Fallon Health Weinberg–MLTC

MEMBER HANDBOOK

fallonhealth weinberg

Fallon Health Weinberg-MLTC

Managed Long Term Care Plan

Erie and Niagara Counties

Communicating with Fallon Health Weinberg-MLTC

If you have questions or need help you can call us anytime, 24 hours a day, 365 days a year.

1-866-882-8185 (toll free)
1-716-250-3100
(TTY users call 711)

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-716-810-1833 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-716-810-1833 (TTY: 711).

Chinese: **注意**：**如果**您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-716-810-1833（TTY：711）。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-716-810-1833 (телетайп: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-716-810-1833 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-716-810-1833 (TTY: 711)번으로 전화해 주십시오.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-716-810-1833 (TTY: 711).

Yiddish:

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון

אפצאל. רופט {(TTY: 711) 716-810-1833-.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1-716-810-1833 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-716-810-1833 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-716-810-1833

(رقم هاتف الصم والبكم: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-716-810-1833 (ATS : 711).

Urdu: {1- خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 716-810-1833 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-716-810-1833 (TTY: 711).

Greek: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-716-810-1833 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-716-810-1833 (TTY: 711).

Special communication services are available for people with special needs. If you have special communication needs, call us and we will provide extra help. We will help you find the services that will meet your needs from providers who understand and are prepared to meet your needs.

Notice of nondiscrimination

Fallon Health Weinberg complies with all applicable State and Federal civil rights laws and does not unlawfully discriminate in access to enrollment or provision of services on the basis of age, sex, race, gender identity including status of being transgender, creed, religion, physical or mental disability including gender dysphoria, sexual orientation, source of payment, type of illness or condition, need for health services, and place of origin.

Fallon Health Weinberg:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services at

1-716-250-3100 option 1, TTY (711)
or (toll free) at 1-866-882-8185,
or by email at cs@fallonhealth.org

If you believe that Fallon Health Weinberg has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a complaint with:

Compliance Director
Fallon Health Weinberg
10 Chestnut St.
Worcester, MA 01608
Phone: 1-508-368-9382 (TTY 711)
Email: compliance@fallonhealth.org

You can file a complaint in person or by mail, fax or email. If you need help filing a complaint, the Compliance Director is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, D.C., 20201
Phone: 1-800-368-1019 (TDD: 1-800-537-7697)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

To our Valued Members:

I would like to thank you for becoming a member of the Fallon Health Weinberg's 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 care services like home care and personal care to stay in their homes and communities as long as possible. We know from your membership that remaining in your home is your first choice for long term care services. Our goal is to coordinate and manage benefits that will keep you in the best possible environment and help maintain your continuum of health. We will work with all of your insurances to coordinate the best possible care for you.

This Member Handbook, along with your signed Enrollment agreement, are your contract with Fallon Health Weinberg, your managed long term care plan. It describes the added benefits Fallon Health Weinberg-MLTC covers since you are enrolled in the plan. It will help you understand what you need to do to obtain services and how best to work with your Care Manager and other Care Team staff to meet your needs. It also tells you how to request a service, file a complaint or disenroll from Fallon Health Weinberg-MLTC. Please keep this handbook as a reference, it includes important information regarding Fallon Health Weinberg-MLTC and the advantages of our plan. You need this handbook to learn what services are covered and how to get these services.

You can contact Member Services at 1-716-250-3100 (TTY 711) who can assist you with many different areas 24 hours a day seven days a week. You have a Care Manager who communicates and works with you regularly that you should always be aware of and how to reach. If you do not know who your Care Manager is or their direct phone number, Member Services can share that information with you. Please review this Handbook carefully and if you have any questions you can contact anyone on the care team or member services.

As a member of Fallon Health Weinberg-MLTC you can get important information about the program in the language you understand the best. If you are hearing impaired or have vision problems we can work to get you the material in the best format for you so that you can understand.

We encourage you and your family to be involved in your care. We want you to have an ongoing relationship with your Care Manager and your doctor, who, working together, will help you receive the home and community based long term care services you need.

Please do not hesitate to contact me personally should you have any questions or concerns at 1-716-810-1824.

Sincerely,

Keith D. Curtis, RN
Program Director
Fallon Health Weinberg
fallonweinberg.org
keith.curtis@fallonweinberg.org

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Overview

What is Fallon Health Weinberg-MLTC?

Fallon Health Weinberg-MLTC is a Managed Long Term Care (MLTC) program for individuals who wish to and are able to live safely at home but need some level of assistance with activities, often called long-term care services and who are on Medicaid or are eligible for Medicaid. This is a program designed to keep these individuals living safely, and independently, in the comfort of their own home. We encourage our members to take an active part in their health care.

Fallon Health Weinberg-MLTC is approved by the New York State Department of Health as a managed long-term care plan for individuals 21 and over who require more than 120 days of home and community-based services in Erie and Niagara counties. Fallon Health Weinberg-MLTC home and community based services to members giving you the flexibility and freedom you need to make the right choices that will help you achieve the best possible state of health.

