are enrolled in one of these:
  - Another Medicaid Managed Care Plan
  - Home- and Community-Based Services waiver program
  - Hospice
  - A State Office for People with Developmental Disabilities (OPWDD) facility
- You're in a waiver program and don't want to disenroll. This can include a Home and Community-based waiver program, hospice, the State OPWDD facility or waiver program.
- If Maximus decides you are ineligible, SWH of NY NHC will work with you to resubmit your request with any new information. If not, your enrollment will stay denied.

If you were previously involuntarily disenrolled and want to return to SWH of NY NHC, we're happy to review your case for possible re-enrollment.

Enrollment withdrawal

We'll withdrawal your enrollment application once we are notified of your request. We cannot cancel your withdrawal request if it occurs after the 20th day of the month before your enrollment date. You'll need to request voluntary disenrollment. For more information on the disenrollment process, go to the "Disenrollment from our plan" section.

Transitional care

Sometimes SWH of NY NHC works with you to keep getting treatment from out-of-network providers.

If you're a new member getting an ongoing course of treatment, you may keep getting treatment from your current provider for up to 60 days. This is even if they are not a SWH of NY NHC network provider. Your provider must agree to keep giving services according to SWH of NY NHC's rules and rates.

Current members whose provider chooses to disenroll from the SWH of NY NHC network may continue getting services from your current provider for up to 90 days to transition to another provider. Your current provider must agree to accept SWH of NY NHC rates as payment in full. They must follow Quality Improvement requirements during the transition period.

Are there any additional costs to me?

To enroll in SWH of NY NHC, the Human Resources Administration (HRA)/Local District of Social Services (LDSS) reviews your financial status for Medicaid eligibility. They may determine that you must spend a portion of your monthly income to meet the maximum income eligibility amount. This is called spend-down. HRA/LDSS will inform you and SWH of NY NHC of the exact amount of spend-down owed each month.

In order to enroll and get SWH of NY NHC benefits, you must pay this amount to SWH of NY NHC. You will be mailed a bill the last week of each month for the next month's spend-down. If you don't pay within 30 days after the date due, we may disenroll you.

If you have any questions about spend-down, please contact your local HRA at:

Home Care Services Program
Centralized Medicaid Eligibility Unity
785 Atlantic Avenue, 7th Floor
New York, NY 11238
(718) 557-1399 (TTY: 711)

Nassau County Department of Social Services
60 Charles Lindbergh Blvd.
Uniondale, NY 11553-3656
(516) 227-7474 (TTY: 711)

Westchester County Department of Social Services
85 Court Street
White Plains, NY 10601-4201
(914) 995-3333 (TTY: 711)

Money Follows the Person (MFP)/Open Doors

There are services and supports available through Money Follows the Person (MFP)/Open Doors program. MFP/Open Doors is a program to help you move from a nursing home back into your own home or community residence.

Who is eligible for MFP?

People who:

- Have lived in a qualifying institution (hospital, nursing home, or ICF/IID) for three months or longer
- Are Medicaid eligible at least one day prior to discharge/transition
- Have health needs that can be met through services in the community
- Agree to participate
- Transition into a qualified residence

What is a qualified residence?

- A home owned or leased by you or a family member

- An apartment with an individual lease which has lockable access and includes space for living, sleeping, bathing and cooking
- A community-based residence where no more than four unrelated people live

MFP/Open Doors Transition specialists and peers will meet with you in the nursing home and talk with you about moving back into the community. Transitions specialists and peers are different from care managers and discharge planners. They can help you:

- Get information about community services and supports
- Find services offered in the community to help you be independent
- Visit or call you after your move to make sure you have what you need at home

To learn more about MFP/Open Doors or to set up a visit from a transition specialist or peer, call the New York Association of Independent Living at (844) 545-7108. You may email to Mfp@health.ny.gov or visit MFP/Open Doors at Health.ny.gov/mfp or Ilny.org.

Chapter 3: Services covered by Medicaid Advantage Plus (MAP) Program

Many of the services you get are covered by Medicare and are in the SWH of NY NHC Evidence of Coverage (EOC). These services may be inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests. Chapter 3 of the EOC explains the rules for using network providers and getting urgent or emergency care.

Deductibles and copays on Medicare covered services

Some services have deductibles and copays. Because you're our member and have Medicaid, SWH of NY NHC will pay these amounts. You do not have to pay these deductibles and copays. If you get a bill for covered services authorized by SWH of NY NHC, you're not responsible for paying the bill. Please contact your care manager.

You may have to pay for covered services that are not authorized by SWH of NY NHC or obtained by providers outside of SWH of NY NHC network.

If there is a monthly premium for benefits. See Chapter 1 section 4 of the SWH of NY NHC Medicare Evidence of Coverage. You will not have to pay the premium since you have Medicaid.

