

Mohawk Valley Health System
Senior Network Health

MEMBER HANDBOOK



TABLE OF CONTENTS

Welcome to Senior Network Health, LLC	1
Managed Long Term Care (MLTC) Plan	
About SNH	
Help From Member Services	2
Interpreter Services	
Services for Hearing-Impaired Members	
Services for Visually Impaired Members	
Eligibility for Enrollment in the MLTC Plan	3
New York Independent Assessor – Initial Assessment Process	4
Learning about SNH	
Enrollment Process	
Enrollment Eligibility Assessment	
Denial of Enrollment	
Care Team	
Plan Member (ID) Card	
Services Covered By The Senior Network Health MLTC Plan	10
Care Management Services	
Care Manager	
Community Benefits/Social Work Department	
Getting Help	
24/7 NurseLine/After-hours Assistance	
Keep Us Informed	
Additional Covered Services	13
Limitations	
Getting Care outside the Service Area	
Emergency Service	
Transitional Care Procedures	17
Money Follows The Person (MFP)/Open Doors	17
Medicaid Services Not Covered by Our Plan	18

TABLE OF CONTENTS CONT'D

Services Not Covered by Senior Network Health or Medicaid	19
Service Authorizations, Actions and Action Appeals	20
Prior Authorization	
Concurrent Review	
Retrospective Review	
What happens after we get your service authorization request?	
What is an action?	
Timing of Notice of Action	
Contents of the Notice of Action	
How do I file an appeal of an action?	
How do I contact my plan to file an appeal?	
How long will it take the plan to decide my appeal of an action?	
Fast Track Appeal Process	
If the plan denies my appeal, what can I do?	
State Fair Hearings	
State External Appeals	
Complaints and Complaint Appeals	29
What is a complaint?	
The Complaint Process	
How do I appeal a complaint decision?	
Participant Ombudsman	
Disenrollment From Senior Network Health MLTC Plan	32
Voluntary Disenrollment	
Transfers	
Involuntary Disenrollment	
Cultural and Linguistic Competency	34
Member Rights and Responsibilities	35
Advance Directives	
Information Available on Request	
Notes	38

Welcome to Senior Network Health, LLC

Managed Long Term Care Plan

Welcome to Senior Network Health, LLC (SNH) Managed Long Term Care (MLTC) plan. The MLTC plan is especially designed for people who have Medicaid and who need health and Community Based Long Term Services and Supports (CBLTSS) like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits SNH covers since you are enrolled in the plan. It also tells you how to request a service, file a complaint, or disenroll from SNH. Please keep this handbook as a reference. It includes important information regarding SNH and the advantages of our plan. You need this handbook to learn what services are covered and how to get these services.

About SNH

Established in 1998, Senior Network Health is an affiliate of the Mohawk Valley Health System (MVHS), a regional system of healthcare organizations and providers who are committed to bringing people and resources together to better plan and deliver accessible, high quality, cost-efficient health care services in the Mohawk Valley.

SNH has a network of area providers selected to assure you the best care possible. When you enroll, you are required to use the providers in our plan and to get authorization from your care manager for services covered by SNH.

Help From Member Services

You can call us at any time, 24 hours a day seven days a week, at the Member Services number below.

There is someone to help you at Member Services: Monday through Friday, from 8 a.m. to 4 p.m.

Oneida County: 315-624-4545

Herkimer County: 315-866-8700

Toll-Free: 888-355-4764

TTY: 1-800-662-1220

If you need help at other times, call us at **315-624-4545**

Interpreter Services

SNH is able to access interpreter services. If such a service is required, please request that the SNH care manager contact an interpreter in the language of your choice, at no charge to you.

Services for Hearing-Impaired Members

Hearing-impaired members who wish to speak with a Member Services representative and who have the capability to send messages through a TTY/TDD should first contact a Verizon relay operator at 1-800-662-1220, who will then facilitate calls between TTY/TDD users and voice customers. If you need a sign language interpreter, we can arrange that service for you, as well.