If you would like to find out more about Fallon Health Weinberg-MLTC you can call:

1-866-882-8185 (toll free)
1-716-250-3100
(TTY users call 711)

Or visit our website at:
fallonweinberg.org

Fallon Health Weinberg-MLTC provides quality long-term care services to Erie and Niagara County residents by bringing experience and expertise to the care and services it delivers to you.

How will Fallon Health Weinberg-MLTC help to keep me living at home?

Our plan is to keep you living independently in the comfort of your own home by coordinating care and paying for many of these services to provide you with the care, support, and services you need, as long as your health and safety are not at risk.

Your care will be managed and coordinated by a care team of health professionals.

Your Care Team works cooperatively with your Primary Care Physician. They include but not limited to the Care Manager, Social Worker, Member Services Representatives and other team members determined by your individualized care plan.

Members of your Care Team will have ongoing communication with your Primary Care Physician. You will be assigned a Care Manager who will work with you to develop an individualized Plan of Care. Your Plan of Care may be modified as your needs change. You will work closely with your Care Manager whose job it is to understand your health needs and coordinate all the care you receive.

Your Care Team will assist with coordinating all covered and non-covered services you need. This may include arranging physician appointments and arranging necessary non-emergency transportation to obtain necessary medical care and services.

If your Plan of Care calls for it, your Care Team can help to make your home safer for you to live in. For example, your Care Team may have grab bars installed in your bathroom, or they may have adaptive devices installed in your kitchen to make it safer for you. Your Care Team may also provide you with a Personal Emergency Response System (PERS) that you can wear whenever you are at home. This will provide you with immediate access to assistance if you should fall or get hurt at home.

Your Care Team will continually monitor your health status and will update your Plan of Care as your health care needs change. Your Plan of Care will be formally re-evaluated annually–or sooner if your condition changes.

Through the Plan of Care and the supports that your Care Team authorizes, you will be able to live safely in the comfort of your own home for as long as possible.

Fallon Health Weinberg-MLTC utilizes a process of Care Management. This is a process that assists members to access necessary covered services identified in the Plan of Care. It also provides referral and coordination of other services in support of the Plan of Care. Your Care Team will assist you in obtaining needed medical, social, educational, psychosocial, financial and other services in support of the care plan, even if the needed services are covered benefits or not under Fallon Health Weinberg-MLTC.

Each member of your care team has a business card available with contact information and can easily be contacted by phone or email utilizing the following format:

Firstname.Lastname@fallonweinberg.org

Once you enroll into Fallon Health Weinberg-MLTC you will receive your identification (ID) card within 30 days of your effective enrollment date. Please verify that all of your information is correct on your card. Be sure to carry your identification card with you at all times along with your Medicaid card and any other insurance cards to include Medicare. If you MLTC card is lost or stolen please contact member services at 716-250-3100 to have it replaced.

Member Services

The member service department is available to answer your questions and help you with a wide range of requests. Member Services is available 24 hours a day, 7 days a week at 1-716-250-3100 option 1. We can assist you with:

- Membership questions
- Connecting with your Care Team/Care Manager
- Benefit questions
- Changing providers
- Getting an interpreter
- Assisting with getting printed material in another language
- Assisting with getting information for members with vision or hearing problems
- Requesting a new ID card
- Updating your contact information

Eligibility

You are eligible to join if you meet the following criteria:

- You are 21 years of age and older
- You live in Niagara or Erie County
- You are eligible for Medicaid as determined by the County Department of Social Services or an entity designated by the New York State Department of Health
- You are determined eligible for an MLTC using the assessment tool designated by the New York State Department of Health
- You are capable, at the time of enrollment, of safely remaining in your home and community without jeopardy to your health and safety, based upon criteria provided by the New York State Department of Health

- You are expected to require at least one (1) of the following Community Based Long-Term Care (CBLTC) services covered by the Managed Long Term Care Plan services for more than 120 days from the effective date of enrollment:
    - nursing services in the home
    - therapies in the home
    - home health aide services
    - personal care services in the home
    - adult day health care (Medical Day)
    - private duty nursing; or
    - Consumer Directed Personal Assistance Services

The following individuals are not eligible for the Managed Long Term Care:

- residents of psychiatric facilities
- residents of residential health facilities at the time of enrollment
- individuals expected to be Medicaid eligible for less than six (6) months
- individuals eligible for Medicaid benefits only with respect to tuberculosis related services
- individuals receiving hospice services at the time of enrollment
- individuals residing in State Office of Mental Health and Residential Facility
- individuals with a “county of fiscal responsibility” code of 98 (i.e. individuals in an Office for People with Developmental Disabilities (OPWDD) facility or treatment center
- individuals eligible for the family planning expansion program
- individuals under 65 years of age in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage
- residents of alcohol/substance abuse long term residential treatment programs
- individuals eligible for emergency Medicaid
- individuals in the OPWDD Home and Community Based Services section 1915(c) waiver program

- individuals in the following 1915(c) waiver programs: Traumatic Brain Injury, Nursing Home Transition & Diversion
- residents of Assisted Living Programs (ALP)
- individuals in receipt of limited Licensed Home Care Services

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

Enrolling in Fallon Health Weinberg-MLTC

New York State has implemented an Independent Assessor system called NYIA (New York Independent Assessor) for new MLTC applicants residing in Erie and Niagara County who are in need of Community Based Long-Term Care (CBLTC) services. The NYIA will manage the initial assessment process, except for expedited initial assessments. 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.