We also cover many services not covered by Medicare but covered by Medicaid. The sections below explain what is covered.

Care management services

As a member of our plan, you get Care Management services. We give you a care manager who is a health care professional. This is usually a nurse or social worker. Your care manager works with you and your doctor to decide the services you need and make a care plan. Your care manager will also set up visits for any services you need. He or she will set up transportation to those services. They will also:

- Call you at least once a month to check in and make sure your health status has not changed
- Provide a home visit every six (6) months with you and your family or caregivers. This is included as part of your in-home assessment and re-assessment visit.
- Check with you on a regular basis to see if you're happy with the care and services you get
- Work with your PCP to get the medical orders needed for covered services in your care plan
- Authorize your covered services based on medical necessity
- Talk to your PCP about changes or updates to your care plan
- Arrange and coordinate covered services
- Help set up services you need that are not covered by the plan or in our network
- Be available to you 24 hours a day to with urgent care or other issues (or have a backup care manager)

Additional covered services

Since you have Medicaid and qualify for SWH of NY NHC, we pay for extra health and social services listed below. You can get these services as long as they are medically necessary and 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 network providers. If you cannot find a provider in our plan, please contact Member Services and your care management team.

Benefit	Description of Covered Service	Amount/Limitations
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.	**$0** Prior authorization required. Contact Member Services for help.

Benefit	Description of Covered Service	Amount/Limitations
Consumer Directed Personal Care 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.	**$0** Prior authorization required.
Dental Services	Covered services include regular and routine dental services, such as preventive dental checkups, cleanings, x-rays, fillings and other services to check for changes or abnormalities that may require treatment and/or follow-up care. Also includes medically necessary dental implants. Must have BOTH: • A letter from you doctor explaining how implants will help with your medical condition • A letter from your dentist explaining why other alternatives will not correct your condition and why you need implants You do not need a referral from your PCP to see a dentist.	**$0** Prior authorization may be required for some services, including dental implants. Show your SWH of NY NHC member ID card.

Benefit	Description of Covered Service	Amount/Limitations
Durable Medical Equipment (DME)	Includes non-Medicare DME covered by Medicaid, like devices and equipment other than medical/surgical supplies, tub stools and grab bars, and prosthetic or orthotic appliances. DME covered as long as the following criteria are met: • DME can withstand repeated use for a protracted period of time • Is primarily and customarily used for medical purposes • Is generally not useful to a person without illness or injury • Is usually fitted, designed or fashioned for a particular individual's use • Is ordered by a qualified practitioner No homebound prerequisite.	**$0** Prior authorization may be required for some equipment.
Hearing Services	Services and products to alleviate disability caused by hearing loss or impairment. Must be medically necessary. Includes: • Hearing aid selection, fitting and dispensing • Hearing aid checks following dispensing • Hearing aid conformity evaluations and repairs • Audiology services including testing and exams, hearing aid evaluations and prescriptions • Hearing aids, ear molds, special fittings and replacement parts	**$0** Prior authorization required.
Home Care Services (Skilled)	Meals provided at home or in congregate settings, such as senior centers for individuals unable to prepare meals or have them prepared.	**$0** Prior authorization required.

Benefit	Description of Covered Service	Amount/Limitations
Inpatient Hospital Care, including Mental Health and Substance Use Disorder Care	Medically necessary care, including days in excess of the Medicare 190-day lifetime maximum for inpatient mental health. Plan covers 365 days a year (366 in leap years)	**$0** Prior authorization required, except in emergencies.
Medical Social Services	Assessment, arrangement and provision of aid for social problems related to maintaining member at home.	**$0** Prior authorization required.
Medical/ Surgical Supplies	Covered benefit is for medical or surgical supplies and enteral/parenteral formula and supplements -- items generally considered to be one-time only usage and/ or consumable items.	**$0** Prior authorization required. Enteral formula and nutritional supplement benefits are limited to individuals who cannot obtain nutrition through other means and to the following conditions: • Tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and • Individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients

Benefit	Description of Covered Service	Amount/Limitations
Medical Transportation (routine/non-emergent)	One-way and roundtrip transportation by ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation or other means appropriate to the member's medical condition. If necessary, includes a transportation attendant to accompany member. May include transportation attendant's meals, lodging and salary. (No salary will be paid to an attendant who is the member's family.	**$0** Prior authorization required
Nutrition	Includes assessment of nutritional needs, development and evaluation of treatment plans, nutrition education and counseling, in-service education. Includes cultural considerations.	**$0** Prior authorization required.
Outpatient Mental Health Treatment	Individual and group therapy visits. Member may self-refer for one assessment from a network provider in a 12-month period.	**$0** Prior authorization required for some services.
Outpatient Treatment for Substance Use Disorder	Individual and group visits. Member must be able to self-refer for one assessment from a network provider in a 12-month period.	**$0** Prior authorization required for some services.
Personal Care Services (PCS)	Covers the provision of medically necessary assistance with activities such as personal hygiene; dressing and feeding; nutritional and environmental support such as meal preparation and housekeeping. Services must be essential to maintain member's health and safety in their own home.	**$0** Prior authorization required.
Personal Emergency Response Services (PERS)	PERS is an electronic device that enables individuals to secure help in a physical, emotional or environmental emergency	**$0** Prior authorization required.

