

2012 MEDICAID ADVANTAGE HANDBOOK

Senior Whole Health of New York (HMO SNP)

Service area includes:
Bronx, Kings, New York and Queens Counties



Approved by NYS DOH 12/6/2011

WELCOME TO SENIOR WHOLE HEALTH OF NEW YORK MEDICAID ADVANTAGE

Medicaid Advantage is a program for people who have both Medicare and Medicaid and live in Bronx, Kings, New York and Queens Counties. This handbook tells you about the added health benefits Senior Whole Health of New York covers since you also have Medicaid and you have joined Senior Whole Health of New York Medicaid Advantage Program.

These benefits are in addition to the Medicare benefits described in the Senior Whole Health of New York Medicare Evidence of Coverage. Keep this handbook with the Senior Whole Health of New York Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

In order to be in Senior Whole Health of New York for the Medicaid Advantage benefits, you must also be enrolled in Senior Whole Health of New York for your Medicare coverage. Enrollment in the Medicaid Advantage Program is voluntary.

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in Senior Whole Health of New York Medicaid Advantage Program.

Since you have decided to join Senior Whole Health of New York for your Medicaid Advantage benefits, Senior Whole Health of New York will cover the deductibles and co-payments that Medicare does not cover, except for pharmacy items. If there is a monthly premium for benefits (see Chapter 1 of the Senior Whole Health of New York Medicare Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover certain services that are not covered by Medicare but are covered by Medicaid.

Chapter 3 of the Senior Whole Health of New York Medicare Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or when there is an urgent need for care.

When you have questions, check this handbook or you can call our Member Services at anytime at the number below. If you live in Bronx, Kings, New York or Queens Counties in New York City, Nassau or Suffolk Counties, you can also call the New York Medicaid CHOICE HelpLine at 1-800-505-5678.

HELP FROM MEMBER SERVICES

You can call to get help **anytime you have a question**. You may call us to ask about benefits and services, to get help with referrals, to replace a lost ID card or ask about any change that might affect your benefits.

There is someone to help you at Member Services:

Monday through Friday

8 A.M. to 8 P.M.

Call 1-866-211-1777

TTY users, please call 711

An on call nurse is available if you need to reach us after hours.

DEDUCTIBLES AND COPAYMENTS ON MEDICARE COVERED SERVICES

- Deductibles and copayments on Medicare covered services are shown in the Benefits Chart in Chapter 4 of Senior Whole Health of New York Medicare Evidence of Coverage under the column “What you must pay when you get these services”. Because you have joined Senior Whole Health of New York, and you have Medicaid, Senior Whole Health of New York will pay these amounts. You do not have to pay for these deductibles and co-payments except for those that apply to chiropractic care unless you are Qualified Medicare Beneficiary (QMB), and pharmacy items.

SERVICES COVERED BY SENIOR WHOLE HEALTH OF NEW YORK MEDICAID ADVANTAGE

Most of your health services and benefits are covered by Medicare and are described in the Senior Whole Health of New York Medicare Evidence of Coverage.

Because you have Medicaid, you get some extra services from our plan. These services must be medically necessary and, in some cases, you may need a referral from your Primary Care Provider. You must get these services from the providers who are in Senior Whole Health of New York network. If you cannot find a provider in our plan, contact Member Services for assistance.

- **Non-Emergency Transportation**
Senior Whole Health of New York will cover non-emergency Transportation cost to medical appointments. If you are unable to use public transportation, a car or ambulette service can be arranged. To arrange a ride, please contact Member Services at least 3 days before your appointment with the day, time and location, and Senior Whole Health of New York will make the arrangements. This service does not require a physician’s order.

- **Dental Care**
 Senior Whole Health of New York believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with DentaQuest an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist. You may see any dentist in the provider network.
- If you need to find a dentist or change your dentist, please call Senior Whole Health of New York at 1-866-211-1777. TTY users, please call 711. Member Services Representatives are there to help you. Many speak your language or have a contract with Language Line Services.
- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.
- You can also self refer to a dental clinic that is run by an academic dental center. Call our Member Services number for assistance.
- **Home Health Care Services Not Covered by Medicare-** Medicaid home health covered services not covered by Medicare (e.g. maintenance level therapies or pre-filling syringes). Authorization is required. Contact Member Services to access this benefit.
- **Non-Medicare Covered Durable Medical Equipment**
 Durable medical equipment covered by Medicaid such as tub stools and grab bars.
- **Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit**
 Authorization required except in an emergency. Contact Member Services for assistance.
- **Outpatient Mental Health & Substance Abuse**
 You can self-refer for one assessment for each benefit from a network provider in a twelve (12) month period.
- **Hearing Services**
 Hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selection, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, ear molds, special fittings and replacement parts.

