Senior Whole Health of New York
Managed Long Term Care (MLTC) Plan


“The difference is in the care.”
Welcome to Senior Whole Health of New York

Thank you for choosing Senior Whole Health of New York (SWH) as your Medicaid Managed Long Term Care (MLTC) plan. Our community based MLTC program helps you to continue living in your home and community for as long as possible.

Each of our members is assigned a Care manager, a registered nurse or social worker, who will assist you in accessing and coordinating the services you need.

We urge you to carefully review this Member Handbook. If you have questions, please call Member Services at 1-877-353-0185 (TTY 711) or write to us at:

Member Services
Senior Whole Health of New York
PO Box 1624
New York, NY 10008-1624

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

Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m.
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What makes Senior Whole Health of New York Special?

Interdisciplinary Care Team
Your Interdisciplinary Care Team identifies and coordinates your care through a comprehensive, integrated and individualized planning process. This team includes you, your family members and caregivers along with your doctors, Care Manager (CM), nurse assessor and Member Support Representative (MSR).

Care Managers
As a member of SWH, you get a Care Manager, a registered nurse or social worker, who will work with you, your primary care provider (PCP) and other providers, and your Interdisciplinary Care Team to help coordinate and deliver your care and services. He or she will arrange discussions with you and your family to assess your health and social needs on an ongoing basis. This ensures you’re getting the right care at the right time in the right place. Care Management helps you access the covered services identified in your Person Centered Service Plan (PCSP), as well as medical, social, educational, financial and other services that support the PCSP.

Your Care Manager or nurse assessor will meet with you at least every six months to review your current health condition, confirm continued eligibility for the plan and review service needs.

Flexible Care Plans
We provide flexibility in developing a plan of care that meets your individual needs. Our benefits include a wide array of long-term care services that help you maintain your independence for as long as possible. Your Care Manager will work with your doctor to help you and your family determine appropriate medical and social services.

Network providers
When you become a SWH member, you agree to use our network providers. These include Home Care Agencies, dentists, podiatrists, optometrists, audiologists and more. Our website, www.seniorwholehealth.com, has a list providers you can choose from and tells you information like the provider name, address, phone number and languages spoken as well as whether he or she is accepting new patients. Our provider search tool allows you to search for a provider by name, type or location. You may also request a printed directory by calling Member Services.

Free services for non-English speaking members
We can communicate with you in your native language. We have employees who speak many languages, including English, Spanish, Cantonese, Mandarin, Russian and Korean. We also provide translation services at no cost to you. You can request alternate languages and formats by calling Member Services.
Services for members with hearing or vision impairments

We offer large print and TTY services as well as other services to help members with hearing or vision impairments. Call 711 for TTY services or Member Services for alternative formats.

Member participation

Membership is completely voluntary, and we want to keep you healthy and happy. So we value your opinion and ask for input on things like the services we offer, the care you receive and more. We do this with a focus on improvement. If we ask you to complete a survey or take part in a focus group, please participate. SWH is your plan; let your voice be heard.
Eligibility and enrollment

Enrollment in Senior Whole Health of New York is voluntary. To be eligible, you must, at the time of enrollment, be:

1. At least 21 years of age
2. A resident of Bronx, Queens, Kings, New York or Westchester County
3. Eligible for Medicaid as determined by the LDSS or entity designated by the Department
4. Eligible for MLTC, as determined by MLTCP or entity designated by the Department of Health, using an eligibility assessment tool designated by the Department
5. Capable of returning or remaining in your home or community without jeopardy to your health and safety
6. Assessed as requiring at least one of the following community-based long-term care services, including care management, for more than 120 days from the effective date of enrollment:
   a. Nursing services in the home
   b. Therapies in the home
   c. Health aide services in the home
   d. Personal care services in the home
   e. Adult day health care
   f. Private duty nursing
   g. Consumer-directed personal assistance services (CDPAS)

Note: Social Day Care used as a substitute for in home Personal Care Services is no longer considered a CBLTCS for purposes of determining plan eligibility. Social Day Care is still a covered benefit.

7. Determined by the New York City Human Resource Administration Medicaid office (HRA) or Westchester County Social Services (LDSS) to be eligible for benefits under the Medicaid program.

To enroll, you must also sign and return the following documents:

- An Enrollment Agreement, which includes a release of information to SWH
- The Acknowledgement and Consent regarding Notice of Privacy Practices (HIPAA) form that allows SWH to release medical information.

If you are an inpatient or resident of a hospital or residential facility operated 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 Disabilities (OPWDD) and are otherwise eligible to join SWH, we will accept your application. However, enrollment will not begin until you are discharged to your home.
During the enrollment process, if we find that you are not eligible, we will call and write you to tell you our decision.

