

Medicaid Advantage Plus Handbook

WELCOME TO SENIOR WHOLE HEALTH OF NEW YORK MEDICAID ADVANTAGE PLUS

Welcome to Senior Whole Health of New York Medicaid Advantage Plus Program. The Medicaid Advantage Plus Program is especially designed for people who have Medicare and Medicaid and who need health and long-term care services like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits Senior Whole Health of New York covers since you are enrolled in the Senior Whole Health of New York Medicaid Advantage Plus Program. It also tells you how to request a service, file a complaint or grievance or disenroll from the Senior Whole Health of New York Medicaid Advantage Plus Program. The benefits described in this handbook 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.

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.

If you have a special need with hearing or vision, Senior Whole Health of New York will be happy to accommodate you. Arrangements will be made on an individual basis as necessary. This is a free service to all members of Senior Whole Health of New York.

ELIGIBILITY FOR ENROLLMENT IN THE MEDICAID ADVANTAGE PLUS PROGRAM

Senior Whole Health of New York Medicaid Advantage Plus is a program for people who have both Medicare and Medicaid. You are eligible to join our Medicaid Advantage Plus Program if you are also enrolled in Senior Whole Health of New York for Medicare coverage and:

- 1) Are age **65** and older
- 2) Reside in the plan's service area: Capital District (Albany, Rensselaer, Schenectady, Saratoga and Montgomery Counties); Lower Adirondack Region (Warren and Washington Counties); Hudson Valley Region (Ulster, Dutchess, Orange, Greene and Columbia Counties)
- 3) Have a chronic illness of disability that makes you eligible for services usually provided in a nursing home
- 4) Are able to stay safely at home at the time you join the plan
- 5) Require care management and are expected to need one or more of the following services for at least 120 days from the date that you join our plan:
 - a. Nursing services in the home
 - b. Therapies in the home
 - c. Home health aide services
 - d. Personal care services in the home
 - e. Adult day health care, or
 - f. Social day care if used instead of in-home personal care services

An Applicant who is a hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office For People With Developmental Disability (OPWDD) or is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, a Comprehensive Medicaid Case Management Program (CMCM) or OPWDD Day Treatment Program or is receiving services from a hospice may be enrolled with the Contractor upon discharge or termination from the inpatient hospital, facility licensed by the OMH, OASAS or OPWDD, other managed care plan, hospice, Home and Community-Based Services waiver program, CMCM or OPWDD Day Treatment Program.

Your physician must agree to collaborate with Senior Whole Health of New York or you must be willing to change to a physician who is willing to collaborate with the managed long-term care plan. Collaboration by a physician means the willingness to write orders for covered services that allow you to receive care from network providers upon enrollment.

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in Senior Whole Health of New York's Medicaid Advantage Plus Program. Enrollment in the Medicaid Advantage Plus Program is voluntary.

You must also sign the following documents:

- (a.) An Enrollment Agreement, which includes a release of information to Senior Whole Health of New York;
- (b.) The Acknowledgement and Consent regarding Notice of Privacy Practices (HIPAA form) that consents to a release of medical information from Senior Whole Health of New York. (If you refuse to consent to the medical release portion of the Enrollment Agreement, then Senior Whole Health of New York will consider, on a case-by-case basis, whether the release is necessary.)

Senior Whole Health of New York will not discriminate against any potential enrollee who meets the above criteria, based on their health status, and need for or cost of covered services.

If during the early enrollment process, we determine you are not eligible for enrollment, we will advise you of this and you will be given an opportunity to withdraw your application.

Denial of Enrollment: You will be denied enrollment to Senior Whole Health of New York if:

- You do not meet the eligibility criteria listed above.
- You cannot be maintained safely in your home.
- You are not eligible for nursing home level of care.
- You do not need long term care services of the plan for at least 120 days.
- You are enrolled in one of the following: Another Managed Care Plan capitated by Medicaid, a Home and Community-Based Services waiver program, a Hospice, a State Office for People with Developmental Disabilities (OPWDD) facility or waiver program and do not want to disenroll.