Fallon Health Weinberg-MLTC 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 Fallon Health Weinberg-MLTC about whether the plan of care meets your needs.

Managed Long Term Care (MLTC) plans receiving calls from Medicaid or pending Medicaid recipients seeking a plan assessment of reenrollment must direct the prospects to the NYIA service desk at 1-855-222-8350.

To join a Medicaid Community-Based Managed Long-Term Care Program, a NYIA nurse must first visit you to determine your eligibility. If the NYIA assessment indicates that you are eligible for the program, the Fallon Health Weinberg Intake Staff will come to your home to fully explain the program, and to review the Fallon Health Weinberg-MLTC Enrollment Agreement. You will receive the Member Handbook, and a list of Network Providers. A home visit will be completed to review your health care needs. You can have a family member or anyone you wish present during this visit.

Fallon Health Weinberg-MLTC will complete your enrollment once we receive approval from the Department of Social Services or the Department of Health designated entity (New York Medicaid Choice).

If your Medicaid eligibility is established and the Enrollment Agreement is received by New York Medicaid Choice by 12:00 p.m. (Noon) on the 20th of the month (unless the 20th lands on a holiday or weekend, then the last business day prior to the 20th is used), your enrollment will take effect on the first (1st) day of the next month. If your Enrollment Agreement is received after 12:00 p.m. (Noon) on the 20th day of the month, your enrollment will take effect no later than the first (1st) day of the second month.

If you decide that that Fallon Health Weinberg-MLTC is not right for you, you may withdraw your application or enrollment agreement by 12:00 p.m. (Noon) on the 20th day of the month (unless the 20th lands on a holiday or weekend, then the last business day prior to the 20th is used) prior to the effective date of enrollment by indicating your wishes orally or in writing.

You can be assured that in evaluating your eligibility for Fallon Health Weinberg-MLTC, you will not be discriminated against because of your health care status or cost of covered services.

Transferring to another MLTC Medicaid Plan

You can try us for 90 days. You may leave Fallon Health Weinberg-MLTC and join another health plan at any time during that time. If you do not leave in the first 90 days, you must stay in Fallon Health Weinberg-MLTC for nine more months, unless you have a good reason (good cause). Some examples of Good Cause include:

- 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 Fallon Health Weinberg-MLTC 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 1-800-505-5678. 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. Fallon Health Weinberg-MLTC 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 Fallon Health Weinberg-MLTC.

How do I access covered services?

Shortly after enrollment you will receive a Fallon Health Weinberg-MLTC identification card, which you should carry along with your Medicaid, Medicare card and any other insurance cards that you may have. Your provider will determine which card(s) to utilize. Until you have received your Fallon Health Weinberg-MLTC identification

card you can give the provider your insurance number or have your provider contact FHW Member Services at 716-250-3100 and we will provide them with your identification number.

Covered services are accessed through the care planning process. Your Plan of Care, which describes the services that you receive, is developed by the Care Team with input from you, your family, caregivers, and your Primary Care Physician. When you ask for approval of a treatment or service, it is called a service authorization request. You can request services from your Care Team, Member services at 716-250-3100 or send your request in writing to the plan at 461 John James Audubon Parkway, Amherst NY 14228.

In most cases, before you can receive a covered service, your Primary Care Physician or the Care Team must order the service by including it in your Plan of Care. A care team member will then complete an authorization for you to access these services. You may, however, go to the optometrist, the podiatrist, the dentist for routine care, and the audiologist as medically needed without prior authorization.

For services covered by Fallon Health Weinberg-MLTC, Network Providers must be used. Since some of the services are covered by Medicare, you would not be limited to the provider network to access those services. An example of this may be a hospital bed which a portion may be covered under you Medicare benefit, the remainder would be paid for by the FHW MLTC and the provider would not have to be in the network. We request that you contact the Care Team when accessing services, whether it is Medicare or program covered services so that services can be arranged for you.

How to obtain services covered by Fallon Health Weinberg-MLTC

Your Care Team will complete an authorization for each covered benefit identified in your Plan of Care. Authorizations will cover a period time from 60 days to as much as 12 months, unless changes in your condition necessitate more frequent changes in your Plan of Care.

A prior authorization is not required to receive audiology, podiatry, basic dental, and optometry services.

Your covered services are provided through one of our Network Providers. You will receive a written explanation each time MLTC-covered services are approved for you.