- **Vision Services**
Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair and the replacement of parts. You can self-refer to clinics that provide optometry services and is affiliated with the College of Optometry of the State University of New York.
- **Private Duty Nursing-** Services provided by a person possessing a license and registered professional nurse and can be provided through an approved home health care agency or private Practitioner. Authorization is required. Contact Member Services to access these benefits.

NOTE: Outpatient Therapy

Senior Whole Health of New York covers outpatient Occupational, Physical and Speech therapies. If you have reached the Medicare limits, Medicaid coverage is available. Outpatient therapies covered by Medicaid include Occupational, Physical and Speech Therapy and are limited to (20) Medicaid visits per therapy per year, except for children under age 21 or if you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities or if you have a traumatic brain injury.

Service Authorization and Actions

When Senior Whole Health of New York determines that services are covered solely by Medicaid, we will make decisions about your care following these rules:

Prior Authorization:

There are some Medicaid treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Private Duty Nursing
- Inpatient Mental Health Care (greater than 190 lifetime days)
- Home Health Care
- Transportation- non-emergent
- Dental Services- non-routine

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services you, or your physician, need to:

Call Member Services at 1-866-211-1777; or write to us at Member Services 200 S. Pearl Street, Albany NY 12202.

You will also need to get prior authorization if you are getting one of these services now, but need to continue the service or get more of the service. This includes a request for Medicaid covered home health care following an inpatient hospital stay. This is called **concurrent review**.

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 medically acceptable standards.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**. 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 or may be 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 case will be handled under the standard review process. If you are in the hospital or have just left the hospital and we receive a request for Medicaid covered home health care, we will handle the request as a fast track review. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision.

Timeframes for prior authorization requests:

- **Standard review:** We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision and you will hear from us within 3 work days. We will tell you by the third work day if we need more information.
- If you are in the hospital or have just left the hospital, and you ask for Medicaid covered home health care on a Friday or a holiday, we will make a decision on your request for service no later than 72 hours after we receive all the necessary

information to make a decision on the service request but in any event no more than 3 business days after we receive the request.

Timeframes for concurrent review requests:

- Standard review: We will make a decision within 1 work day 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 tell you by the 14th day if we need more information.
- Fast track review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 3 work days after we received your request. We will tell you by the third work day if we need more information.

If we need more information to make either for standard or fast track decision about your service request 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 no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-866-211-1777 or write to us at Member Services 200 S. Pearl Street, Albany NY 12202.

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

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

Other Decisions About Your Care:

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we take these other actions.

Timeframes for notice of other actions:

- In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid covered services that Senior Whole Health of New York does not provide. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-866-211-1777 if you have a question about whether a benefit is covered by Senior Whole Health of New York or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription drugs are covered by Senior Whole Health of New York through Medicare as described in chapter 6 of the Senior Whole Health of New York Medicare Evidence of Coverage (EOC). Regular Medicaid will cover certain drugs not covered by Senior Whole Health of New York or Medicare, such as barbiturates, benzodiazepines, some prescription vitamins and some non-prescription drugs. You can also get certain enteral formulas and some medical supplies that we do not cover, with a physician's order, from any pharmacy that takes Medicaid. Regular Medicaid co-payments may apply.

Certain Mental Health Services, including:

- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units.)
- Partial Hospital Care not covered by Medicare
- Rehabilitation Services to those in community homes or in family-based treatment
- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Mental Retardation and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination

- Services received under the Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

Other Medicaid Services

- Methadone Treatment
- Personal Care Services
- Comprehensive Medicaid Case Management
- Directly Observed Therapy for TB (Tuberculosis)
- Adult Day Treatment for Persons with HIV/AIDS
- HIV COBRA Case Management
- Adult Day Health Care
- Personal Emergency Response Services
- Skilled Nursing Facility Days Not Covered by Medicare
- Out of Network Family Planning Services

FAMILY PLANNING

Medicaid Advantage Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).

SERVICES NOT COVERED BY MEDICAID ADVANTAGE OR MEDICAID

You must pay for services that are not covered by Senior Whole Health of New York 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 Senior Whole Health of New York or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Services of a Provider that is not part of the plan (unless Senior Whole Health of New York sends you to that provider)

If you have any questions, call Member Services at 1-866-211-1777.

DISENROLLMENT FROM SENIOR WHOLE HEALTH OF NEW YORK MEDICAID ADVANTAGE PROGRAM

You Can Choose to Disenroll

You can ask to leave the Senior Whole Health of New York Medicaid Advantage Program at any time for any reason.