If you were previously involuntarily disenrolled and would like to return to Senior Whole Health of New York, we will be happy to review your case for possible re-enrollment.

During the enrollment process, if we have found that you are not eligible for enrollment into Senior Whole Health of New York we will call you and also inform you in writing of the decision.

Network providers will be paid in full directly by Senior Whole Health of New York for each service authorized and provided to you with no co-pay or cost to you. If you receive a bill for covered services authorized by Senior Whole Health of New York you are not responsible to pay the bill, please contact your Care Manager. You may be responsible for payment of covered services that were not authorized by Senior Whole Health of New York, or for covered services that are obtained by providers outside of Senior Whole Health of New York network.

Transitional Care

New Members:

If you are a new Member, and your healthcare provider is not a Senior Whole Health of New York network provider, you may request to continue an ongoing course of treatment with your current provider. The provider's agreement to continue service is subject to meeting the requirements of the provider application and credentialing process. The provider must agree to accept the plan's rates as payment in full. The period of transition is up to 60 days if you have a life threatening disease or condition, or a degenerative and disabling disease or condition.

Current Members:

If your network provider chooses to no longer be a Senior Whole Health of New York network provider, we will provide continued coverage with your provider to complete services that you are receiving for up to 90 days to facilitate transition to another provider. The provider must agree to accept Senior Whole Health of New York rates as payment in full and adhere to Quality Improvement requirements during the transition period.

Monthly Spenddown

In order to enroll in Senior Whole Health of New York, your Local Department of Social Services reviews your financial status for Medicaid eligibility. They may determine that you must spend a portion of your monthly income in order to meet the maximum income eligibility amount of Medicaid. Your Local Department of Social Services will inform you and Senior Whole Health of New York of the exact amount of "spend-down" owed to Senior Whole Health of New York each month. In order to enroll and receive Senior Whole Health of New York benefits you must pay this amount to Senior Whole Health of New York. You will be mailed a bill the last week of the month for the next month's "spend-down". If you do not pay the "spend-down" amount within 30 days after the date due, Senior Whole Health of New York may have to initiate the disenrollment process.

If you have any questions regarding the Medicaid "spend-down", please contact your LDSS at:

Albany County	(518)-447-7492	Rensselaer County	(518)-270-3928
Columbia County	(518)-828-9411	Saratoga County	(518)-884-4148
Dutchess County	(845)-486-3340	Schenectady County	(518)-388-4445
Greene County	(518)-719-3700	Ulster County	(845)-334-5000
Montgomery County	(518)-853-4646	Warren County	(518)-761-6321
Orange County	(845)-291-4000	Washington County	(518)-746-2300

SERVICES COVERED BY MEDICAID ADVANTAGE PLUS PROGRAM

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the Senior Whole Health of New York Medicare Evidence of Coverage. Sections 2 and 3 of Senior Whole Health of New York Medicare Evidence of Coverage explain the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Section 4 of Senior Whole Health of New York Medicare Evidence of Coverage under the column "What you must pay when you get these covered 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 these deductibles and co-payments except for those that apply to chiropractic care unless you are Qualified Medicare Beneficiary (QMB), and pharmacy items. If there is a monthly premium for benefits (see Section 8 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 many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

Care Management Services

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

- Call you and visit with you and your family or other individuals who may be assisting.
- Call you on a regular basis to assure that you are satisfied with the care and services you are receiving.
- Work with your primary care physician to obtain the medical orders needed for covered services in your Plan of Care.
- Authorize covered services for you based on medical necessity.
- Talk to your primary care physician about changes or updates to your Plan of Care.
- Arrange and coordinate services that are covered by Senior Whole Health of New York Medicaid Advantage Plus.
- Help arrange for services that you need but which are not covered by Senior Whole Health of New York Medicaid Advantage Plus or are not available within Senior Whole Health of New York Medicaid Advantage Plus existing network.

- Be available to you, or provide coverage by another Care Manager, 24 hours a day to assist you with urgent care or other issues.

Additional Covered Services

Because you have Medicaid and qualify for the Senior Whole Health of New York Medicaid Advantage Plus program, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in Senior Whole Health of New York network.