If you were previously involuntarily disenrolled and want to return to SWH, we will be happy to review your case for reenrollment.
## Covered services

SWH MLTC plan offers the benefits and services described in the chart below.

<table>
<thead>
<tr>
<th>Benefits/Services</th>
<th>Explanation</th>
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<tbody>
<tr>
<td><strong>Care Management</strong></td>
<td>All plan members get a Care Manager (CM) who is part of your Interdisciplinary Care Team. He or she is a registered nurse or social worker who will work with you, your family and caregivers, your doctors and other providers to manage the care and services you receive. Your CM will coordinate the care and delivery of services including medical care and social, educational and financial services.</td>
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| **Nursing Home Care** | Benefits include:  
  - Short-term rehabilitative stays, typically after a hospitalization  
  - Long-term stays for ongoing care when staying in your home is no longer safe  
**Physician’s orders required.**  
**Prior authorization required.** |
| **Home Health Care**  | Health care in your home including:  
  - Nursing services:  
    - Aide supervision  
    - Assessments, teaching and treatment  
  - Services from a Home Health Aide  
  - Physical therapy  
  - Occupational Therapy  
  - Speech Pathology  
  - Medical social services  
**Physician’s orders required.**  
**Prior authorization required.** |
| **Personal Care**     | An Aide to assist you with activities of daily living (ADL), such as dressing, feeding, bathing or walking.  
**Physician’s order required.**  
**Prior authorization required.** |
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| **Adult Day Health Care**               | Care and services provided in a residential health care facility or approved extension site. For members with functional impairment who require preventive, diagnostic, therapeutic, rehabilitative or palliative care and services. Services include:  
  • Medical  
  • Nursing  
  • Food and nutrition  
  • Social services  
  • Rehabilitation therapy  
  • Leisure time activities (a planned program of diverse meaningful activities)  
  • Dental  
  • Pharmaceutical  
  • And other services  
  **Physician’s order required.**  
  **Prior authorization required.**                                                                                                                   |
| **Institutional Long-Term Services and Supports (LTSS)** | Includes residential Health Care Facility (nursing home) services when medically necessary.  
  **Prior authorization required.**                                                                                                                   |
| **Long-Term Placement (Permanent Placement)** | Placement in a Residential Health Care Facility (RHHCF) when a member is not expected to return home. Placement is based on medical evidence provided by a state-designated entity.  
  **Prior authorization required.**                                                                                                                   |
| **Social Day Care**                     | Socialization, supervision and monitoring, and nutrition in a protective setting for members with functional impairments. Covered for part-day services less than 24-hours. Additional services include personal care maintenance and enhancement of daily living skills, transportation and caregiver assistance.  
  **Prior authorization required.**                                                                                                                   |
| **Non-Emergency Transportation**       | Includes transportation to and from medical appointments. If you’re able to use public transportation and not currently a member of the New York City Transit Metro Card Program, your Member Service Representative will help you get this discount card. If you’re unable to use public transportation, SWH will supply car or ambulatory services.  
  To arrange transportation, contact SWH at least 24 hours before your appointment.                                                              |
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<tr>
<td><strong>Vision Services</strong></td>
<td>Vision services include:</td>
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<tr>
<td></td>
<td>• Annual preventive eye exams</td>
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<tr>
<td></td>
<td>• Medically necessary eye exams</td>
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<tr>
<td></td>
<td>• Eyeglasses provided by network optometrists (must be medically necessary)</td>
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<tr>
<td></td>
<td>̶ Limited to one pair of glasses every 2 years unless your prescription changes</td>
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<tr>
<td></td>
<td>̶ For members who require both distance and reading correction, one pair of each every 2 years</td>
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<tr>
<td><strong>Hearing Services</strong></td>
<td>Benefit includes:</td>
</tr>
<tr>
<td></td>
<td>• Hearing exams performed by a registered audiologist</td>
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<td></td>
<td>• Hearing aids including fitting when medically necessary</td>
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<tr>
<td></td>
<td>• Hearing aid batteries</td>
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<td></td>
<td>• Replacement if lost or damaged</td>
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<td></td>
<td>• New hearing aids with prescription changes</td>
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<td><strong>Podiatry Services</strong></td>
<td>Foot care including initial examination, nail trimming and callous removal when medically necessary.</td>
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<td></td>
<td><strong>Prior authorization required.</strong></td>
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<tr>
<td><strong>Dental Care</strong></td>
<td>When provided by a network dentist, services include:</td>
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<tr>
<td></td>
<td>• Annual oral examination and cleanings</td>
</tr>
<tr>
<td></td>
<td>• Medically needed dentures, fitting and alignment (one full set every 4 years)</td>
</tr>
<tr>
<td></td>
<td>• Dental implants, when medically necessary</td>
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<td></td>
<td><strong>Prior authorization required for dental implants.</strong> Request must be accompanied by a physician’s letter explaining how the implants will help with your medical problem and a dentist’s letter explaining why other alternatives will not correct your condition and why you require implants.</td>