Services include:

Care Management Services

In order to meet your care needs, a complete approach with specific health care goals will be provided to you through an individualized Plan of Care. Our plan will provide you with a care manager who is a health care professional who will be a Registered Nurse. Care management and care coordination services help you to access necessary covered and non-covered services identified in your Plan of Care. The Care Team also provides referral and coordination of other services in support of the Plan of Care. Care Managers will assist you in accessing needed medical, social, education, psychosocial, financial, and other services in support of the Plan of Care. Your care team will work with you to develop a care plan that is based on an assessment of your health care needs. How effective your care plan is in meeting your goals will be monitored through ongoing reassessments of your health care needs. Services not covered by your plan as well as those services of informal supports necessary to your health care goals will be clearly identified on the care plan or elsewhere in the care management record. Our care managers and care team staff will visit you in your home throughout your time as a member in our plan which will assist with monitoring the care plan and developing other interventions as needed.

Additional 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. You must get these services from the providers who are in the Fallon Health Weinberg network. If you cannot find a provider in our plan, our Care Managers and Care Team will work with you for medically necessary services that are solely covered by Medicaid and not available from one of our in-network providers.

If you would like to access one of the services below, please communicate with your Care Team who will assist and add this to your care plan. All of the services identified below will require us to provide an authorization prior to utilizing the service and we will send you an authorization letter for each of them.

Adult Day Health Care (Medical Day)

Care and services provided in a residential health care facility to a person who is 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, meals and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of meaningful activities, dental, pharmacy, and personal care.

Audiology and Hearing Aids

Audiology services include hearing examination or testing, hearing aid evaluation, fitting of hearing aids and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, hearing aid batteries, ear molds, special fittings and replacement parts.

Congregate Meals

You will receive a lunch meal with fellow members on the day(s) you attend a social day program or other site.

Consumer Directed Personal Assistance Services (CDPAS)

Personal care services, home health aide services or skilled nursing tasks received by a consumer directed personal assistant under the instruction, supervision and direction of you (member) or someone you choose (designated representative). You will be in charge of finding, hiring, training, scheduling, supervising and, if needed, terminating the personal assistants (attendants). You may request a consumer directed personal assistant at the time of enrollment, assessment or reassessment or when in receipt of personal care, home care or skilled nursing services. CDPAS is intended to permit chronically ill or physically disabled individuals greater flexibility and freedom of choice in getting such services. We will connect you with a Fiscal Intermediary (FI) in our network that manages your personal assistants wages and benefits. The FI will conduct background checks and drug tests to make sure your assistants are able to work. The FI will manage the employment documents, time sheets and annual assistant health assessments. The FI does not oversee your medical or personal care, you are your designated representative are in charge of this. Once the FI reviews and approves the assistants work status, they can begin working.

In the event you are not self-directing, a designated representative will need to be identified to assume the responsibilities for CDPAS. Your CDPAS Designated Representative may not work as your personal assistant at any time.

Dentistry

Includes but shall not be limited to your preventative and other dental care services, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition.

Durable Medical Equipment (DME)

DME coverage is for items covered under traditional Medicaid including equipment servicing and Medical/Surgical supplies, enteral and parenteral formulas, and hearing aid batteries.

DME also includes prosthetics and orthotics:

- Prosthetic appliances and devices
- Orthotic appliances and devices
- Orthopedic footwear are shoes

Home Delivered Meals

Meals delivered to your home in accordance with your individual Plan of Care when medically necessary.

Home Health Care

At some point you may need care which includes the following services which are of a preventive, therapeutic, rehabilitative, and/or supportive in nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy, respiratory therapy and speech/language pathology provided in your home.

Medical Social Services

Provides you with information, referral, and assistance with obtaining or maintaining benefits which include financial assistance, medical assistance, food stamps, or other support programs provided by the LDSS, Social Security Administration, and other sources. Social Services also involve providing support and addressing problems in your living environment and daily activities to assist you to remain in the community.

Non-Emergent Medical Transportation

Transportation by ambulance, ambulette, wheel chair van, or taxi service at the appropriate level for your condition for you to be transported to and from medical appointments as medically necessary.

Nursing Home Care

Nursing Home Care that is not covered by Medicare, provided you are eligible for institutional Medicaid. Long term 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.

Nutrition Services

Supports your nutritional needs and food patterns, or the planning for the provision of food and beverages appropriate for your physical and medical needs and environmental conditions, or nutritional education and counseling to meet normal and therapeutic dietary needs. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake within your home environment and cultural considerations, nutritional education regarding therapeutic diets, development of a nutritional treatment plan, regular evaluation and revision of nutritional plans as well as consultation on your specific dietary problems and nutrition education for you and your family. These services are provided by a Registered Dietician.

Ophthalmic Dispenser

Fills your prescription provided by an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of qualified practitioner. Coverage includes the replacement of lost or destroyed eyeglasses. Coverage also includes the repair or replacement of damaged frames and/or lenses. Repairs and replacement of frames and/or lenses must be medically necessary. Eyeglasses do not require changing more frequently than every two years unless lost, damaged, destroyed or medically indicated.