To request Medicaid Advantage disenrollment, call member services or New York Medicaid CHOICE at 1-800-505-5678 for help in disenrolling or transferring. It could take up to six weeks to process, depending on when your request is received. You can ask for a faster disenrollment if you believe that a delay could harm your health. You can also ask for faster action if you leave our Medicare plan, or believe that you were enrolled in this program without your permission. Just call New York Medicaid CHOICE at 1-800-505-5678.

You may disenroll to regular Medicaid or join another Medicaid Advantage Plan as long as you also join that plan for your Medicare coverage.

You Will Have to Leave Senior Whole Health of New York’s Medicaid Advantage Program if you:

- No longer are in Senior Whole Health of New York for your Medicare coverage;
- Permanently move out of the Senior Whole Health of New York service area;
- Join a Long-Term Home Health Care Program or Managed Long-Term Care Program;
- Are considered in permanent status in a Nursing Home or certain other institutions;
- Are incarcerated; or
- Have a change in your Medicaid or become part of a program that makes you ineligible for Medicaid Advantage.

In some cases you may be “guaranteed” coverage by Senior Whole Health of New York. That means we will not drop you as member of our Medicaid Advantage Program during the first six months of your enrollment—even if you are no longer eligible for Medicaid and your Medicaid case is closed. During this time, you can get the services that our Medicaid Advantage Program covers. You can also get family planning care and limited Medicaid pharmacy benefits using your Medicaid card. Your coverage will not be “guaranteed” if the reason you lost your Medicaid eligibility is related to death, moving out of state or incarceration. Guaranteed coverage does not apply if you choose to leave Senior Whole Health of New York or if Senior Whole Health of New York leaves the Medicaid Advantage program.

We Can Ask You to Leave the Plan

We will ask that you leave our Medicaid Advantage Plan if you are asked to leave our Medicare Advantage Plan (See chapter 10 of the Medicare Evidence of Coverage for reasons and process).

WHAT TO DO IF YOU HAVE A COMPLAINT ABOUT OUR PLAN OR WANT TO APPEAL A DECISION ABOUT YOUR CARE

Because you have both Medicare and Medicaid, the way you make complaints and appeals about your services will depend on whether Senior Whole Health of New York determines that the services are covered by Medicare or Medicaid.

For complaints and appeals about a service that is covered only by Medicare (e.g. chiropractic services), you will follow the rules outlined in Chapter 9 of Senior Whole Health of New York Medicare Evidence of Coverage.

For complaints and appeals about a service that is covered only by Medicaid (e.g. private duty nursing, non-emergency transportation and dental services (if covered by plan), you will follow the Medicaid rules listed below.

For complaints and appeals about all other services covered by Senior Whole Health of New York you may choose to follow either the Medicare rules outlined in Chapter 9 Senior Whole Health of New York Evidence of Coverage or the Medicaid rules described below.

If you choose to follow the Medicare rules, you cannot use your Medicaid complaint and appeal rights, including the right to a state Fair Hearing regarding the complaint or appeal. But if you choose to follow the Medicaid rules, you will have up to 60 days from the day of Senior Whole Health of New York's notice of action to use your Medicare complaint and appeal rights.

Senior Whole Health of New York will explain the complaints and appeals processes available to you depending on the complaint you have. Call Member Services at 1-866-211-1777 to get more information on your rights and the options available to you.

MEDICAID RULES FOR APPEALS AND COMPLAINTS

Action Appeals

If you are not satisfied with our decisions about your Medicaid care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 business days after hearing from us to file an action appeal.
- You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services 1-866-211-1777 if you need help filing an action appeal.
- We will not treat you any differently or act badly toward you because you file an action appeal.
- The action appeal can be made by phone or in writing. If you make an action appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

Your action appeal will be reviewed under the fast track process:

- If you or your doctor asks to have your action appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your action appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- If your request was denied when you asked for Medicaid covered home health care after you were in the hospital.
- Fast track action appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your action appeal:

- Within 15 days, we will send you a letter to let you know we are working on your action appeal.
- Action Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom 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.
- Before and during the appeal you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.
- You can also provide information to be used in making the decision in person or in writing.
- You will be given the reasons for our decision and our clinical rationale, if it applies.

- If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us:
 1. a written statement that the service you asked for is different from the service we have in our network; and
 2. two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you and will not cause you more harm than the service we have in our network.