</tr>
<tr>
<td>**Home Delivered Meals/</td>
<td>Congregate meals provided at local senior centers or meals delivered to your home when you are unable to prepare your own.</td>
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<tr>
<td>Congregate Meals**</td>
<td><strong>Prior authorization required.</strong></td>
</tr>
<tr>
<td>Benefits/Services</td>
<td>Explanation</td>
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| **Physical & Occupational Therapy and Speech Pathology** | These services are provided to help you achieve your best physical and psychosocial functional levels. Covered when provided by a licensed therapist in a setting other than your home.  
Limited to 40 visits for physical therapy per calendar year and 20 visits for occupational and speech therapy per calendar year.  
**Physician’s order required.**  
**Prior authorization required.**                                                                 |
| **Private Duty Nursing Services**                     | Nursing services provided in your permanent or temporary resident by licensed registered professionals, RNs or LPNs when medically needed. Services may be continuous or extend beyond care available from a certified home health care agency (CHHA).  
**Physician’s order required.**  
**Prior authorization required.**                                                                         |
| **Respiratory Therapy**                               | Covered services include but are not limited to the use of nebulizer treatments and oxygen. Must be provided by a licensed therapist.  
**Physician’s order required.**  
**Prior authorization required.**                                                                           |
| **Nutritional Counseling**                            | Includes nutritional counseling and diet planning by a Registered Dietician with special regard for chronic illnesses.  
**Prior authorization required.**                                                                            |
| **Durable Medical Equipment (DME)**                  | Medically necessary equipment such as:  
- Canes  
- Walkers  
- Wheelchairs  
- Commodes  
- Oxygen and respiratory equipment  
**Physician’s order required.**  
**Prior authorization required.**                                                                           |
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| **Medical Surgical Supplies/Parenteral Nutrition & Associated Supplies** | Includes coordination and provision of all necessary supplies, including:  
  - Wound care supplies  
  - Colostomy and diabetic supplies  
  - Parenteral nutrition and supplies  
    - Medicaid coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) individuals who are fed via nasogastric, jejunostomy, or gastrostomy tube; 2) individuals with rare inborn metabolic disorders; and 3) children up to age 21 who require liquid oral enteral nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. 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  
    - Incontinence products  
  Physician’s order required.  
  Prior authorization required.                                                                                                                                                                                                                                                      |
| **Prosthesis and Orthotics**                         | Artificial limbs, braces, shoe inserts or orthopedic shoes.  
  Physician’s order required.  
  Prior authorization required.                                                                                                                                                                                                                                                                                                                                                                               |
| **Social and Environmental Supports**                | Benefit includes environment supports necessary to insure your health and safety. This includes:  
  - Household modifications or additions:  
    - Construction of wheelchair ramps  
    - Widening of doorframes to accommodate wheelchairs  
  - Installation of shower seats or handrails  
  Prior authorization required.                                                                                                                                                                                                                                                                                                                                                                               |
| **Personal Emergency Response Services (PERS)**      | Electronic personal devices activated in an emergency or injury. Available to all members.  
  Prior authorization required.                                                                                                                                                                                                                                                                                                                                                                               |
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<tr>
<td><strong>Medical Social Services</strong></td>
<td>Aid for social problems related to the ability to stay in your own home. Benefit includes need assessment and provision of service by a qualified social worker. Must be included in the Plan of Care. Must be provided by a qualified social worker.</td>
</tr>
<tr>
<td><strong>Consumer Directed Personal Assistance Services (CDPAS)</strong></td>
<td>Personal care services, home-health aide services and skilled nursing services provided in home and supervised by you or your designated representative. Contact your care manager for more information.</td>
</tr>
<tr>
<td><strong>Telehealth Services</strong></td>
<td>Covered health care benefits delivered using electronic information and communication technologies by telehealth providers. Telehealth services include assessment, diagnosis, consultation, treatment, education, care management and/or self-management.</td>
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Medically necessary (or needed) services are needed to prevent, diagnosis, correct or cure conditions that cause acute suffering, endanger life, result in illness or injury, interfere with the capacity for normal activity or threaten a significant handicap. Medical necessity is determined by the health care team in conjunction with the plan Medical Directory.