Optometry

Includes the services by an optometrist and an ophthalmic dispenser and includes eyeglasses; medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by your condition. Examinations which include refraction are limited to every two years unless otherwise justified as medically necessary.

Personal Care

Some or total assistance with such activities as personal hygiene, dressing and feeding, bathing, and nutritional and environmental tasks such as light housekeeping, laundry, grocery shopping, cooking, and cleaning dishes. Personal care must be medically necessary, ordered by your physician and provided by aides from a contracted in network licensed agency in accordance with your Plan of Care.

Personal Emergency Response System (PERS)

PERS is an electronic devise which enables you to secure help in the event of an emergency in your home. In the event of an emergency, the signal is received and appropriately acted on by a response center.

Podiatry

Podiatry means services by a podiatrist which must include routine foot care when your physical condition poses a hazard due to an illness, injury or when they are performed as a necessary part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a medical condition.

Private Duty Nursing

Medically necessary continuous and skilled nursing care provided in your home, or under certain conditions, a hospital or nursing home, by properly licensed registered professional or licensed practical nurses.

Respiratory Therapy

The performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel. These services must be provided by a qualified respiratory therapist.

Social Day Care

Is a structured program which provides functionally impaired individuals with socialization; supervision and monitoring; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to personal care, maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.

Social and Environmental Supports

Services and items that support your medical needs and are included in your Plan of Care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, home improvement, and respite care.

Telehealth

Health care services delivered by telehealth are covered by Fallon Health Weinberg-MLTC. Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a member.

Therapy

Physical Therapy

Refers to rehabilitative services and exercises to restore and/or maintain you at your best functional level. These may include: wheelchair training, walking and/or transfer training, and balance and coordination exercises performed in an outpatient setting.

Occupational Therapy

Refers to therapy and/or exercises to keep you at your best functional level in your home. These may include but are not limited to: dressing, range of motion, grooming, hygiene and home safety performed in an outpatient setting.

Speech Therapy

Refers to services for Members with speech and language needs, which may include swallowing therapy, language therapy, and education for alternative means of communication. Speech Therapy is performed by a licensed and registered speech-language pathologist in an outpatient setting.

Please note: Regarding Physical Therapy, Occupational Therapy, and Speech Therapy, Fallon Health Weinberg-MLTC will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional.

If you are currently receiving Community Based Long-Term Care (CBLTC) services from Fee For Service Medicaid (FFS), another Managed Care Organization (MCO) or Institutional Long-Term Support Services from a Skilled Nursing Facility, Fallon Health Weinberg-MLTC will authorize and cover these services at the same level, scope and amount as you currently receive under the FFS/MCO Program for 90 days following Enrollment or until another Plan of Care is in place, whichever is later.

Services the Fallon Health Weinberg-MLTC does not cover but will coordinate for you:

By coordinating, we mean that the Care Team will help you identify the provider of the service you need, will arrange the appointment with the provider, and will arrange non-emergency transportation to and from the provider if needed.

For the services that we do not cover, the provider bills Medicare or Medicaid directly for their services on a fee-for-service basis, or in some cases a third-party insurance.

Medicaid services not covered by the Plan

There are some Medicaid services that Fallon Health Weinberg 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 716-250-3100 or your Care Manager if you have a question about whether a benefit is covered by our Plan or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

- Physician services
- Inpatient hospital services
- Out-patient hospital services
- Laboratory services
- Radiology and radioisotope services
- 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
- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services
- Alcohol and substance abuse services
- Chronic renal dialysis
- Emergency transportation

- Prescription and Non-Prescription medications – covered by regular Medicaid or Medicare Part D if you have Medicare
- Services rendered under the Home and Community Based Services Waiver
- Methadone Treatment
- Family planning

Services not covered by Fallon Health Weinberg or Medicaid

You must pay for services that are not covered by Fallon Health Weinberg 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 Fallon Health Weinberg 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 Fallon Health Weinberg sends you to that provider)

If you have any questions, call Member Services at 1-716-250-3100.

When can I get assistance from Fallon Health Weinberg-MLTC?

A Care Manager is available 24 hours a day, 7 days a week, 365 days a year. If you need to speak to a Care Team member you can call:

1-866-882-8185 (toll free)
1-716-250-3100
(TTY users call 711)

Getting care outside of 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 manger 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. Prior authorization is not needed for emergency service. However, you should notify Fallon Health Weinberg

within 24 hours of the emergency. You may be in need of long-term care services that can only be covered through Fallon Health Weinberg.

If you are hospitalized, a family member or other caregiver should contact Fallon Health Weinberg 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 Fallon Health Weinberg at 1-716-250-3100 so that we may work with them to plan your care upon discharge from the hospital.

Service Providers

Can I keep my physician?

You can keep your Primary Care Physician (PCP). If you do not have a PCP, or wish to change your PCP, we can help you find a new physician.