Services for Visually Impaired Members

SNH has a large print handbook available upon request for those members who are visually impaired. Please contact Member Services to request a copy. Staff is also available to come to your house and read any material to you.

Note: You are not required to call SNH if you are having a medical emergency. Call 911.

Eligibility for Enrollment in the MLTC Plan

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

1. Are age 18 and older,
2. Reside in the plan's service area which is Oneida County or Herkimer County,
3. Have Medicaid,
4. Have Medicaid or are aged 18-20 with both Medicaid and Medicare and are eligible for nursing home level of care,
5. Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, and
6. Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the MLTC Plan for a continuous period of more than 120 days from the date of enrollment:
 - a. Nursing services in the home
 - b. Therapies in the home
 - c. Home health aide services
 - d. Personal care services in the home
 - e. Adult day health care
 - f. Private duty nursing; or
 - g. Consumer Directed Personal Assistance Services (CDPAS)

The coverage explained in this Handbook becomes effective on the date of your enrollment in Senior Network Health MLTC plan. Enrollment in the MLTC plan is voluntary.

New York Independent Assessor – Initial Assessment Process

Effective May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) is now known as the New York Independent Assessor (NYIA). The NYIA will manage the initial assessment process. NYIA will start the expedited initial assessments at a later date.

The initial assessment process includes completing the:

- **Community Health Assessment (CHA):** The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a Managed Long Term Care plan.
- **Clinical appointment and Practitioner Order (PO):** The PO documents your clinical appointment and indicates that you:
 - Have a need for help with daily activities, and
 - That your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIA will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIA will complete a clinical appointment and PO a few days later.

SNH will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIA Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care, and any other medical documentation. If more information is needed, someone on the panel may examine you or discuss your needs with you. The IRP will make a recommendation to SNH about whether the plan of care meets your needs.

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

Learning about SNH

To find out more information about SNH, an enrollment coordinator can speak with you by phone or visit you in person. Within ten (10) business days of learning about your interest in SNH, a coordinator will make contact with you. He or she will review the above enrollment criteria chart to help determine if you are eligible to enroll in SNH, the enrollment process and what to expect from us. If it is decided that SNH is a good fit for you, a coordinator will schedule a home visit with a registered nurse who will administer the enrollment eligibility assessment.

Enrollment Process

To start the SNH enrollment process, our registered nurse/enrollment coordinator will contact you via telephone within five business days of notification by the NYIA that you are eligible for enrollment. Applicants cannot be discriminated against based on their health status, and/or the need for or cost of services.

The enrollment coordinator will arrange the first in-person visit within 30 days of the initial telephone contact. This visit will include a review of your CHA and PO. This process will enable the care manager to develop a tailored, individualized Plan of Care, also called a Person-Centered Service Plan, to meet your specific needs, as well as your individually identified goals and preferences. The Person-Centered Service Plan will reflect both formal and informal supports. At this time, a full explanation of SNH's managed long-term care plan will be discussed and you will have the opportunity to ask questions and to discuss your specific needs.

If you continue to be interested in enrolling with SNH, you will be required to sign enrollment application forms, which includes a release of information so that SNH may have permission to contact the Local Department of Social Services (LDSS) and your health care providers. We ask that you sign these important forms so that SNH can speak with your primary care provider and other healthcare providers to manage the services included in the plan of care. After the enrollment visit, SNH will make contact with your primary care provider to discuss the proposed care plan. If a member is auto-assigned to SNH by NYS Medicaid Choice, this member is presumed to be eligible for MLTC and SNH will initiate the enrollment process.

Enrollment will begin the first day of the month. Upon enrollment, you will be assigned a care manager and issued a SNH plan membership card. It is important that you bring this membership card, in addition to your Medicare and Medicaid cards and any other health insurance cards, to all healthcare appointments.

If you need additional home visits to help answer your questions about SNH, please contact us. Your enrollment in SNH is subject to review and approval by NYS Medicaid Choice.