Timeframes for Action Appeals:

- Standard action appeals: If we have all the information we need we will tell you our decision in 30 days from your action appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.
- Fast track action appeals: If we have all the information we need, fast track action appeal decisions will be made in 2 working days from your action appeal. We will tell you in 3 work days after giving us your action appeal, if we need more information. We will tell you our decision by phone and send a written notice later.

If we need more information to make either a standard or fast track decision about your action appeal we will:

- Write you 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 no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-866-211-1777 or write to us.

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 action appeal.

If your original denial was because we said the service was not medically necessary or the service was experimental or investigational or the out of network service was not different from a service that is available in our network, and we do not tell you our decision about your action appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

If you don't agree with the decision to take more time to review your action appeal or if you are not satisfied with the decision we make on your action appeal, any further appeal rights you have will be explained to you. You or someone you trust can file a complaint with the New York State Department of Health at 1-866-712-7197.

Aid to Continue while appealing a decision about your care:

In some cases you may be able to continue the services while you wait for your action appeal case to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for a Fair Hearing:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your Fair Hearing results in another denial you may have to pay for the cost of any continued benefits that you received. The decision you receive from the Fair Hearing officer will be final.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary or because it is experimental or investigational or the out-of-network service was not different from a service that is available in our network, you can ask New York State for an independent **external appeal**. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an external appeal.

Before you appeal to the state:

1. You must file an action appeal with the plan and get the plan's final adverse determination; **or**
2. If you had a fast track action appeal and are not satisfied with the plan's decision you can choose to file a standard action appeal with the plan or go directly to an external appeal; **or**
3. You and the plan may agree to skip the plan's appeals process and go directly to external appeal.

You have 45 days after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 45 days of when you made that agreement.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the State Department of Insurance within 45 days from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

You will lose your right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the State Insurance Department. You can call Member Services at 1-866-211-1777 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 State Insurance Department, 1-800-400-8882
- Go to the State Insurance Department's website at www.ins.state.ny.us
- Contact the health plan at 1-866-211-1777

Your external appeal will be decided in 30 days. More time (up to five work days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

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

You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

Complaints

We hope our plan serves you well. If you have a problem, please call Member Services at 1-866-211-1777 or write to Member Services. Please remember that complaints about services that are only a benefit under Medicare should be handled through the Senior Whole Health of New York Medicare complaint process. Complaints about services only covered by Medicaid should be handled through the Senior Whole Health of New York Medicaid complaint process. You can choose to use either the Medicare or Medicaid complaints process for complaints about services that Senior Whole Health of New York determines are a benefit under both Medicare and Medicaid.

Most problems can be solved right away. Problems that are not solved over the phone and any complaint that comes in about a Medicaid service will be handled according to the procedures described below. You can ask someone you trust (such as a legal representative, a family member or friend) 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 will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint with the Plan:

To file by phone, call Member Services at 1-866-211-1777, Monday-Friday 8AM-8PM. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to Member Services, 200 S. Pearl St. Albany NY 12202.

What happens next:

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

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

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals:

If you disagree with a decision we made about your complaint, 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 60 business days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of 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 will 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

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information we need you will know our decision in 30 working days. 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. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866-712-7197.

Fair Hearings

In some cases you may ask for a Fair Hearing from New York State.

- You are not happy with a decision your local department of social services or the State Department of Health made about your staying or leaving the Medicaid Advantage Program.
- You are not happy with a decision that Senior Whole Health of New York made about one of the services that you were getting. You feel the decision limits your Medicaid benefits or that the plan did not make the decision in a reasonable amount of time.

- You are not happy with a decision that Senior Whole Health of New York made that denied services. You feel that the decision limits your Medicaid benefits or that Senior Whole Health of New York did not make the decision in a reasonable amount of time.
- You are not happy with a decision that your doctor would not order one of the Medicaid services that you wanted. You feel that the doctor's decision stops or limits your Medicaid benefits. You must file a complaint and an appeal with Senior Whole Health of New York. If Senior Whole Health of New York agrees with your doctor, you may ask for a State Fair Hearing.
- In some cases, you may be able to keep getting care the same way while waiting for your Fair Hearing.

If you filed a complaint or appeal under Medicare rules, you may not then request a state Fair Hearing about the same complaint or appeal.

You can use one of the following ways to request a Fair Hearing:

- By phone: Call toll free 1-800-342-3334
- By fax: 518-473-6735
- By Internet: www.otda.state.ny.us/oah/forms.asp
- By mail: Fair Hearing Section
NYS Office of Temporary and Disability Assistance
Office of administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

Remember, you can file a complaint anytime to the New York State Department of Health by calling 1-866-712-7197. Call Member Services at 1-866-211-1777 if you have any questions.