Benefit	Description of Covered Service	Amount/Limitations
Private Duty Nursing Services	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.	**$0** Prior authorization required.
Prosthetic and Orthotic Devices	Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices.	**$0** Prior authorization required.
Outpatient Rehabilitation Services	Covered services include: • Physical and occupational therapy • Speech language therapy • Cardiac rehabilitative therapy • Social and psychological therapy • Comprehensive Outpatient Rehabilitation Facility (CORF) services	**$0** Prior authorization required. Physical therapy visits are limited to 40 visits per year, while occupational and speech therapies are limited to 20 visits each per year, except for members with developmental disabilities or traumatic brain injury.
Skilled Nursing Facility (SNF)	Covers custodial care and care provided in a SNF in excess of the Medicare 100-day limit per benefit period. Covers 365 days a year (366 days in leap years)	**$0** Prior authorization required.

Benefit	Description of Covered Service	Amount/Limitations
Social Day Care	Structured comprehensive program providing socialization, supervision, monitoring, personal care and nutrition in a protective setting during any part of the day. May include assistance with ADL, case management and transportation. Coverage based on medical necessity.	**$0** Prior authorization required.
Social and Environmental Supports	Includes services and items to support medical need. May include home maintenance tasks, homemaker/chore services, housing improvement and respite care.	**$0** Prior authorization required.
Limits may apply.		

Getting care outside the service area

If you plan to be away from home or outside our service area, please notify your care manager as early as possible so we can arrange any needed services. We'll work with you and continue to provide non-emergency covered services to the extent they can be arranged with area providers.

If you are out of the area and have an emergency, go to the nearest emergency facility.

Know where to go

Emergency services

Emergencies are when there may be serious danger or damage to your health if you don't get care right away. If you have an emergency, call 911 or go to the nearest hospital emergency room (ER).

Call your PCP and SWH of NY NHC as soon as you can after you visit the ER. Your PCP can help with your follow-up care.

Urgent care

An urgent medical condition is when care is needed for a sudden illness, injury or condition that is not an emergency but needs to be treated in the next 24 to 48 hours. If you need help finding an urgent care center call Member Services at (833) 671-0440. You can call 24 hours a day for help. Our nurses can advise you on where to go when you need care. Call your PCP and SWH of NY NHC as soon as you can after you visit urgent care. Your PCP can help with your follow-up care.

Your PCP

When you're sick or hurt, always call your PCP first (unless it's an emergency). Even if you call outside of their normal hours, someone on call can help you.

Chapter 4: Medicaid services not covered by our plan

There are some services covered by Medicaid that SWH of NY NHC does not cover. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at (833) 671-0440 (TTY: 711) if you have a question about whether a benefit is covered by SWH of NY NHC or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

- Over the counter (OTC) drugs and some prescription drugs not covered by Medicare
- Some mental health services like:
  - Intensive Psychiatric Rehabilitation treatment
  - Day treatment
  - Case Management for mental illness
  - 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
- Some services for people with developmental disabilities like:
  - Long-term therapies
  - Day Treatment
  - Medicaid Service Coordination
  - Services received under the Home and Community Based Services Waiver
- Methadone treatment
- Directly observed therapy for TB (Tuberculosis)
- HIV COBRA case management
- Family Planning. You may go to any family planning doctor or clinic that accepts Medicaid. You do not need a referral from your PCP.

Services not covered by SWH of NY NHC

If you get services not covered by SWH of NY NHC or Medicaid, you may be responsible for payment. If your provider informed you in advance, and you agree to pay for them, you will receive a bill from your provider. Examples of services not covered by SWH of NY NHC or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Infertility treatment
- Services from an out-of-network provider (unless SWH of NY NHC sends you to that provider)

If you have any questions, call Member Services at (833) 671-0440 (TTY: 711).

Chapter 5: Service Authorizations, Actions, Appeals and Complaints

You have Medicare and get assistance from Medicaid. Information in this section covers your rights for all of your Medicare and most of your Medicaid benefits. In most cases, you will not use one process for your Medicare benefits and a different process for your Medicaid benefits. You will usually use one process for both. This is sometimes called an "integrated process" because it integrates Medicare and Medicaid processes.

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page 29 for more information on the External Appeals process.