Enrollment Eligibility Assessment

Eligibility for Managed Long Term Care is determined by the NY Independent Assessor. The NYIA CHA that determines eligibility will also be used to develop your plan of care. Well-experienced registered nurses act as enrollment specialists at SNH. A home enrollment visit will be scheduled within ten (10) business days of your showing interest in SNH. The Enrollment Specialist will review the NYIA CHA and PO for accuracy and consistency with you before developing and proposing a person centered service plan. Any inaccurate information or inconsistencies can be addressed by asking for a new assessment with the NYIA, which the enrollment specialist can request on your behalf. This is called a variance.

If your comprehensive assessment and practitioner order are accurate and consistent, the enrollment specialist will work with you or your chosen representative(s) to develop your person centered service plan. They will also administer a risk assessment including (but not limited to) your health, safety, social factors and your environment.

Enrollment is subject to approval by the NYS Enrollment Broker.

Prior to your enrollment month, you may withdraw your enrollment application at any time prior to noon on the 20th of the month. When the 20th falls on a weekend, you may withdraw your enrollment application any time before noon of the Friday before the 20th. This can be done prior to the date with a written statement or orally.

Denial of Enrollment

You may be denied enrollment for one or more of the following reasons:

- Applicant is not 18 years of age.
- Applicant is not Medicaid-eligible or is expected to be Medicaid eligible for less than 6 months.
- Applicant is receiving Hospice services at the time of enrollment.
- Applicant has limited Medicaid coverage:
 - Is only eligible for breast and cervical cancer services.
 - Is only eligible for tuberculosis-related services.
- Applicant is eligible for Emergency Medicaid.
- Applicant is in receipt of Limited Licensed Home Care Services.
- Applicant is eligible for the family planning expansion program.
- Applicant is not eligible for nursing home level of care (this applies to potential members with only Medicaid only).
- Applicant is not capable of returning to or remaining in the home without jeopardy to his/her health or safety at time of enrollment.
- Applicant does not require community-based, long-term care services from the SNH Managed Long-Term Care plan for 120 days of continuous services or more.
- Applicant whose sole service is identified as Social Day Care.
- Applicant has been previously involuntarily disenrolled from SNH.
- Applicant is currently enrolled in another Medicaid managed care plan, a home – and community-based services waiver program, a State Office for People with Developmental Disabilities (OPWDD) Day Treatment Program, or is receiving services from a hospice and does not wish to end his/her enrollment in one of these programs.
- Applicant resides in an Assisted Living Program (ALP).
- Applicant is enrolled in a Traumatic Brain Injury or Nursing Home Transition and Diversion Waiver.
- Applicant could otherwise reside in an intermediate care facility for the developmentally disabled but choose not to do so.
- Applicant is an inpatient or resident of a hospital, psychiatric facility or residential facility operated by the state Office of Mental Health (OMH), Office of Alcohol and Substance Abuse Services (OASAS) or the State OPWDD; applications for enrollment may be taken but enrollment may only begin upon discharge to the applicant's home in the community.
- Applicant is in the Foster Family Care Demonstration.

If after the NYIA approval for MLTC, it is later determined that the enrollment should be denied by the criteria provided, SNH will recommend that the New York State Enrollment Broker denies enrollment. SNH will also notify the applicant. The New York State Enrollment Broker will determine if SNH was correct in informing you that you are ineligible to enroll in SNH. The New York State Enrollment Broker will make the final decision in the denial of enrollment and will notify you of your rights.

If NYIA determines that you are clinically ineligible to enroll in SNH, you will be notified of this and your rights in writing. Clinical ineligibility means that based on your in-home assessment, you do not require a nursing home level of care (UAS-NY score of five or more for Medicaid only), and/or you do not meet health and safety criteria and/or you do not require community-based long-term care services of the plan for 120 continuous days.

If you do not wish to withdraw your application, it will be processed as a proposed denial by the New York State Enrollment Broker agreement.