If you cannot find a provider in our plan, please contact Member Services. If you need medical care that Medicaid requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In this case, please contact our plan for prior approval before seeking care. In this situation, we will cover these services as if you got the care from a network provider.

Benefit	Description of Covered Services	Senior Whole Health of New York <i>Medicaid Advantage Plus</i>
Adult Day Health Care	Adult Day Health Care means care and services provided to a registrant in a residential health care facility or approved extension site under the medical direction of a physician and which is provided by personnel of the adult day health care program in accordance with a comprehensive assessment of care needs and an individualized health care plan, and providing ongoing implementation and coordination of the health care plan, and transportation.	\$0 co-pay. Benefits based on Medical necessity. Authorization required. Contact Senior Whole Health of New York for assistance.
Dental Services	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	\$0 co-pay. Ambulatory or inpatient surgical dental services subject to prior authorization. You may see any dentist in the

Benefit	Description of Covered Services	Senior Whole Health of New York <i>Medicaid Advantage Plus</i>
	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.	<p>provider's network. If you need to find a dentist or change your dentist, please call Senior Whole Health Member Services.</p> <p>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.</p>
Durable Medical Equipment	Medicaid covered durable medical equipment, including devices and equipment other than medical/surgical supplies, tub stools and grab bars, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use.	<p>\$0 co-pay.</p> <p>Authorization required for some equipment, including prosthetics and orthotics. Contact Senior Whole Health of New York for assistance.</p>
Hearing Services	Hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, 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	<p>\$0 co-pay.</p> <p>Benefits based on medical necessity.</p> <p>Authorization required. Contact Senior Whole Health of New York for assistance.</p>

Benefit	Description of Covered Services	Senior Whole Health of New York <i>Medicaid Advantage Plus</i>
	molds, special fittings and replacement parts.	
Home Care Services (skilled)	Medicaid covered home health services include the provision of skilled services not covered by Medicare (e.g. physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and /or home health aide services as required by an approved plan of care developed by a certified home health agency.	<p>\$0 co-pay for skilled home health services (e.g. home health aide services with nursing supervision) when ordered by a participating provider.</p> <p>Benefits based on medical necessity.</p> <p>Authorization required. Contact Senior Whole Health of New York for assistance.</p>
Home Delivered and Congregate Meals	Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or have them prepared.	<p>\$0 co-pay.</p> <p>Benefit based on medical necessity.</p> <p>Authorization required. Contact Senior Whole Health of New York for assistance.</p>
Inpatient Hospital Care, including Mental Health and Substance Abuse Care	Medically necessary care, including days in excess of the Medicare 190-day lifetime maximum for inpatient mental health.	<p>\$0 co-pay.</p> <p>Plan covers 365 days a year, 366 days in a leap year.</p> <p>Except in an emergency, authorization required.</p> <p>Contact Senior Whole Health of New York for assistance.</p>
Medical Social Services	Assessment, arranging and providing aid for social problems related to maintaining individual at home.	<p>\$0 co-pay.</p> <p>Benefit based on medical necessity.</p> <p>Authorization required. Contact Senior Whole Health of New York for assistance.</p>

Benefit	Description of Covered Services	Senior Whole Health of New York <i>Medicaid Advantage Plus</i>
Medical Transportation (routine/non-emergent)	Transportation services means transportation by ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the Enrollee's medical condition; and a transportation attendant to accompany the Enrollee, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the Enrollee's family.	\$0 co-pay for one-way / roundtrip transportation to and from medical appointments. Authorization required. Contact Senior Whole Health of New York for assistance.
Nutrition	Assessment of nutritional status/needs, development and evaluation of treatment plans, nutrition education and counseling, in-service education. Includes cultural considerations.	\$0 co-pay for assessment of nutritional status/needs, development and evaluation of treatment plans. Benefit based on medical necessity. Authorization required. Contact Senior Whole Health of New York for assistance.
Outpatient Mental Health Treatment	Individual and group therapy visits. Enrollee can self-refer for one assessment from a network provider in a twelve (12) month period.	\$0 co-pay. Authorization required for some services. Contact Senior Whole Health of New York for assistance.
Outpatient Substance Abuse Treatment	Individual and group visits. Enrollee must be able to self-refer for one assessment from a network provider in a twelve (12) month period.	\$0 co-pay. Authorization required for some services. Contact Senior Whole Health of New York for assistance.