Service Authorization Request (also known as Coverage Decision Request)

Information in this section applies to your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

When you ask for approval of a treatment or service, it is called a service authorization request (also known as a coverage decision request). To get a service authorization request, you or your provider may call Member Services at (833) 671-0440 (TTY: 711). You can call Monday through Friday from 8 a.m. to 8 p.m. (from October 1—March 31, 7 days a week). Or you can send your request in writing to:

SWH of NY NHC
15 MetroTech Center, 11th Floor
Brooklyn, New York
11201

If we approve your request, we'll 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 SWH of NY NHC before you get them. You or someone you trust can ask for prior authorization. The following treatments and services must be approved before you get them:

- Adult Day Health Care
- Bone Mass Measurement
- Certified Home Health Agency (CHHA)
- Chiropractic Services
- Consumer Directed Personal Assistance Services (CDPAS)
- Dental Services
- Durable Medical Equipment
- Health Education Part C Benefit

- Hearing Services
- Home Delivered meals / Congregate Meals
- Hospice
- Inpatient Hospital Care
- Inpatient Mental Health
- Medical nutrition services
- Medical social services
- Medicare Part B prescription drugs covered under Original Medicare
- Medicare Part D Prescription Drug Benefit as approved by CMS
- Non-emergency transportation
- Outpatient hospital services
- Outpatient mental health services
- Outpatient rehabilitation services
- Outpatient surgery
- Outpatient substance abuse
- Personal Emergency Response Services (PERS)
- Personal care services
- Partial hospitalization service
- Podiatry
- Private duty nursing
- Rehabilitation services
- Prosthetic devices and related supplies
- Screening
- Screening and counseling to reduce alcohol misuse
- Screening for lung cancer with low dose computed tomography (LDCT)
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs
- Services to treat kidney disease and conditions
- Skilled nursing facility
- Smoking and tobacco use cessation
- Adult social day care

- Vision care

Concurrent Review

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

Retrospective Review

Sometimes we'll 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'll tell you if we do these reviews.

What happens after we get your service authorization request?

The health 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 you asked for. A qualified health care professional will make these decisions. If we decide that the service you asked for is not medically necessary, a clinical peer reviewer will make the decision. A clinical peer reviewer may be a doctor, a nurse, or a health care professional who typically provides the care you asked for. You can ask for the specific medical standards, called clinical review criteria, used to make the decision about medical necessity.

After we get your request, we'll review it under either a standard or a fast track process. You or your provider can ask for a fast track review if you or your provider believes that a delay will cause serious harm to your health. If we deny your request for a fast track review, we'll tell you and handle your request under the standard review process. In all cases, we'll review your request as fast as your medical condition requires us to do so, but no later than mentioned below. More information on the fast track process is below.

We'll tell you and your provider both by phone and in writing if we approve or deny your request. We'll also tell you the reason for the decision. We'll explain what options you have if you don't agree with our decision.

Standard Process

Generally, we use the standard timeframe for giving you our decision about your request for a medical item or service unless we have agreed to use the fast track deadlines.

- A standard review for a prior authorization request means we'll give you an answer within three (3) working days of when we have all the information we need, but no later than 14 calendar days after we get your request. If your case is a concurrent review where you are asking for a change to a service you are already getting, we'll make a decision within one (1) working day of when we have all the information we need, but will give you an answer no later than 14 calendar days after we get your request.
- We can take up to 14 more calendar days if you ask for more time or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide

to take extra days to make the decision, we'll tell you in writing what information is needed and why the delay is in your best interest. We'll 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.

- If you believe we should not take extra days, you can file a "fast complaint." When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 5 "What To Do If You Have A Complaint About Our Plan")

If we do not give you our answer within 14 calendar days (or by the end of the extra days if we take them), you can file an appeal.

- If our answer is yes to part or all of what you asked for, we'll 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'll send you a written notice that explains why we said no. Section 2: Level 1 Appeals (also known as Level 1) later in this chapter tells how to make an appeal.

Fast Track Process

If your health requires it, ask us to give you a "fast service authorization."

- A fast review of a prior authorization request means we'll give you an answer within one (1) working day of when we have all the information we need but no later than 72 hours from when you made your request to us.
- We can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get information to us for the review. If we decide to take extra days, we'll tell you in writing what information is needed and why the delay is in your best interest. We'll 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.
- If you believe we should not take extra days, you can file a "fast complaint" (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.) We'll call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 2: Level 1 Appeals, below for how to make an appeal.

To get a fast service authorization, you must meet two requirements:

1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a fast service authorization if your request is about payment for medical care you already got.)
2. Using the standard deadlines could cause serious harm to your life or health, or hurt your ability to function.

If your provider tells us that your health requires a "fast service authorization," we'll automatically agree to give you a fast service authorization.

If you ask for a fast service authorization on your own, without your provider's support, we'll decide whether your health requires that we give you a fast service authorization.

If we decide that your medical condition does not meet the requirements for a fast service authorization, we'll send you a letter that says so (and we'll use the standard deadlines instead).