Medicare may cover these services based on certain criteria. If you have Medicare, your Medicare plan will be billed first. If you have additional insurance (other than Medicare or Medicaid) that covers the above services, the other insurance will be billed before Medicare. Always show your Medicaid, Medicare and Senior Whole Health of New York cards when getting care or services.

When you get any of the services above that are reimbursable by Medicare, you can choose your provider. However, we encourage you to use our network providers. When Medicare stops paying for services, you must switch to a SWH network provider. If you have questions above these services, please call Member Services.

**Services not covered by Senior Whole Health of New York**

The following services are not covered by SWH:

- Inpatient or outpatient hospital care: Care you may get while hospitalized or in a hospital clinic.
- Physician services: Care provided by a medical doctor, physician assistant or nurse practitioner.
- Laboratory and diagnostic tests: Tests such as blood and urine tests and electrocardiograms.
- Radiology and Radio Isotope x-rays: X-rays, bone scans, cat scans and MRIs.
- Hospice: Hospice home visits and inpatient hospice care.
- Hospital emergency room care.
- Renal dialysis: Includes hemodialysis or peritoneal dialysis.
• Mental health services: Includes inpatient and outpatient treatment for mental health problems, including but not limited to depression and schizophrenia.
• Alcohol and substance abuse treatment: Care received for the treatment of alcohol or drug use, including hospitalization or outpatient treatment.
• Services through the Office for People with Developmental Disabilities: Services like day programs and vocational training.
• Emergency transportation
• Family planning services
• Prescription and non-prescription drugs

While SWH does not cover these services that are covered directly by Medicaid, we can help you coordinate them. Please let your Care Manager know about any of these services you receive. This will ensure your ICT can continue to help you manage your care.

**Other health insurance**

As a member of SWH, you must have a Medicaid. It’s important that you comply with Medicaid eligibility requirements and annual recertification.

If you have Medicare, your Medicare coverage will not change when you join SWH. You will continue to get all the same Medicare benefits. We can help you access and coordinate Medicare services such as inpatient and outpatient hospital services, physician visits, laboratory services, pharmacy services and renal dialysis services. You do not need approval from SWH to get these services.

It’s important that you carry all your ID cards with you at all times:

• Medicaid card
• Medicare card
• Private insurance card
• SWH card
How to enroll

Enrolling in SWH is a multi-step process that involves you, your family and/or caregiver, your physician, the New York City Department of Human Resources Administration (HRA) or Westchester County Social Services (LDSS) and Senior Whole Health of New York:

- If you’re interested in joining our MLTC program, you may contact us Monday through Friday from 8 a.m. to 8 p.m.

- An Outreach Representative will contact you to explain the program. He or she will determine whether you meet the basic eligibility requirements. The outreach representative will arrange an appointment for you to meet with a SWH nurse assessor in your home. The Outreach Representative will explain that during the visit, we will ask that you sign a Medical Release form and agree to follow the rules of the program described in this handbook if you decide to enroll.

- The nurse assessor will perform a comprehensive assessment which includes a physical, social and environmental assessment of you and your home. This will include questions regarding your past and current health status. Based on your assessment, the nurse assessor will provide a service plan that outlines the services you’ll receive.

- You must sign the service plan along with an enrollment agreement so that we can process your application. You will also be asked to sign a Medical Release form and agree to follow the rules of the program described in this handbook.

- The nurse assessor will contact your physician to notify him or her of your interest in applying for enrollment and to explain the services provided through SWH.

- When the above steps are complete, we will submit the enrollment packet to NY Medicaid Choice (MAXIMUS) for review and processing.
  - If NY Medicaid Choice receives the completed enrollment packet on or before noon on the 20th of the month, enrollment must take effect no later than the first day of the next month. (For example, if NY Medicaid Choice receives your completed package by January 20, your enrollment takes place on February 1.)
  - If NY Medicaid Choice receives the packet after noon on the 20th day of the month, the enrollment must take effect no later than the first day of the second month. (For example, if NY Medicaid Choice receives your packet on or after January 21, your enrollment would take effect on March 1.)

- We will give you access to a list of all network providers. Your Care Manager will work with you to select a provider.

- The service plan will be used to develop a comprehensive plan of care that will be mailed to you within 30 days of enrollment.
What if I decide not to become a member after the enrollment process has started?

The enrollment process begins with the initial nurse visit. An applicant may withdraw an application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment by indicating his/her wishes orally or in writing. All withdrawals must be acknowledged in writing to the applicant by the contractor.

Conflict free evaluation and enrollment center (CFEEC)

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

When you enroll, you, your physician, your Interdisciplinary Care Team (including a CM) and other health care providers will work together to determine your needs. They will then work together to develop a plan of care that meets those needs. The plan of care is a written description of all the services you need. It’s based on an assessment of your health, your physicians’ recommendations and your personal preferences.