Benefit	Description of Covered Services	Senior Whole Health of New York <i>Medicaid Advantage Plus</i>
Personal Care Services	Personal care services (PCS) are the provision of some or total assistance with such activities as personal hygiene, dressing and feeding; and nutritional and environmental support function tasks (meal preparation and housekeeping). Such services must be essential to the maintenance of the Enrollee's health and safety in own home.	<p>\$0 co-pay.</p> <p>Benefits based on medical necessity.</p> <p>Authorization required. Contact Senior Whole Health of New York for assistance.</p>
Personal Emergency Response Services (PERS)	Personal Emergency Response Services (PERS) is an electronic device that enables individuals to secure help in a physical, emotional or environmental emergency.	<p>\$0 co-pay.</p> <p>Benefit based on medical necessity.</p> <p>Authorization required. Contact Senior Whole Health of New York for assistance.</p>
Private Duty Nursing Services	Private duty nursing services provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse. Private duty nursing services can be provided through an approved certified home health agency, a licensed home care agency, or a private Practitioner.	<p>\$0 co-pay for medically necessary private duty nursing services when ordered by a participating provider.</p> <p>Benefit based on medical necessity.</p> <p>Authorization required. Contact Senior Whole Health of New York for assistance.</p>
Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language)	Covered services include: physical therapy, occupational therapy, speech language therapy, cardiac rehabilitative therapy, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.	<p>\$0 co-pay.</p> <p>There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits.</p>

Benefit	Description of Covered Services	Senior Whole Health of New York <i>Medicaid Advantage Plus</i>
Therapy, Respiratory Therapy Services, Social/Psychological Services, and more)		Authorization required. Contact Senior Whole Health of New York for assistance.
Skilled Nursing Facility (SNF)	Care provided in a SNF in excess of the Medicare 100 day limit per benefit period and custodial care.	<p>\$0 co-pay for care you receive in a SNF in excess of the 100 day limit per benefit period.</p> <p>Plan covers 365 days a year, 366 days in a leap year.</p> <p>Authorization required. Contact Senior Whole Health of New York (HMO SNP) for assistance.</p>
Social Day Care	Structured comprehensive program providing socialization; supervision, monitoring; personal care, nutrition in a protective setting during any part of the day; may include assistance with ADLs, case management, transportation.	<p>\$0 co-pay.</p> <p>Benefit based on medical necessity.</p> <p>Authorization required. Contact Senior Whole Health of New York (HMO SNP) for assistance.</p>
Social and Environmental Supports	Services and items to support member's medical need. May include home maintenance tasks, homemaker/chore services, housing improvement, and respite care.	<p>\$0 co-pay.</p> <p>Benefit based on medical necessity.</p> <p>Authorization required. Contact Senior Whole Health of New York for assistance.</p>

Limitations

- Outpatient Physical, Occupational and Speech therapies is limited to 20 Medicaid visits per therapy per year except if you have been determined developmentally disabled by the Office for People With Developmental Disabilities or if you have a traumatic brain injury.

- Enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
- Orthopedic footwear and inserts coverage is limited to individuals when used as an integral part of a lower limb orthotic appliance or as part of a diabetic treatment plan.
- Compression and support stockings are is limited to treatment of venous stasis ulcers or pregnancy.
- Nursing Home Care is covered for individuals who are considered a permanent placement provided you are eligible for institutional Medicaid coverage.

Getting Care Outside the Service Area

If you plan to be away from home or outside the service area, please notify your Care Manager as early as possible so that she/he can help arrange any appropriate services that you may need in the area you will be visiting. Senior Whole Health of New York will work with you to plan for your needs and will continue to provide non-emergency covered services to the extent that they can be arranged with the area providers. You can use your Medicare or Medicaid card or any other health insurance card to access non-covered services in the service area and outside of the service area if the health care provider accepts Medicare or New York State Medicaid.