What role will my Primary Care Physician play in my care?

Your Primary Care Physician will work with you and your Care Team to develop your Plan of Care and provide orders for your care as needed to the other providers involved in your care.

Your Primary Care Physician will work closely with you and your Care Team in monitoring the care you are receiving to make sure it is exactly what you need.

When do I have to use providers in the Fallon Health Weinberg-MLTC network?

If a service is paid for by Medicare or other insurance, you have the freedom to use a provider of your choice. However, when Medicare/other insurances no longer pay for the service you are receiving and it becomes a Fallon Health Weinberg-MLTC covered service, you must switch to one of our network providers in order to keep receiving the service. For continuity of care, you may want to receive covered services paid for by Medicare from one of our Network Providers.

If a covered service that Fallon Health Weinberg-MLTC will pay for is not paid for by Medicare, you must use a provider in our network to receive that service.

Network providers are paid for each service they provide to you, and will be paid either at cost, at the Medicaid rate, or at the rate we have negotiated with them. You

will be provided with a list of the Fallon Health Weinberg-MLTC Network Providers upon enrollment. We will also provide you with an updated list of providers on an annual basis.

Fallon Health Weinberg-MLTC will provide members with prior written notice of significant changes to the Member Handbook and provider network.

If you have any questions about the qualifications of any provider, please ask your Care Team.

Can I go to a specialty care provider of a covered service?

You can go to a specialty care provider in the Fallon Health Weinberg-MLTC Network if you are referred by your Care Team and have the appropriate authorization.

If we do not have a provider in our network that can provide the service you need, your Care Team will refer you to an appropriate provider outside of the Fallon Health Weinberg-MLTC Network. Your Care Team will also arrange your appointments and will arrange transportation to and from your appointments.

Can I continue to receive care from a non-network provider who is treating me on an ongoing basis before I enroll?

If you are being treated by a non-network provider on an ongoing course of treatment, before you are enrolled, you can continue to be treated by that provider for up to sixty (60) days from the effective date of enrollment for any covered service that you receive as part of that treatment. However, the provider must agree to accept Fallon Health Weinberg-MLTC payment rate as payment in full, and must agree to abide by Fallon Health Weinberg-MLTC policies and procedures, adhere to our quality assurance and provide medical information to the plan in order for us to pay the provider for the service provided to you.

What happens if I am being treated by a provider that leaves the network?

If you are receiving a covered service on an ongoing basis from a provider that leaves our network, we will continue to allow you to use that provider for up to ninety (90) days after we have notified you that the provider has left the network. However, the provider must agree to accept Fallon Health Weinberg-MLTC payment rate as payment in full, and must agree to adhere to our quality assurance and other policies, and provide medical information about the care to the plan in order for us to pay the provider for the service provided to you.

Our authorization process

When you ask for approval of a treatment or service, it is called a service authorization request. Most of the services covered by Fallon Health Weinberg-MLTC require authorization. This means that if you need any of the services, you will need to have an authorization in advance of receiving the care.

Please speak with any member of your Care Team if you have any questions about your services, care plan or our authorization process. All services are based on medical necessity.

You can also request additional services from our member services department at 716-250-3100 option 1 or (toll free) at 1-866-882-8185. If you or your provider call this number, the staff member will discuss your needs with your Care Team. We may ask your physician or health care provider to explain why the service is medically necessary. You or your provider may call us or send the request in writing to us at the address:

Fallon Health Weinberg-MLTC
461 John James Audubon Parkway
Amherst, NY 14228

Attention: Member Services

Whenever you ask for services that require an authorization, it is our policy to tell you our decisions by telephone and in writing. If you disagree with any of the authorization decisions my by the MLTC, please feel free to discuss with us. You may always appeal the decision which is described in this handbook and each decision letter that you receive.

Authorization Period

This is the period of time that an authorization covers. Fallon Health Weinberg-MLTC will authorize most services for a 12-month period. There are services that may be for smaller periods to include Home Care services for 60 days as an example. Whenever you ask for a service that requires an authorization, we will inform you of the authorization decision.

Prior Authorization

Some covered services require prior authorization (approval in advance) from Fallon Health Weinberg-MLTC before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this.

- *Standard Review:* We will make a decision about your request within three (3) work days of when we have all the information we need. You will always here from us about our decision within fourteen (14) days of your request for services. We will tell you by the 14th day if we need more information. We will notify you by phone and in writing of our decision.
- *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.

If your health would be put in danger by taking the amount of time listed above to make our decision, we will treat your request as a Fast Track request and will make our decision as quickly as possible. We will take no longer than seventy-two (72) hours from your request to make a decision unless it is in your best interest for us to extend this time frame. We will tell you within one (1) day if we need to extend this time frame.

Concurrent Reviews

When you make a request for more of the service that you are currently authorized in your plan of care, this is call a Concurrent Review.