Care Team

All of your health needs will be coordinated and registered by a registered nurse care manager. He/she will also make periodic visits to your home to reassess your condition. SNH will arrange for the right care at the right time based on medical necessity. Your plan of care can be changed on an as-needed basis.

Your care team will include an assigned care manager, your primary care provider and other providers providing you care as well as other SNH support staff. SNH support staff includes Member Services coordinators, medical social workers, community benefits coordinators and our medical director. Together, SNH will work with you and your primary care provider to ensure you are receiving the best level of care. If your care manager notices changes in your health status, he/she will notify your primary care provider.

Plan Member (ID) Card

You will receive your Senior Network Health identification (ID) card within ten (10) business days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your ID card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Member Services at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764.

	<i>Senior Network Health, LLC</i> <i>1650 Champlin Ave; Utica NY</i>
Name: Member ID# Enrollment Date: Group# EDI Payer ID: 15682 Customer Service/Preauthorization Required: (888) 355-4764	

	<i>Senior Network Health, LLC</i> <i>mvhealthsystem.org/snh</i>
Members: Please carry this card at all times. Show this card before you receive any covered MLTC services. Providers: Medicare and/or other private insurance benefits are not affected by MLTC coverage. Please do not try to collect a copay or deductible from this individual. Please tell us of any inpatient activity. Please send MLTC claims to Senior Network Health. Member Services: 315-624-4545 TTY: 711 or 1-800-662-1220 On-Call Care Manager:: 315-624-4545	

Services Covered By The Senior Network Health MLTC Plan

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 registered nurse or a social worker. Your care manager will work with you, your chosen representatives(s), 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. Care Management Services are available to you 24 hours a day, 7 days a week by calling Member Services at 315-624-4545 (Oneida County), 315-866-8700 (Herkimer County) or 1-888-355-4764.

Care Manager

Your care manager is an employee of SNH and is the person you speak with when you call SNH about your long-term care needs. Your care manager will contact you once a month either in-person or by phone. Your care manager is required to complete an in-person visit with you at least every 6 months.

Your care manager will be responsible for coordinating solutions to meet your health and long-term care needs while ensuring quality outcomes with the goal to enhance your quality of life. Your care manager will put together a care plan keeping in mind your wishes, personal goals, health needs, and long-term care services. Each care manager is a registered nurse whose field of expertise is acute and long-term care services. He/she will discuss plans with you, any representatives you choose to include, members of your care team, the community care coordinator, as well as your primary care provider to authorize and order the services outlined in your personal plan of care.

Your care manager will work cooperatively with your primary care provider as well as other healthcare professionals (such as your home healthcare provider, nurses and physical therapists) to coordinate all of your healthcare needs for both covered and non-covered services. Your care manager is matched, based upon availability, to best meet your individual language and cultural needs.

To contact your assigned care manager, call the Member Services department at 315-624-4545 (Oneida County), 315-866-8700 (Herkimer County) or 1-888-355-4764.

Community Benefits/Social Work Department

The Community Benefits/Social Work department will work with you and your care manager to assist you with your social and environmental concerns. SNH is available to advise members and their families on how to cope with chronic illness and social issues. With a referral from your care manager, a medical social worker will assist you with coordination of behavioral healthcare. Community Benefits coordinators can also assist you with applying for community benefits such as the Home Energy Assistance Program and food stamps, the Medicaid application and recertification process as well as any other benefits for which you are eligible. Contact your care manager for assistance.

Getting Help

SNH Member Services department wants you to understand your managed long-term care plan and receive the best possible care. The Member Services department exists for this purpose. If you need to reach your care manager; have any questions about benefits, services or procedures, or replacing a lost ID card; or have a concern about any aspect of SNH, please contact Member Services. Our Member Services coordinators are available by telephone to help you regarding your membership, including benefit questions, what services are or are not covered, to verify the date and time that you have scheduled appointments, or if you need to arrange medical transportation. These courteous staff members work with your care team to schedule your appointments and order the supplies and services that you need. We also welcome any ideas or suggestions you might have regarding SNH.