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

Emergency Service

An **emergency** is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity including severe pain that a prudent lay-person possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of the person or others in serious jeopardy.
- Serious impairment to such person's bodily functions.
- Serious dysfunction of any bodily organ or part of such person.
- Serious disfigurement of such person.

- Emergency services are services needed to evaluate or stabilize an emergency medical condition, and are not subject to prior authorization by Senior Whole Health of New York Medicaid Advantage Plus.

If you have an emergency:

- **Call 911, or**
- **Go to the nearest emergency facility, and show them your Senior Whole Health of New York Medicaid Advantage Plus ID** and any other health insurance card.

You or someone on your behalf should notify Senior Whole Health of New York and your physician as soon as possible afterwards so that we and/or your physician can provide or help you obtain any services you may need after your condition is stabilized.

An **urgent** medical or behavioral condition happens unexpectedly and usually care or services are needed within 24 to 48 hours. If you are outside the service area and become ill and it is urgent but **not an emergency**, please telephone Senior Whole Health of New York for guidance or seek the care you need and notify Senior Whole Health of New York as soon as possible afterwards. This will enable your Care Manager to change your Plan of Care if necessary, arrange follow-up care if needed, and coordinate services for you.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that Senior Whole Health of New York does not cover. 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 Medicare Part D as described in section 6 of the Senior Whole Health of New York Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Medicare.

Certain Mental Health Services, including:

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

- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Mental Retardation and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services

- Methadone Treatment
- Comprehensive Medicaid Case Management
- Directly Observed Therapy for TB (Tuberculosis)
- Adult Day Treatment for Persons with HIV/AIDS
- HIV COBRA Case Management

FAMILY PLANNING

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 SENIOR WHOLE HEALTH OF NEW YORK MEDICAID ADVANTAGE PROGRAM

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.

Service Authorizations 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

Some covered services require **prior authorization** (approval in advance) from Senior Whole Health of New York before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Adult Day Health Care
- Non-routine Dental Services
- Durable Medical Equipment
- Hearing Aids
- Home Delivered Meals (Meals on Wheels and Congregate Meal Programs)
- Home Health Care
- Inpatient Mental Health Care (over the 190 day Lifetime Medicare Limit)
- Inpatient Substance Abuse Care
- Medical Social Services
- Non-Emergency and Routine Transportation for health-related appointments
- Nursing Home Care Not Covered by Medicare (see Skilled Nursing Facilities)
- Nutrition Services
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care
- Oxygen and Respiratory Therapy
- Personal Care Services (assistance with bathing, eating and dressing)
- Personal Emergency Response Systems (PERS)
- Private Duty Nursing Services
- Prosthetics and Orthotics
- Rehabilitation Services including Occupational, Physical and Speech Therapies
- Social and Environmental Supports(chore services, home modifications or respite services)
- Social Day Care
- Vision Care

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

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 South Pearl Street, Albany NY 12202.

Services will be authorized in a certain amount and for a specific period of time. This is called an **authorization period**.

You will also need to get prior authorization if you are getting one of these services now, but need to get more of the care during an authorization period. This includes a request for Medicaid covered home health care services 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 acceptable medical 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, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

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

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.

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.
- 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.

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

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

If you are not satisfied with our answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

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 writing.

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

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 within an authorization period, 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.**

Action Appeals

When Senior Whole Health of New York denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal.

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

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 45 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. You can call Member Services 1-866-211-1777 if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you file an appeal.
- The appeal can be made by phone or 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 should sign and return the form to us. You can make any needed changes before sending the form back to us.

Your provider can ask for reconsideration:

If we made a decision about your service authorization request without talking 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.

What happens after we get your appeal?

- Within 15 days, we will send you a letter to let you know we are working on your appeal. We will let you know if we need additional information to make our decision.
- 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 still not satisfied, any further appeal rights you have will be explained or you or someone you trust can file a complaint with the New York State Department of Health at 1-866-712-7197.

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

- If you or your doctor asks to have your 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 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.
- Fast track appeals can be made by phone and do not have to be followed up in writing.