- *Standard review:* We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- *Fast track review:* We will make a decision within 1 work day of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 work day 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 1-866-882-8185 or writing.

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

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?* that explains how to make an appeal if you do not agree with our decision.

Retrospective Review

Sometimes we will perform a review of the care you are getting to see if you still need the care. We may also review other treatments and services that you have already received. This is called a retrospective review.

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.

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.

What about accessing services that I need in an emergency?

An emergency is a sudden change in medical condition or behavior that is so severe that if you do not get medical attention, it will place your health or someone else's health in serious jeopardy. An emergency can include severe pain, an injury, or a sudden illness.

When you have an emergency*, the best thing for you or your caregiver to do is call 911.

You can always call us for urgent or emergent concerns, and someone will be available to help you 24 hours a day. If you need to reach us at any time, you can call us:

1-866-882-8185 (toll free)
1-716-250-3100
(TTY users call 711)

You do not have to notify your Care Team before you seek emergency treatment. However, so that we can manage your care in the best possible way, you, your family, or caregiver, should notify your Care Team as quickly as possible after you receive emergency treatment. By contacting us as quickly as possible, we can revise your Plan of Care to reflect changes in your health care status when they are needed, and we can help you access additional services and arrange appointments.

What happens if I need nursing home care?

There may be occasions where you, your Care Team, and your Primary Care Physician agree that your care needs would best be met by a short or long-term nursing home stay.

If you need nursing home care for a short or long-term stay, your Care Team will coordinate your placement and all of your care for as long as you are enrolled in the Fallon Health Weinberg-MLTC. If you will be permanently placed for a long term stay in a nursing home the process will be started to implement institutional Medicaid. Once the institutional Medicaid is in place, you will have a minimum of 3 months to remain on the MLTC. After 3 months NY Medicaid may process a disenrollment from our plan and your continued stay will be covered under regular Medicaid. We will notify you prior to your disenrollment with all of the information.

You may be required to complete further documentation for New York State regarding your finances, which are commonly referred to as an addendum A, or a "Five (5) year look back".

If you medically require nursing home care but are not eligible for such care under the Medicaid program's institutional rules, we must initiate involuntary disenrollment within five (5) business days from the date that we know such information.

Plan of Care

How often will my plan of care change?

Your Care Team will continually monitor and evaluate your health care status and will update your Plan of Care to reflect changes in your health care status as changes occur. However, your Plan of Care will be formally re-evaluated every 180 days.

What if I believe I need more or different services?

You can request a re-evaluation of your Plan of Care at any time. This includes asking for more or different covered services. All you have to do is speak to a member of your Care Team. Your Care Team will review your request as soon as they get it. If your Care Team agrees with your request, your Plan of Care will be changed.

A decision regarding your request will be made as quickly as possible, taking the urgency of your request into consideration.

What if I do not agree with my Plan of Care or with the re-evaluation of my Plan of Care?

If you do not agree with your Plan of Care, or your Care Team's decision regarding your request for re-evaluation of your Plan of Care, you can express your concern to your Care Team. If you disagree with your Care Team's response, you can file an appeal with Fallon Health Weinberg-MLTC. Instructions on how to file an appeal is described later on in this Member Handbook in Section *"How do I file an Appeal".*

Leaving the Service Area

What happens if I leave the Service Area?

If you leave our Service Area (Erie or Niagara Counties) you must be sure to notify your Care Team.

If you notify us before you leave, we will be able to help you to make care arrangements before you leave. We will also be able to continue to coordinate your care for up to thirty (30) days while you are away. During that time, we will be able to help you with any issues or concerns that you have about your care, and with accessing other services. If you do not return after thirty (30) days, we will have to begin the involuntary disenrollment process.

If you need assistance while you are out of the service area, you can call your Care Team at any time at:

1-866-882-8185 (toll free)
1-716-250-3100
(TTY users call 711)

What if I need urgent or emergency care while I am out of the Service Area?

Urgent or emergent care is medically necessary care that you need to prevent a serious deterioration in your health and/or life-threatening illness while you are out of the service area. If you need urgent or emergency care while you are out of the service area you should get the care you need. You do not need to tell us first. However, you should call your Care Team as soon as possible after you receive the care so that we can help you arrange necessary appointments, and so that we can modify your Plan of Care to reflect changes in your health care status when necessary.

Fallon Health Weinberg-MLTC Complaints and Appeals processes

How do I express a concern?

To express a concern, all you have to do is speak to a Fallon Health Weinberg-MLTC Care Team or a staff member.

We will try our best to address 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 the concern you have.

There will be no change in your services or the way you are treated by Fallon Health Weinberg-MLTC 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:

1-866-882-8185 (toll free)
1-716-250-3100
(TTY users call 711)

or write to:

Fallon Health Weinberg-MLTC
c/o Program Director
461 J.J. Audubon PKWY
Amherst, NY 14228.

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

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.