You will receive a copy of your plan of care which includes a list of how often and how long you’ll receive services. To request services or changes to your current plan, please call your Care Manager. We are happy to discuss any request for additional services or changes to existing services with your physician, if necessary. Your physician will order most health care services for you. You can contact your Interdisciplinary Care Team from 8 a.m. to 8 p.m. Monday through Friday.

Veteran’s protections

Senior Whole Health of New York will contract with at least one veteran’s home in our service area as long as one exists.

If you are a veteran, veteran’s spouse or Gold Star parent in need of long-term placement, we’ll notify you about the availability of a veteran’s home in our network. If there is not a veteran’s home in our network, we will refer you to the enrollment broker for help choosing another plan.

If there is no network provider with the expertise to deliver the requested covered services (specialized wheelchair, etc.), we will refer you to an out-of-network provider and assure payment unless the service is covered by Medicare or a third-party payer.

If you wish to receive veteran’s home services, we must allow you to access a veteran’s home services and agree to pay out-of-network until you have transferred to another plan with a network veteran’s home.

Transitional care

If you are a new member and your health care provider is not in our network, you may request to continue ongoing treatment with your current provider. Your current provider must:

- Agree to accept SWH’s rates as payment in full.
- Meet the requirements of the provider application and credentialing process.

The transition period is up to 60 days for members with a life-threatening disease or condition or a degenerative or disabling disease or condition.

If you are a current member and your provider chooses to leave the SWH network, we’ll provide continued coverage with that provider so that you can complete the services you’re receiving for up to 90 days. The provider must agree to the SWH rates as payment in full and adhere to Quality Improvement requirements during the transition period.
Requests for new services not on your plan of care

If you request new services that are not included on your plan of care, we will review your request and tell you our decision by telephone and in writing. We will inform you of our decision within three (3) business days of receiving all the necessary information and no more than 14 calendar days from the date we receive the request. If you or your health care provider believes you need a fast decision, you may request an expedited review. We will notify you no more than 72 hours from the day we received your request.

Requests for additional services included on your plan of care

If you feel you need more of a service that is included on your plan of care, please call your SWH Care Manager. He or she will review your request and notify you of our decision by telephone and writing. We will tell you our decision within as fast as your condition requires and not more than 14 calendar days of receiving the request.

If you or your health care provider believes you need a fast decision, you may request an expedited review. We will notify you no more than 72 hours from the day we received your request.

If you request extra time or if we need more information, we can increase the review time by up to 14 days. However, the delay must be in your best interest.

Following an inpatient hospital visit, you may request home health care services covered by Medicaid. We will review your request and notify you one (1) business day after we receive all the necessary information. If the day following receipt of your request falls on a weekend or holiday, we’ll notify no more than 72 hours after receiving your request.

If you’ve already received the requested services and you’re asking us to reimburse you or your service provider, please call us within 30 days of the date of service. We will review your request and inform you of our decision in writing, within 45 days.

If you disagree with any of the decisions we make on your request, you have the right to request an appeal. To request an appeal, please follow the process described on pages 23-24. If you disagree with any other services on your care plan or have a complaint about accessing your services, you may file a complaint following the process on pages 21-22.

Additional services or equipment order by your physician

If your physician thinks you need additional services or equipment, please contact your CM between 8 a.m. and 8 p.m. Monday through Friday. If you physician thinks the service must being right away and it’s after hours, please call Member Services and ask to speak to the on-call Care Manager.

If you receive services without getting prior approval, we may deny payment. In situation of emergency, you do not need prior approval.
**Getting emergency care**

In an emergency, call 911 or go to the nearest hospital. An emergency is a medical or behavioral condition with a sudden onset and symptoms so severe that a prudent layperson with an average knowledge would expect that, without immediate attention, could result in:

- Serious jeopardy to your health; or in the case of a behavioral condition, serious jeopardy to those around you.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ.
- Serious disfigurement.

You’re entitled to emergency care 24 hours a day, 7 days a week. Emergency services do not require prior authorization.

Whether you are discharged from the ER to your home or a hospital, please contact SWH immediately. For a scheduled hospitalization, please notify us as soon as you know the dates of your admission. This will allow us to cancel scheduled appointments or work with hospital personnel to plan for your release and follow-up care.

**Non-emergency medical care**

If you need same day medical care but it isn’t an emergency, please notify us or call your physician directly. We can help you with arrangement and transportation if you need it.

**Getting care outside the service area**

If you’re travelling outside the service area for 30 consecutive days or less and believe you may need covered services, contact your Interdisciplinary Care Team. If services are medically necessary, we will help you get them. To avoid any problems, let your ICT know you’re leaving the area. They can arrange for needed services.

Again, if you need emergency care, please call 911 or to the nearest emergency room.