Timeframes for Action Appeals

- Standard appeals: If we have all the information we need, we will tell you our decision in 30 days from your appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.

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

If we do not have the information we need to make either a standard or fast track decision about your action appeal within the above timeframes we will:

- Write to tell you that we need more time to collect the information. 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.
- Take no more than 14 additional days to make a decision.

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 writing.

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

If your original denial was because we said the service was not medically necessary or was experimental or investigational, and we do not tell you our decision about your appeal, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care

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

- 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 appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

If we deny your appeal and you are not satisfied, you can appeal further using the process Fair Hearing process or External Appeals described below.

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 Plus 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 services listed above 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. 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.

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

- By phone 1-800-342-3334 (toll free)
- 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
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

NOTE: 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.

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.

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, 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. You do not have to pay for an external appeal.

Before you appeal to the state:

- You must file an action appeal with the plan and get the plan's final adverse determination; **or**
- If you have not gotten the service, and you ask for a fast track action appeal with the plan, you may ask for an expedited external appeal at the same time. Your doctor will have to say an expedited external appeal is necessary **or**
- You and the plan may agree to skip the plan's appeals process and go directly to external appeal; **or**
- You can prove the plan did follow the rules correctly when reviewing your action appeal.

You have 4 months 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 4 months 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 Financial Services within 4 months 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 Department of Financial Services. 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.

Here are some ways to get an application:

- Call the State Department of Financial Services, 1-800-400-8882
- Go to the State Insurance Department's website at www.dfs.ny.gov/
- 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.

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

As a Dually-Eligible member of our plan, 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 Sections 10 and 11 of Senior Whole Health of New York's Medicare Evidence of Coverage.
- For complaints and appeals about a service that is covered only by Medicaid (e.g. personal care services, private duty nursing, non-emergency transportation, dental services, etc.), you will follow the Medicaid rules listed below.
- For complaints and appeals about all other services covered by Senior Whole Health of New York's 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 denial of coverage 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 COMPLAINTS AND APPEALS

Complaints

We hope our plan serves you well. If you have a problem with the care or treatment you receive from our staff or providers or you do not like the quality of care or services you receive from us, 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 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 through Friday 8 A.M. to 8 P.M. 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 South Pearl Street, 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 it 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 day 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 business 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.

We will 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. 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.

DISENROLLMENT FROM SENIOR WHOLE HEALTH OF NEW YORK MEDICAID ADVANTAGE PLUS PROGRAM

Senior Whole Health of New York will not pursue disenrollment based on a member's health status, and need for or cost of covered services.

You Can Choose to Disenroll

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

To request disenrollment, call or write to Senior Whole Health of New York 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.

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

- No longer are in Senior Whole Health of New York for your Medicare coverage;
- Need nursing home care, but are not eligible for institutional Medicaid;
- Are out of the plan's service area for more than 90 consecutive days;
- Permanently move out of the Senior Whole Health of New York service area;
- No longer require a nursing home level of care; or
- Join a Long-Term Home Health Care Program, 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 will ask that you leave Senior Whole Health of New York if:

- You or family member or caregiver behaves in a way that prevents the plan from providing the care you need;
- You knowingly provide false information or behave in a deceptive or fraudulent way;
- You fail to complete or submit any consent form or other document that is needed to obtain services for you; or
- Fail to pay or make arrangements to pay money owed to the plan (spenddown/surplus/NAMI).

Senior Whole Health of New York will work with you to attempt to resolve these issues. If the issues are not resolved, then Senior Whole Health of New York will notify your Local Department of Social Services of request for disenrollment. The Local Department of Social Services must agree with any involuntary disenrollment, and will send written notification of such to you. Senior Whole Health of New York will continue to provide or arrange for the provision of the covered services to you until the effective date of your disenrollment. Program personnel will assist you with arrangements for future services from another provider. The time frame for the effectiveness involuntary disenrollment is the same as for voluntary disenrollment.

Re-Enrollment Provisions

If you voluntarily disenroll, you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled and want to re-enroll, please contact Member Services. Senior Whole Health of New York will review your request on a case-by-case basis. If you are eligible for re-enrollment, you will have to complete a new application.