- This letter will tell you that if your provider asks for the fast service authorization, we'll automatically give a fast service authorization.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints. See page 23 "What To Do If You Have A Complaint About Our Plan")

If our answer is yes to part or all of what you asked for, we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service authorization on your request for a medical item or service, we'll give you our answer by the end of that extended period.

I**f our answer is no to part or all of what you asked for,** we'll send you a detailed written explanation as to why we said no. If you are not satisfied with our answer, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If you do not hear from us on time, it is the same as if we denied your service authorization request. If this happens, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If we're changing a service you are already getting

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved that you are now getting, we must tell you at least 15 days before we change the service.
- If we are checking care that you got in the past, we'll make a decision about paying for it within 30 days of getting necessary information for the retrospective review. If we deny payment for a service, we'll send a notice to you and your provider the day we deny the payment. You will not have to pay for any care you got that the plan or Medicaid covered even if we later deny payment to the provider.

You may also have special Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending. For more information about these rights, refer to Chapter 7 of the SWH of NY NHC Evidence of Coverage.

What to do if you have a complaint about our plan or want to appeal a decision about your care

If we say no to your request for coverage for a medical item or service, you decide if you want to make an appeal.

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).
- SWH of NY NHC can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at (833) 671-0440 (TTY: 711) to get more information on your rights and the options available to you.

At any time in the process you or someone you trust can also file a complaint about the review time. You can call the New York State Department of Health at (866) 712-7197.

Level 1 Appeals (also known as a Plan Level Appeal)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

There are some treatments and services that you need approval for before you get them or to be able to keep getting them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. We describe this process earlier in Section 1 of this chapter. If we decide to deny a service authorization request or to approve it for an amount that is less than asked for, you will receive a notice called an Integrated Coverage Determination Notice.

If you receive an Integrated Coverage Determination Notice and disagree with our decision, you have the right to make an appeal. Making an appeal means trying to get the medical item or service you want by asking us to review your request again.

You can file a Level 1 Appeal:

When you appeal a decision for the first time, this is called a Level 1 Appeal, or a Plan Appeal. In this appeal, we review the decision we made to see if we properly followed all the rules. Different reviewers handle your appeal than the ones who made the original unfavorable decision. When we complete the review, we'll give you our decision. Under certain circumstances, which we discuss below, you can request a fast appeal.

Steps to file a Level 1 Appeal:

- If you are not satisfied with our decision, you have 60 days from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for asking for an appeal.
- If you are appealing a decision we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a "fast appeal."
    - The requirements and procedures for getting a "fast appeal" are the same as for getting a "fast track service authorization." To ask for a fast appeal, follow the instructions for asking for a fast track service authorization. (These instructions are given in Section 1, in the Fast Track Process section.)

- If your provider tells us that your health requires a "fast appeal," we'll give you a fast appeal.
- If your case was a concurrent review where we were reviewing a service you are already getting, you will automatically get a fast appeal.

- You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you
- You can call Member Services at (833) 671-0440 (TTY: 711) if you need help filing a Level 1 Appeal.
  - Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an "Appointment of Representative" form, or write and sign a letter naming your representative.
    - To get an "Appointment of Representative" form, call Member Services and ask for the form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at Seniorwholehealth.com. The form gives the person permission to act for you. You must give us a copy of the signed form; OR
    - You can write a letter and send it to us. (You or the person named in the letter as your representative can send us the letter.)
- We'll not treat you any differently or act badly toward you because you file a Level 1 Appeal.
- You can make the Level 1 Appeal by phone or in writing.

Continuing your service or item while appealing a decision about your care

If we told you we were going to stop, suspend, or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we'll send you a notice before taking action.
- If you disagree with the action, you can file a Level 1 Appeal.
- We'll continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.
- Note: If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative.

What happens after we get your Level 1 Appeal

- Within 15 days, we'll send you a letter to let you know we are working on your Level 1 Appeal. We'll let you know if we need additional information to make our decision.

- We'll send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records we'll use to make the appeal decision. If your Level 1 Appeal is fast tracked, there may be a short time to review this information.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You can also provide information to be used in making the decision in person or in writing. Call us at (833) 671-0440 (TTY: 711) if you are not sure what information to give us.
- We'll give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you asked for we'll send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we'll automatically send your case on to the next level of the appeals process.