Call Member Services with your comments to help us improve our services to you at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County, toll-free at 888-355-4764 or TTY/TTD at 1-800-662-1220.

Hours of operation: Monday through Friday, 8 a.m. to 4 p.m.

24/7 NurseLine/After-hours Assistance:

If you have medical questions and cannot reach your primary care provider (PCP) or care manager, or if it is after normal business hours (8 a.m. to 4 p.m.), you can always call SNH and speak directly to a nurse.

The 24/7 NurseLine can give you guidance about whether you should go to the emergency room, how to deal with a personal crisis in the home, or provide instructions on how to take your medications in accordance with your prescription.

We want you to know how to use your managed long-term care plan no matter what language you speak. The SNH staff speaks a limited variety of languages, but if you speak a language that our staff does not know, we can access an oral interpretation service to make sure that you receive all of the information you need and that your questions are answered in your language. We also have written information in the most prevalent languages of our members (English and Spanish). Oral interpretation of SNH written material is also available to all our members in different languages. Taped English and Spanish versions of our member handbook are also available upon request.

Please feel free to call Member Services at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764 and request to speak to an interpreter or request written materials in your language, at no charge to you.

Keep Us Informed

Call Member Services whenever these changes happen in your life:

- You change your name, address or telephone number.
- You have a change in circumstances that may affect your eligibility for managed long-term care, such as changes in income/resources, your loss of Medicaid or living conditions.
- You become covered under another health insurance such as a private health insurance.
- You experience a change in your condition and require re-evaluation of your needs and/or plan of care.

Additional Covered Services

Because you have Medicaid and qualify for MLTC, our plan will arrange and pay for the extra health and social services described below. You may get these services 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. Routine medical visits do not require prior authorization (pre-approval), however any assistive devices that are requested by the provider as a result of these visits would require prior authorization (examples: eyeglasses, dentures, hearing aids, DME supplies). You must get these services from the providers who are in SNH's network. If you cannot find a provider in our plan, please call your care manager. If it is determined that the service you are requesting is a service that is necessary for your care and is covered by SNH and not another insurance, we will work to find the coverage from an out of network provider if necessary.

Contact Member Services or your care manager by calling 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764. Authorization is the process by which a covered service in SNH Managed Long-Term Care is determined to be medically necessary for the member's condition, illness or ailment by the member's primary care provider and/or SNH.

The following is a list of covered services available through your participation in Senior Network Health:

- + ® Outpatient Rehabilitation: Physical, occupational, speech or other therapies in a setting other than the home rehabilitative services provided by a licensed, registered therapist; these services should help the member restore as much of his or her physical or mental function as possible.
- ® Personal Care (such as assistance with bathing, eating, dressing, toileting and walking).
- + ® Home Health Care Services Not Covered by Medicare including nursing, home health aide, occupational, physical and speech therapies.

- ® Nutrition (Enteral and Parenteral Supplements): enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism.
- ® Nutritional counseling: offering the member nutrition education and counseling to meet normal and therapeutic needs.
- Medical Social Services
- Home Delivered Meals and/or meals in a group setting such as a day care: meals provided to help support a member's specific plan of care.
- Social Day Care: a structured, complete program that provides functionally impaired members with socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of the day, and may include maintenance and enhancement of daily living skills, transportation, caregiver help and case coordination and assistance.
- Non-Emergency Transportation: transport by ambulette, taxi, van or livery service or public transportation to obtain necessary medical care and services.
- ® Private Duty Nursing: continuous, skilled nursing care given in the home by properly licensed, registered professionals or licensed practical nurses.
- ® Dental: preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition.
- ® Social/Environmental Supports (such as chore services, home modifications or respite): services and items that support the medical needs of the member and are included in the member's plan of care; they include home maintenance tasks, homemaker chore services, home modifications and respite care.
- Personal Emergency Response System (PERS): an electronic device used by certain high-risk patients so they can get help if they have a physical, emotional or environmental emergency.
- ® Adult Day Health Care: care and services provided in a residential healthcare facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical and other ancillary services.