If you are outside the service area for more than 30 consecutive days, you will need to disenroll from SWH.
Costs associated with Senior Whole Health of New York

When you enroll in SWH, the Human Resources Administration reviews your financial status for Medicaid eligibility. The HRA may determine that you must spend a portion of your monthly income in order to meet the maximum income eligibility amount for Medicaid, called “spend-down”. HRA will inform you and SWH of the exact spend-down amount you owe SWH each month. We will bill you each month for next month’s payment. If you fail to pay within 30 days after the due date, SWH may initiate disenrollment.

If you have questions regarding the Medicaid spend-down, please contact HRA at:

   Human Resources Administration  
   Medical Assistance Program  
   505 Clermont Ave., 7th Floor  
   New York, NY 11238  
   718-557-1399

If you live in Westchester County, contact your local LDSS at:

   Mount Vernon District Office  
   100 East First Street  
   Mount Vernon, NY 10550-3442  
   914-995-3333  
   Mon.-Fri., 8:30 a.m. - 5 p.m. (except holidays)

   Peekskill District Office  
   750 Washington Street  
   Peekskill, NY 10566-5499  
   914-995-3333  
   Mon.-Fri., 9 a.m. – 5 p.m. (except holidays)

   White Plains District Office  
   85 Court Street  
   White Plains, NY 10601-4201  
   Mon.-Fri., 8:30 a.m. – 5 p.m. (except holidays)

   Yonkers District Office  
   131 Warburton Avenue  
   Yonkers, NY 10701  
   914-995-3333  
   Mon.-Fri., 8:30 a.m. – 5 p.m. (except holidays)

There are no other payments owed to SWH. If you receive a bill from any health care provider for covered services, please inform us so we can investigate.
Money Follows the Person (MFP)/Open Doors

MFP/Open Doors is a program that can help you move from a nursing home setting back into your own home or community residence. You may qualify for MFP if you:

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

MFP/Open Doors’ Transition Specialists and Peers will meet with you in the nursing home and talk with you about moving back into the community. Transitions Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

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

For more information about MFP/Open Doors or to set up a visit from a transition specialist or peer, please call the New York Association of Independent Living at 1-844-545-7108. You may email to mfp@health.ny.gov or visit MFP/Open Doors at www.health.ny.gov/mfp or www.ilny.org.
Complaints and appeals

SWH will try our best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by SWH staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

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

Senior Whole Health of New York
Quality Improvement Department
Church St. Station
New York, NY 10008-1624

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The complaint process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process will be completed within 7 days of receipt of the complaint.

2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

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

**How do I appeal a complaint decision?**

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

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

**What is an action?**

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

**Timing of notice of action**

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

**Contents of the notice of action**

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right
to the State’s external appeal process);

• Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;

• Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;

• Describe the information, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

**How do I file an appeal of an action?**

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our letter notifying you of the action.

**How do I contact my plan to file an appeal?**

We can be reached by calling 1-877-353-0185 or writing to:

*Senior Whole Health of New York*
*Church St. Sta.*
P.O. Box 1624
*New York, NY 10008-1624.*

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan’s initial decision or action that you are appealing.

**For some actions, you may request to continue service during the appeal process**

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while your appeal is being decided. We must continue your service if you make your request no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the
intended effective date of the proposed action, whichever is later.

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

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

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

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

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

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

**Expedited appeal process**

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 72 hours. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

**If the plan denies my appeal, what can I do?**

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing,
who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

**Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.**

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

**State Fair Hearings**

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

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

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

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

- Online Request Form: [http://otda.ny.gov/oah/FHReq.asp](http://otda.ny.gov/oah/FHReq.asp)
- Mail a Printable Request Form to:
  
  NYS Office of Temporary and Disability Assistance Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023
Fax a Printable Request Form: 1-518-473-6735

Request by telephone:
Standard Fair Hearing line: 1-800-342-3334
Emergency Fair Hearing line: 1-800-205-0110
TTY/TDD line: 711 (request that the operator call 1 (877) 502-6155)

Request in person in New York City:
14 Boerum Place, 1st Floor
Brooklyn, NY 11201

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

State External Appeals

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

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

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

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

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

Service authorizations & action requirements

Definitions

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee’s behalf, for
coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such service is provided to the Enrollee.

**Concurrent Review**: review of a request by an Enrollee, or provider on Enrollee’s behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

**Expedited Review**: An Enrollee must receive an expedited review of his or her Service Authorization Request when the plan determines or a provider indicates that a delay would seriously jeopardize the Enrollee’s life, health, or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.

**General Provisions**

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered health care professional when such determination is based on an assessment of the Enrollee’s health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit when coverage is dependent on an assessment of the Enrollee’s health status, and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals, and out-of-network services.

The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance.

The Contractor shall utilize the Department’s model MLTC Initial Adverse Determination and 4687 MLTC Action Taken notices.