Timeframes for a "standard" appeal

- If we are using the standard appeal timeframes, we must give you our answer on a request within 30 calendar days after we get your appeal if your appeal is about coverage for services you have not gotten yet.
- We'll give you our decision sooner if your health condition requires us to.
- However, if you ask for more time or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide we need to take extra days to make the decision, we'll tell you in writing what information is needed and why the delay is in your best interest. We'll 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.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours.
  - For more information about the process for making complaints, see page 23 "What To Do If You Have A Complaint About Our Plan."
- If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process.
  - An independent outside organization will review it.
  - We talk about this review organization and explain what happens at Level 2 of the appeals process in Section 3: Level 2 Appeals.
- If our answer is yes to part or all of what you asked for, we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision.
- If our answer is no to part or all of what you asked for, to make sure we followed all the rules when we said no to your appeal, we are required to send your appeal to the next level of appeal. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Timeframes for a "fast" appeal

- When we are using the fast timeframes, we must give you our answer within 72 hours after we get your appeal. We'll give you our answer sooner if your health requires us to do so.
- If you ask for more time or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we'll tell you in writing what information is needed and why the delay is in your best interest. We'll 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.
- If we do not give you an answer within 72 hours (or by the end of the extra days we took), we are required to automatically send your request on to Level 2 of the appeals process which is discussed below in Section 3: Level 2 Appeals.

If our answer is yes to part or all of what you asked for, we must authorize or provide the coverage we have agreed to provide within 72 hours after we get your appeal.

If our answer is no to part or all of what you asked for, we'll automatically send your appeal to an independent review organization for a Level 2 Appeal. You or someone you trust can also file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal.

- During the Level 2 Appeal, an independent review organization, called the "Integrated Administrative Hearing Office" or "Hearing Office," reviews our decision on your first appeal. This organization decides whether the decision we made should be changed.
- We tell you about this organization and explain what happens at Level 2 of the appeals process later in Section 3: Level 2 Appeals.

At any time in the process you or someone you trust can also file a complaint about the review time. Call the New York State Department of Health at (866) 712-7197.

Section 3: Level 2 Appeals

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

If we say No to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Hearing Office reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- The Hearing Office is an independent New York State agency. It is not connected with us. Medicare and Medicaid oversee its work.
- We'll send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a free copy of your case file.
- You have a right to give the Hearing Office additional information to support your appeal.
- Reviewers at the Hearing Office will take a careful look at all of the information related to your appeal. The Hearing Office will contact you to schedule a hearing.
- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed

by waiting for a decision under a standard timeframe, you may have a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it gets your appeal. In some cases, if you had a fast appeal to our plan at Level 1 you will not automatically receive a fast appeal at Level 2. In these cases, if you want a fast appeal at Level 2 you will need to ask the Integrated Administrative Hearing Office for one. The notice that we send you with our Level 1 decision will tell you how.

- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically get a standard appeal at Level 2.
- The review organization must give you an answer to your Level 2 Appeal within 60 calendar days of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 10 for information about continuing your benefits during Level 1 Appeals.

The Hearing Office will tell you its decision in writing and explain the reasons for it.

- If the Hearing Office says yes to part or all your request, we must authorize the service or give you the item within one business day of when we get the Hearing Office's decision.
- If the Hearing Office says no to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")

If the Hearing Office says no to part or all of your appeal, you can choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal).
- If your Level 2 Appeal is turned down, you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you got after your Level 2 Appeal has the details on how to do this.
- The Medicare Appeals Council handles the Level 3 Appeal. After that, you may have the right to ask a federal court to look at your appeal.
- The decision you get from the Medicare Appeals Council related to Medicaid benefits will be final.

At any time in the process you or someone you trust can also file a complaint about the review time. Call the New York State Department of Health at (866) 712-7197.

Section 4: External Appeals for Medicaid Only

You or your doctor can ask for an External Appeal for Medicaid covered benefits only.

You can ask New York State for an independent external appeal if our plan decides to deny coverage for a medical service you and your doctor asked for because it is:

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

This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State. The service must be in SWH of NY NHC's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

- You must file a Level 1 appeal with the plan and get the plan's Final Adverse Determination; or
- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); or
- You and SWH of NY NHC may agree to skip the plan's appeals process and go directly to External Appeal; or
- You can prove SWH of NY NHC did not follow the rules correctly when processing your Level 1 appeal.

You have 4 months after you get the SWH of NY NHC's Final Adverse Determination to ask for an External Appeal. If you and SWH of NY NHC agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services.

- You can call Member Services at (833) 671-0440 (TTY: 711) if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, (800) 400-8882
- Go to the Department of Financial Services' website at Dfs.ny.gov.
- Contact the health plan at (833) 671-0440 (TTY: 711)

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five work days) may be needed. The reviewer will tell you and SWH of NY NHC the final decision within two days after making the decision.

You can get a faster decision if your doctor says 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 SWH of NY NHC the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process you or someone you trust can also file a complaint about the review time. Call the New York State Department of Health at (866) 712-7197.

Section 5: What to do if you have a Complaint about our plan

Information in this section applies to all of your Medicare and Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

We hope our plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Member Services at (833) 671-0440 (TTY: 711) or write to Member Services. The formal name for "making a complaint" is "filing a grievance."