- * + ® Nursing Home Care not covered by Medicare (provided you are eligible for institutional Medicaid): continuous, skilled nursing care given in the home by properly licensed, registered professionals or licensed practical nurses
- ® Audiology/Hearing Aids: audiology services that include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated.
- ® Durable Medical Equipment (DME): includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula and hearing aid batteries.
- ® Medical Supplies: items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear which treat a specific medical condition.
- ® Prosthetics and Orthotics: Prosthetics are a service or device that includes artificial arms, legs, internal body parts, breasts (including reconstructive breast surgery) and eyes. Orthotics are appliances and devices used to support a weak or deformed part of the body or to restrict or eliminate motion in a diseased or injured part of the body.
- Optometry: includes the services of an eye doctor or optometrist, and includes exams and eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.
- ® Consumer Directed Personal Assistance Services (CDPAS)
- + Podiatry: include routine foot care when illness, injury or symptoms involving the foot pose a danger, or when performed as necessary for medical care.
- + ® Respiratory Therapy: care to prevent breathing problems, to maintain breathing health or re-habilitate breathing using medicines, machines and patient education.

* Institutional Medicaid eligibility rules apply

+ Medicare coverage may apply

® May require a referral from your provider

Limitations

Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions:

1. Tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; *and*
2. Individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.

Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

Nursing Home Care is covered for individuals who are considered a permanent placement for at least three months. Following that time period, your Nursing Home Care may be covered through regular Medicaid, and you will be disenrolled from Senior Network Health.

Getting Care outside the Service Area

You must inform your care manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your care manager should be contacted to assist you in arranging services.

Emergency Service

Emergency Service means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial 911. As noted above, prior authorization is not needed for emergency service. However, you should notify SNH within 24 hours of the emergency. You may be in need of long term care services that can only be provided through SNH.

If you are hospitalized, a family member or other caregiver should contact SNH within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact SNH so that we may work with them to plan your care upon discharge from the hospital

Transitional Care Procedures

New members in SNH may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider if the provider accepts payment at the plan rate, adheres to SNH quality assurance and other policies, and provides medical information about the care to your plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

Money Follows The Person (MFP)/Open Doors

This section will explain the services and supports that are available through **Money Follows the Person (MFP)/Open Doors**. MFP/Open Doors is a program that can help you move from a nursing home back into your home or residence in the community.

You may qualify for MFP/Open Doors if you:

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

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners.

They can help you by:

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

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

Medicaid Services Not Covered by Our Plan

There are some Medicaid services that SNH does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764 if you have a question about whether a benefit is covered by SNH or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription and non-prescription drugs, as well as compounded prescriptions are covered by regular Medicaid or Medicare Part D if you have Medicare.

Certain Mental Health Services, including:

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

Certain Intellectual and Developmental Disabilities Services, including:

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

Other Medicaid Services including:

- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Family Planning
- Certain medically necessary ovulation enhancing drugs, when criteria are met.

Services Not Covered by Senior Network Health or Medicaid

You must pay for services that are not covered by SNH 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 SNH or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a Provider that is not part of the plan (unless SNH sends you to that provider)

If you have any questions, call Member Services at 315-624-4545 in Oneida County, 315 – 866-8700 in Herkimer County or toll free at 888-355-4764.

Service Authorizations, Actions and Action Appeals

When you ask for approval of a treatment or service, it is called a service authorization request. To submit a service authorization request, you or your provider on your behalf, may request new or additional benefits or services orally or in writing to your care manager. Requests can be made by calling Member Services at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County, or toll-free at 888-355-4764 or by writing SNH at: 1650 Champlin Ave., Utica NY 13502. Any request that you make will be submitted to your assigned care manager for review.

We will authorize services in a certain amount and for a specific period of time. This is called an authorization period.