**Timeframes for Service Authorization Determination and Notification**

1. For Prior Authorization requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee’s condition requires and no more than:
   a. **Expedited**: Seventy-two (72) hours after receipt of the Service Authorization Request
   b. **Standard**: Fourteen (14) days after receipt of request for Service Authorization Request.

2. For Concurrent Review Requests, the Contractor must make a Service Authorization
Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee’s condition requires and no more than:

a. ** Expedited:** Seventy-two (72) hours of receipt of the Service Authorization Request  
   
b. **Standard:** Fourteen (14) days of receipt of the Service Authorization Request

3. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information.

4. Up to 14 calendar-day extensions: Extension may be requested by Enrollee or provider on Enrollee’s behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee’s interest. In all cases, the extension reason must be well documented.
   
a. The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination, and help the enrollee by listing potential sources of the requested information.

5. Enrollee or provider may appeal decision – see Appeal Procedures.

6. If the plan denied the Enrollee’s request for an expedited review, the plan will handle as standard review.
   
a. The Contractor must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee’s service request will be reviewed in the standard timeframe.

**Other Timeframes for Action Notices**

1. When the Contractor intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:
   
a. The period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or

b. The Contractor may mail notice not later than date of the Action for the following:
   
i. The death of the Enrollee;
   
ii. The Enrollee’s admission to an institution where the Enrollee is ineligible for further services;
iii. The Enrollee’s address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;

iv. The Enrollee has been accepted for Medicaid services by another jurisdiction; or

v. The Enrollee’s physician prescribes a change in the level of medical care.

c. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)-(b).

i. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a non-business day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to complaints, complaint appeals and action appeals

d. The Contractor must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,

e. When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

Contents of Action Notices

1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.

2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:

a. the date the restriction will begin;

b. the effect and scope of the restriction;

c. the reason for the restriction;

d. the recipient's right to an appeal;

e. instructions for requesting an appeal including the right to receive aid continuing if the
request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;

f. the right of Contractor to designate a primary provider for recipient;

g. the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;

h. the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;

i. the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;

j. the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;

k. the name and telephone number of the person to contact to arrange a conference;

l. the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;

m. the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;

n. the right of the recipient to examine his/her case record; and

o. the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This information is generally referred to as “claim detail” or “recipient profile” information.
**Disenrollment**

**Voluntary disenrollment**

Enrollment in SWH is voluntary and you may initiate disenrollment at any time, either verbally or in writing, or by enrolling in another Managed Care Plan.

If your disenrollment is due to a complaint or concern, please let us know. We value your membership and would appreciate the opportunity to address and resolve your dissatisfaction.

In order to continue to receive community-based long-term care services you must choose another MLTC plan or waiver program; or, if you are Medicaid only, join a managed care plan. You cannot receive long-term care services through Medicaid Fee for Service.

If you require continuation of Medicaid-covered service upon your disenrollment, please contact Maximus, the Medicaid enrollment broker to assist with enrollment in another plan.

If you do not require continuation of community-based long-term care services and you notify us of your wish to disenroll by the 10th day of the month, your disenrollment will be effective on the first day of the following month.

You’ll receive written notification of your disenrollment effective date. We will continue to provide or arrange for covered services until the effective date. We will also help with the transfer to new service providers.

**Involuntary disenrollment**

There are certain situations in which you must be disenrolled.

**You must be disenrolled if:**

- You permanently move out of the service area.
- You leave the service area for more than 30 consecutive days.
- You are incarcerated.
- You are hospitalized or receive services from an OMH, OPWDD or OASAS residential program for 45 consecutive days or longer.
- You are admitted to a Skilled Nursing Home and are not eligible for Institutional Medicaid.
- Your Medicaid is terminated.
- You’re not eligible for MLTC because you’ve been assessed as no longer demonstrating a functional or clinical need for community-based long-term care services; or for non-dual eligible members, you no longer meet the nursing home level of care as determined using the assessment tool prescribed by the department; your sole service is identified as Social Day care.
  - We must provide LDSS or the entity designated by the department the results of the assessment and recommendation regarding the disenrollment within five (5) business days of the assessment.
You may be disenrolled if:

- You or others in your home exhibit abusive, disruptive or uncooperative behavior to such a degree as to jeopardize the provision of care.
- You or your family give false information or engage in fraudulent conduct.
- You knowingly fail to complete and submit requested documentation.
- You fail to pay your spend-down/surplus within 30 days.

SWH will work with you to resolve these issues. If issues can’t be resolved, we’ll notify the New York Medicaid Choice (NYMC) or the Local Department of Social Services (LDSS)/Human Resources Administration (HRA) of our request for disenrollment. NYMC or LDSS/HRA must agree with any involuntary disenrollment and will send you written notification. We will continue to provide or arrange for covered services until the disenrollment effective date.