You can ask someone you trust to file the complaint for you. If you need our help because of a hearing or vision impairment or if you need translation services, we can help you. We'll not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint:

- Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services will let you know. (833) 671-0440 (TTY: 711) Monday through Friday, from 8 a.m. to 8 p.m. (from October 1—March 31, 7 days a week).
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.
- If you write us mail it to:

  Attn: Grievances & Appeals
  Senior Whole Health of New York NHC
  15 MetroTech Center, 11th Floor
  Brooklyn, New York
  11201

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters it will be reviewed by one or more qualified health care professionals.

- Whether you call or write, you should contact Member Services right away. You can make the complaint at any time after you had the problem you want to complain about.

What happens next:

- If possible, we'll answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.
- We answer most complaints in 30 calendar days.
- If you are making a complaint because we denied your request for a "fast service authorization" or a "fast appeal," we'll automatically give you a "fast" complaint. If you have a "fast" complaint, it means we'll give you an answer within 24 hours.
- If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- However, if you have already asked us for a service authorization or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples of when you can make a complaint:
  - If you asked us to give you a "fast service authorization" or a "fast appeal" and we said we'll not.
  - If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made.
  - When a service authorization we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines.
  - When we do not give you a decision on time and we do not forward your case to the Hearing Office by the required deadline.
- If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we'll let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Complaint Appeals

If you disagree with a decision we made about your complaint about your Medicaid benefits, you or someone you trust can file a complaint appeal with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 working days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;
- You must make the complaint appeal in writing.
  - If you make an appeal by phone, you must follow it up in writing.
  - After your call, we'll send you a form that summarizes your phone appeal.

- If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

After we get your complaint appeal, we'll send you a letter within 15 working days. The letter will tell you:

- Who is working on your complaint appeal
- How to contact this person
- If we need more information

One or more qualified people will review your complaint appeal. These reviewers are at a higher level than the reviewers who made the first decision about your complaint.

If your complaint appeal involves clinical matters, one or more qualified health professionals will review your case. At least one of them will be a clinical peer reviewer who was not involved in making the first decision about your complaint.

We'll let you know our decision within 30 working days from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 working days of when we have all the information we need to decide the appeal. We'll give you the reasons for our decision and our clinical rationale, if it applies.

If you are still not happy, you or someone on your behalf can file a complaint at any time. Call the New York State Department of Health at (866) 712-7197.

Chapter 6: Your rights and responsibilities

Senior Whole Health of New York NHC 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 to help you use your rights.

Member Rights:

You have the Right to:

- Receive medically necessary care
- Timely access to care and services.
- Privacy about your medical record and when you get treatment.
- Have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.
- Get information in a language you understand; you can get oral translation services free of charge.
- Get information necessary to give informed consent before the start of treatment.

- Be treated with respect and dignity.
- Get a copy of your medical records and ask that the records be amended or corrected.
- Take part in decisions about your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- 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.
- Complain to the New York State Department of Health or your Local Department of Social Services.
- Use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- Appoint someone to speak for you about your care and treatment.
- Get help from the Participant Ombudsman program.

Member responsibilities:

- Receiving covered services through Senior Whole Health of New York NHC;
- Using Senior Whole Health of New York NHC 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 Senior Whole Health of New York NHC 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 Senior Whole Health of New York NHC staff (with your input);
- Cooperating with and being respectful with the Senior Whole Health of New York NHC staff and not discriminating against Senior Whole Health of New York NHC staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status;
- Notifying [Senior Whole Health of New York NHC within two business days of receiving non-covered or non-pre-approved services;
- Notifying your Senior Whole Health of New York NHC health care team in advance whenever you will not be home to receive services or care that has been arranged for you;
- Informing Senior Whole Health of New York NHC 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.

Disenrollment from our plan

Enrollees shall not be disenrolled from the Medicaid Advantage Plus Product based on any of the following reasons:

High utilization of covered medical services, an existing condition or a change in the Enrollee's health, diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs unless the behavior results in the Enrollee becoming ineligible for Medicaid Advantage Plus.

You Can Choose to Voluntary Disenroll

You can ask to leave the Senior Whole Health of New York NHC, MAP Program at any time for any reason.

To request disenrollment, call (833) 671-0440 (TTY: 711). 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 or Home and Community Based Waiver program, in order to receive CBLTC services.