Prior Authorization

Some covered services require prior authorization (approval in advance) from SNH before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this by calling SNH or speaking with your Care Manager.

The following treatments and services must be approved before you get them:

- Audiology Devices
- Dental Devices
- Durable Medical Equipment
- Enteral and Parenteral Supplements
- Medical/Surgical Supplies
- Non-emergency Transportation
- Nursing Home Care
- Eyeglasses and Visual Aid Devices
- Podiatry Services
- Prosthetics
- Orthotics
- Social Day Care
- Social and Environmental Supports
- Rehabilitative Therapies

Concurrent Review

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

Retrospective Review

Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

What happens after we get your service authorization request?

The plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

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

Timeframes for Prior Authorization Requests

- **Standard review:** 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 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

- **Standard review:** We will make a decision within 1 workday of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- **Fast track review:** We will make a decision within 1 workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 workday if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the 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 day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling Member Services at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County, or toll-free at 888-355-4764 or by writing SNH at: 1650 Champlin Ave., Utica NY 13502.

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.

If our answer is YES to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

If our answer is NO to part or all of what you asked for, we will send you a written notice that explains why we said no. See How do I File an Appeal of an Action? which explains how to make an appeal if you do not agree with our decision.

What is an Action?

When SNH 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 involved issues of medical necessity or whether the treatment or service in question was experimental or investigational; and
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

The notice will also tell you about your right to an appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing;
- It will say that that you must file an appeal before asking for a Fair Hearing; and
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service the notice will also

tell you about your rights to have your services continued while your appeal is decided. To have your services continued you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on the notice. If we are reducing, suspending or terminating an authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 day of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764, or writing to: Senior Network Health, 1650 Champlin Ave., Utica NY 13502. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a plan appeal, and to ask for aid to continue, see "How do I File an Appeal of an Action?" above.

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

How Long Will It Take the Plan to Decide My Appeal of an Action?

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

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

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

Fast Track Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for a fast tracked review of your appeal. of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for a fast track appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for a fast track appeal within 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 deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under ***“How Long Will It Take the Plan to Decide My Appeal of an Action?”*** above, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice. If we are reducing, suspending or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

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. 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 (OTDA):

- Online Request Form: Request Hearing | Fair Hearings | OTDA (ny.gov)

- Mail a Printable Request Form:

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: (518) 473-6735

- Request by Telephone:

Standard Fair Hearing line – 1 (800) 342-3334
Emergency Fair Hearing line – 1 (800) 205-0110
TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:

New York City

14 Boerum Place, 1st Floor
Brooklyn, New York 11201

Albany

40 North Pearl Street, 15th Floor
Albany, New York 12243

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 a fast track external appeal. The external appeal reviewer will decide a fast track appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a 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."

Complaints and Complaint Appeals

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

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

To file a complaint, please call: 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764 or write to SNH at: 1650 Champlin Ave., Utica NY 13502. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

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

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two 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 must be completed within 7 days of the receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

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

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision, we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal orally or in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial complaint decision.

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

Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MLTC plan like SNH. This support includes unbiased health plan choice counseling and general plan related information.

Contact ICAN to learn more about their services:

- Phone: 1-844-614-8800 (TTY Relay Service: 711)
- Web: www.icannys.org | Email: ican@cssny.org

Disenrollment From Senior Network Health MLTC Plan

You will not be disenrolled from the MLTC Plan based on any of the following reasons:

- High utilization of covered medical services
- An existing condition or a change in your health
- Diminished mental capacity or uncooperative or disruptive behavior resulting from your special needs unless the behavior results in your becoming ineligible for MLTC.

Voluntary Disenrollment

You can ask to leave the SNH MLTC Plan at any time for any reason

To request disenrollment, call 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764 or you can write to us. The plan will provide you with written confirmation of your request. We will include a voluntary disenrollment form for you to sign and send back to us. It could take up to six weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require CBLTSS, like personal care, you must join another MLTC plan, Medicaid Managed Care plan or Home and Community Based Waiver program, in order to receive CBLTSS.