Program personnel will help you arrange for future services from another provider. In order to prevent a lapse in delivery of services, services from your new provider will be effective on the date of disenrollment from SWH. The timeframe for involuntary disenrollment is the same for voluntary disenrollment.
Rights and responsibilities

As a SWH member, you have rights and responsibilities. Your rights include:

- The right to receive medically necessary care.
- The right to timely access to care and services.
- The right to privacy about your medical record and when you get treatment.
- The right to get information in a language you understand, including oral translation services free of charge.
- The right to get information necessary to give informed consent before the start of treatment.
- The right to be treated with respect and dignity.
- The right to get a copy of your medical records and ask that the records be amended and corrected.
- The right to take part in decisions about your care, including the right to refuse treatment.
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- The right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- The right to be told where, when and how to get the services you need from SWH, including how you can get benefits from out-of-network providers.
- 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.
- The right to appoint someone to speak for you about your care and treatment.
- The right to make advance directives and plans for your care; you’ll receive written information on advance directives including a description of applicable state laws.
- The right to receive assistance in completing a Health Care Proxy form and to ensure your advance directive will be carried out.
- The right to begin disenrollment at any time.
- The right to assist in the development and evaluation of new and existing programs and policies for SWH.
- The right to choose your primary care physician.
- The right to seek assistance from the Participant Ombudsman program.
- The right to receive information about SWH and managed long-term care in a manner which doesn’t disclose you as participating in the MLTC plan.
Along with these rights, you have responsibilities. These include the responsibility to:

- Accept services without regard to the race, color, religion, age, sex, national origin or disability of the caregiver.
- Get prior authorization for services and treatments provided by us from your physician and Interdisciplinary Care Team (emergency services do not require prior approval).
- When applicable, make payment for any “spend-down” amount identified by the LDSS/HRA.
- Keep appointments or notify the program if an appointment cannot be kept.
- Supply accurate and complete information to caregivers.
- Participate in developing and updating 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 noted in the Member Handbook.
- Get services from network providers when necessary.
- Participate in questionnaires, surveys and focus groups to enhance our quality of service regarding this program.

Upon request, SWH will provide you with the following information:

- A list of names, business addresses and official positions of members of the Board of Directors, officers, controlling persons, owners or partners of SWH of NY.
- SWH’s most recent annual certified financial statement.
- Information relating to consumer complaints regarding SWH.
- Written description of the organizational arrangement of SWH.
- Descriptions of SWH procedures regarding protecting the confidentiality of medical records and other member information; and the ongoing quality assurance program.
- Health practitioners’ hospital affiliations.
- Descriptions of the criteria utilized when making decisions for approval or denial of services.
- Application procedures and minimum qualification requirements for health care providers who participate in our network.
- A copy of your SWH program record when requested from the Medical Director.

How to contact the Participant Ombudsman

The Participant Ombudsman is an independent organization that provides free ombudsman services to long-term care recipients in the state of New York. These services include, but are not necessarily limited to:
• Providing pre-enrollment support, such as unbiased health plan choice counseling and general program-related information.

• Compiling enrollee complaints and concerns about enrollment, access to services and other related matters.

• Helping enrollees understand the Fair Hearing and complaint and appeal rights and processes within the health plan and at the State level, and assisting them through the process if needed/requested, including making requests of plans and providers for records.

• Informing plans and providers about community-based resources and supports that can be linked with covered plan benefits.

The Participant Ombudsman for the state of New York is the Independent Consumer Advocacy Network (ICAN), an independent network of consumer advocacy organizations. ICAN is available to answer long-term care questions regarding enrollee rights, Medicare, Medicaid and long-term care services. ICAN can also assist enrollees with resolution of any issues related to access to care and with filing appeals and complaints. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.
**Important Information about Advance Directives**

You have a right to make your own health care decisions. Sometimes, as a result of a serious accident or illness, that may not be possible. You can prepare for situations when you are unable to make important health care decisions on your own by filling out and submitting an Advanced Directives Packet. Preparing Advance Directives will help in insuring that your health care wishes are followed. There are many different types of Advance Directives:

- Living will
- Power of Attorney
- Durable Power of Attorney for Health
- Health Care Proxy
- Do Not Resuscitate Orders

It is your choice whether you wish to complete an Advance Directive and which type of Advance Directive is best for you. The law forbids any discrimination against you in medical care based on your advance directive decisions.

For more information regarding Advance Directives, please speak with your Care Manager or your primary care physician. SWH will provide written information about Advance Directives.

Forms are available if you wish to complete an Advance Directive. SWH staff is also available to answer questions you may have concerning Advance Directives.