You Will Have to Leave Senior Whole Health of New York NHC, MAP Program if:

- You no longer are in Senior Whole Health of New York NHC for your Medicare coverage
- You no longer are Medicaid eligible
- You need nursing home care, but are not eligible for institutional Medicaid
- You are out of the plan's service area for more than 30 consecutive days
- You permanently move out of Senior Whole Health of New York NHC service area
- You no longer require a nursing home level of care as determined using the Uniform
- Assessment System (UAS) or other tool designated by SDOH
- You are no longer eligible for nursing home level of care as determined at any comprehensive assessment using the assessment tool prescribed by the SDOH, unless the Contractor, or the LDSS or entity designated by the State agree that termination of the services provided by the Contractor could reasonably be expected to result in the Enrollee being eligible for nursing home level of care (as determined with the assessment tool prescribed by the SDOH) within the succeeding six-month period. The Contractor shall provide the LDSS or entity designated by the State the results of its assessment and recommendations regarding continued enrollment or disenrollment within five (5) business days of the comprehensive assessment;

- 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;
- Your sole service is identified as Social Day Care must be disenrolled from the MAP plan
- You join a Home and Community Based Services Waiver program, or are enrolled in a program or become a resident in a facility that is under the auspices of the Offices for People with Developmental Disabilities, or Alcoholism and Substance Abuse Services.

We Can Ask You to Leave the Plan

We'll ask that you leave Senior Whole Health of New York NHC if you:

- Or a 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.
- Knowingly provide fraudulent information on an enrollment form or you permit abuse of an enrollment card in the MAP Program.
- Fail to complete and submit any necessary consent or release.
- Fail to pay or make arrangements to pay the amount money, as determined by the Local District of Social Services, owed to the plan as spenddown/surplus within 30 days after amount first becomes due. We'll have made reasonable effort to collect.

Before being involuntarily disenrolled, Senior Whole Health of New York NHC will obtain the approval of 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 the disenrollment is processed. If you continue to need community based long term care services, you will be required to choose another plan or you will be auto assigned to another plan to provide you with coverage for needed services.

Re-enrollment requirements

If you voluntarily disenroll, you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment.

Cultural and Linguistic Competency

Senior Whole Health of New York NHC 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 enrollees. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

Chapter 7: Advance directive

An advance directive is a written statement by you telling you how you want medical decisions made if you are unable to decide for yourself. It helps make sure you get the medical care you want if you are ever so sick or injured that you can't speak for yourself. That's why it's important to choose someone you trust.

How do you get an advance directive?

- Ask your provider for a healthcare proxy form or call Member Services to get one.
- Fill out the form and appoint an adult you trust to make decisions for you.
- Take or mail the completed form to your provider. Your provider will then know what kind of care you want if you cannot decide for yourself.
- You can change your mind and these documents at any time.

Additional helpful documents

Cardiopulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR)

You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you don't want this treatment or CPR, talk to your provider who can document your wishes in your medical record. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

Organ Donor card

This wallet-sized card says that you are willing to donate parts of your body to help others when you die. You may also use the back of your driver's license to let others know if and how you want to donate your organs.

Chapter 8: Information you may request

As a member, you have the right to access certain information about SWH of NY NHC. We'll provide this information upon your request:

- List of the names, business addresses and official positions of the members of the Board of Directors, officers, controlling persons, owners or partners of SWH of NY NHC
- The most recent annual certified financial statement of SWH of NY NHC
- Information relating to consumer complaints regarding SWH of NY NHC
- Written description of the organizational arrangements for SWH of NY NHC
- Description of SWH of NY NHC procedures with regard to protecting the confidentiality of medical records and other member information and ongoing quality assurance program
- Health practitioners' affiliations with hospitals
- •Description of criteria used when making decisions about approval or denial of services
- Application procedures and minimum qualification requirements for health care providers to participate in SWH of NY NHC
- A copy of your SWH of NY NHC program record (when you make a request in writing to the director).

MEDICAID ADVANTAGE PLUS (MAP)

Starting January 1, 2023, Senior Whole Health will cover behavioral health (mental health and addiction) services. You may have had some of these services before. Now you can use your [Senior Whole Health] plan card to get these services. We will now cover:

Adult outpatient mental health care

- Continuing Day Treatment (CDT)
- Partial Hospitalization (PH)

Adult outpatient rehabilitative mental health care

- Assertive Community Treatment (ACT)
- Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)
- Personalized Recovery Oriented Services (PROS)

Adult outpatient rehabilitative mental health and addiction services for members who meet clinical requirements. These are also known as Community Oriented Recovery and Empowerment (CORE) Services:

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Supports and Treatment (CPST)
- Empowerment Services – Peer Supports
- Family Support and Training (FST)

Adult mental health crisis services

- Comprehensive Psychiatric Emergency Program (CPEP)
- Mobile Crisis and Telephonic Crisis Services
- Crisis Residential Programs

Adult outpatient addiction services

- Opioid Treatment Centers (OTP)

Adult residential addiction services

- Residential Services

Adult Inpatient addiction rehabilitation services

- State Operated Addiction Treatment Center's (ATC).
- Inpatient Addiction Rehabilitation
- Inpatient Medically Supervised Detox

How do I get these services?

To learn more, call Member Services at <877-353-0185>. You may ask your providers how to get these services.

Senior Whole Health
BY MOLINA HEALTHCARE

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