Transfers

You can try our plan for 90 days. You may leave SNH and transfer and join another plan at any time during that time. If you do not leave in the first 90 days, you must stay in SNH for nine more months, unless you have good reason (good cause.)

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving SNH is best for you.
- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the State

If you qualify, you can change to another type of managed long term care plan like Medicaid Advantage Plus (MAP) or Programs of All-Inclusive Care for the Elderly (PACE) at any time without good cause

To change plans: Call New York Medicaid Choice at 1-888-401-6582. The New York Medicaid Choice counselors can help you change health plans.

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

Call New York Medicaid Choice if you need to ask for faster action because the time it takes to transfer plans will be harmful to your health. You can also ask them for faster action if you have told New York Medicaid Choice that you did not agree to enroll in SNH.

Involuntary Disenrollment

An involuntary disenrollment is a disenrollment initiated by SNH. If you do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) business days from the date we know you meet any of involuntary disenrollment reasons.

You Will Have to Leave Senior Network Health if you are:

- No longer are Medicaid eligible.
- Permanently move out of SNH service area.
- Out of the plan's service area for more than 30 consecutive days.
- Needing nursing home care but are not eligible for institutional Medicaid.
- Hospitalized or enter an Office of Mental Health, Office for People with Developmental Disability or Office of Alcoholism and Substance Abuse Services residential program for forty-five (45) consecutive days or longer.
- Assessed as no longer having a functional or clinical need for Community Based Long Term Services and Supports (CBLTSS) on a monthly basis.
- Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- Receiving Social Day Care as your only service.
- No longer require, and receive, at least one CBLTSS in each calendar month.

- At the point of any reassessment, while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- Incarcerated.
- Providing the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

We Can Ask You to Leave SNH if you:

- Or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs the plan's ability to furnish services.
- Fail to pay or make arrangements to pay the amount money, as determined by the Local Department of Social Services, owed to the plan as spenddown/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, SNH will obtain the approval of New York Medicaid Choice (NYMC) or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which you become ineligible for enrollment. If you continue to need CBLTSS you will be required to choose another plan or you will be automatically assigned (auto-assigned) to another plan.

Cultural and Linguistic Competency

SNH honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all members. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

Member Rights and Responsibilities

SNH will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

Member Rights

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the Right to get information in a language you understand; you can get oral translation services free of charge.
- You have the Right to get information necessary to give informed consent before the start of treatment.
- You have the Right to be treated with respect and dignity.
- You have the Right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the Right to take part in decisions about your health care, including the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the Right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services.
- You have the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

- Receiving covered services through SNH.
- Using SNH network providers for covered services to the extent network providers are available.
- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies; Being seen by your physician, if a change in your health status occurs.
- Sharing complete and accurate health information with your health care providers.
- Informing SNH staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions.
- Following the plan of care recommended by the SNH staff (with your input).
- Cooperating with and being respectful with the SNH staff and not discriminating against SNH staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status.
- Notifying SNH within two business days of receiving non-covered or non-pre-approved services.
- Notifying your SNH health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- Informing SNH before permanently moving out of the service area, or of any lengthy absence from the service area.
- Your actions if you refuse treatment or do not follow the instructions of your caregiver.
- Meeting your financial obligations.

Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf.

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents. If you already have an advanced directive, please share a copy with your care manager.

Information Available on Request

- Information regarding the structure and operation of SNH.
- Specific clinical review criteria relating to a particular health condition and other information that SNH considers when authorizing services.
- Policies and procedures on protected health information.
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.
- Provider credentialing policies.
- A recent copy of the SNH certified financial statement; policies and procedures used by SNH determine eligibility of a provider.

Notes

[illegible]

Notes



MVHEALTHSYSTEM.ORG

**Center for Rehabilitation
and Continuing Care Services**
1650 Champlin Avenue, Utica, NY 13502