RIGHTS AND RESPONSIBILITIES: What Are My Rights and Responsibilities?

As a member of Senior Whole Health of New York you have the following rights:

- **You have the Right** to receive medically necessary care;
- **You have the Right** to timely access to care and services;
- **You have the Right** to privacy about your medical record and when you get treatment;
- **You have the Right** to get information on available treatment options and alternatives presented in a manner and language you understand;
- **You have the Right** to get information in a language you understand; you can get oral translation services free of charge;
- **You have the Right** to get information necessary to give informed consent before the start of treatment;
- **You have the Right** to be treated with respect and dignity;
- **You have the Right** to get a copy of your medical records and ask that the records be amended and corrected;
- **You have the Right** to take part in decisions about your health care, including the right to refuse treatment;
- **You have the Right** to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- **You have the Right** to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- **You have the Right** to be told where, when and how to get the services you need from Senior Whole Health of New York, including how you can get benefits from out-of-network providers;
- **You have the Right** to complain to the New York State Department of Health or your Local Department of Social Services; and, the right to use the New York State Fair Hearing System; and the right to use the New York State External Appeals Program;

- **You have the Right** to appoint someone to speak for you about your care and treatment;
- **You have the Right** to make advance directives and plans about your care (you will receive written information on advance directives including a description of the applicable State Law);
- **You have the Right** to receive assistance in completing a Health Care Proxy form and to ensure your Advanced Directives may be carried out;
- **You have the Right** to begin disenrollment from Senior Whole Health of New York at any time;
- **You have the Right** to assist in the development and evaluation of new and existing programs and policies for Senior Whole Health of New York; **and**
- **You have the Right** to choose your Primary Care Physician.

As a member of Senior Whole Health of New York you have the following responsibilities:

- Accept services without regard to the race, color religion, age, sex, national origin or disability of the caregiver;
- Obtain prior authorization for services and treatments provided by Senior Whole Health of New York from your Physician and Interdisciplinary Care Team (emergency services do not require prior approval);
- When applicable, make payment to Senior Whole Health of New York of any “spend-down” amount identified by the Local Department of Social Services;
- Keep appointments or notify the program if an appointment cannot be kept;
- Supply accurate and complete information to caregivers;
- Participate in the development and updating of your care plan;
- Request further information from your Interdisciplinary Care Team regarding anything you do not understand;
- Assist in developing and maintaining a safe environment;

- Comply with all requirements of Senior Whole Health of New York as noted in the Member Handbook;
- Obtain services within the Senior Whole Health of New York Network Provider List when necessary; **and**
- Participate in questionnaires and/or surveys and focus groups to enhance our quality of service regarding this program.

Advanced Directives

There may come a time when you can't decide about your own healthcare. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your Primary Care Provider (PCP), your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you get these documents. They do not change your right to quality healthcare benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Healthcare Proxy - With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so he or she knows what you want.

Cardiopulmonary Resuscitation and Do Not Resuscitate - 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 do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a Do Not Resuscitate (DNR) order for your medical records. 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. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

Information Upon Request

You Will Be Provided With The Following Information Upon Your Request:

- List of the Names, Business Addresses and Official positions of the membership of the Board of Directors, Officers, Controlling persons, Owners or partners of Senior Whole Health of New York.
- The most recent annual certified financial statement of Senior Whole Health of New York.
- Information relating to Consumer Complaints in regard to Senior Whole Health of New York.
- Written description of the organizational arrangements for Senior Whole Health of New York.
- Description of Senior Whole Health of New York procedures with regard to protecting the confidentiality of medical records and other member information and ongoing process of the quality assurance program.
- Health Practitioners' affiliations with hospitals.
- Description of criteria utilized when making decisions regarding approval or denial of services.
- Application procedures & minimum qualification requirements for health care providers to participate in Senior Whole Health of New York.
- A copy of your Senior Whole Health of New York program record (written request to the Director).

**We would like to welcome you to Senior Whole Health of New York
and assure you that your health is important to us.**