The Complaint Process

You may file a complaint orally or in writing. Each complaint will be documented, and appropriate Fallon Health Weinberg-MLTC staff will oversee the review of the complaint. Within 15 business days of receipt, 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 seven (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 in writing or orally. 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 fifteen (15) 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 decision.

For standard complaint appeals, we will make the appeal decision within thirty (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 two (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 Fallon Health Weinberg-MLTC 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 with the date this action will take place;
- Cite the reasons for the action, including the clinical rationale, if any;
- Outline the procedure for you to request an aide to continue when applicable and your responsibilities;
- Describe your right to file an appeal (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, (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 tell you about your right to an appeal and a State Fair Hearing to include:

- The difference between an appeal and a Fair Hearing;
- It will say that you must file an appeal before asking for a Fair Hearing; and
- How to ask for a Fair Hearing

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. You must ask for an appeal within 10 days of the date on the Notice of Action 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 file an 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. An Action is when the plan sends you a letter regarding an action they are taking such as denying, limiting services, or not paying for services. You must file your appeal request within 60 days of the date of the notice.

How do I Contact my Plan to file an Appeal?

To file an Appeal please call:

1-800-333-2535 ext. 69950 (toll free)
1-716-250-3100
(TTY users call 711)

or write to:

Attn: Appeals Department

Fallon Health Weinberg-MLTC
10 Chestnut St.
Worcester MA 01608

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. 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 a continuation of 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 our intent to restrict, reduce, suspend or terminate your services, or by the intended effective date of our action, 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 continuing see *"How do I File an Appeal of an Action?"* above.

Although you may request a continuation of services, if the Fair Hearing 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 your Internal Appeal to be fast tracked (also called an Expedited Appeal), 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 best 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

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 an expedited 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 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 the decision about your appeal is not 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. If your appeal is denied 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.

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

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.

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

- **Online Request Form:** https://errswebnet.otda.ny.gov/errswebnet/erequestform.aspx
- **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:** 1-518-473-6735
- **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	Albany
14 Boerum Place, 1st Floor	40 North Pearl St., 15th Floor
Brooklyn, NY 11201	Albany, NY 12243

For more information on how to request a Fair Hearing, please visit:

- http://otda.ny.gov/hearings/request/

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.

Fallon Health Weinberg-MLTC will not act in any manner so as to restrict your right to a Fair Hearing or influence your decision to pursue a Fair Hearing.

State External Appeals

If we deny your appeal because the service is:

1. Determined not medically necessary
2. Experimental or investigational
3. Not different from care you can get in our network, or
4. Available from a participating provider who has the training and experience to meet your needs

You may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for FHW or New York State. These reviewers are qualified and 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.

Before you ask for an External Appeal you must file an Internal Plan Appeal and get the Final Adverse Determination notice; or if you ask for a Fast Track Plan Appeal you may ask for a Fast Track External Appeal at the same time or you and Fallon Health Weinberg-MLTC may jointly agree to skip the Internal Plan Appeal process and go directly to the external appeal.

You have four (4) months to ask for an External Appeal from the date you receive the Final Adverse Determination, or from when you agreed to skip the Internal Appeal process.

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. Fast track decisions are made in 72 hours. The decision will be sent to you in writing. The reviewer will inform you Fallon Health Weinberg-MLTC of the final decision within two (2) 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 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 final decision.

To get an External Appeal application and instructions:

- Call Fallon Health Weinberg-MLTC at 1-866-882-8185;
  or
- Call the New York State Department of Financial Services at 1-800-400-8882;
  or
- Go on line: www.dfs.ny.gov

Other Ways to Express a Complaint or Concern

We hope you will always discuss your concerns with us. However, if you are dissatisfied with Fallon Health Weinberg-MLTC, or if you disagree with the way we have handled your complaint, you also have the right to file a complaint with the New York State Department of Health.

You can call them or write to them at any time at the following location:

New York State Department of
Health Division of Long-Term Care Services
1-866-712-7197
Bureau of Managed Long-Term Care

Disenrollment from Fallon Health Weinberg-MLTC

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.

Can I leave the program once I have enrolled?

Yes. This is called a Voluntary Disenrollment. To voluntarily disenroll, you can make a verbal or written request, and can do so at any time. A Care Team or staff member can help you do this. You can call member services at 716-250-3100 or contact your Care Team directly. We will ask you to complete and sign a Voluntary Disenrollment Form.

Fallon Health Weinberg-MLTC will notify the Department of Social Services or the Department of Health designated entity of your request to disenroll from Fallon Health Weinberg-MLTC. It could take up to six weeks to process the disenrollment depending on when your request is received by the plan.

You may disenroll to regular Medicaid or join another plan as long as you qualify. Individuals who are 21 and older and who are assessed as needing Community Based Long-Term Care services, like personal care, for more than 120 days must transfer to another MLTC plan, Medicaid Managed Care plan or Home and Community Based Waiver programs in order to receive those services. The Department of Health designated entity will work with you to assist in enrolling you into another Managed Long-Term Care (MLTC) plan, Managed Care Plan or alternative service program to meet your needs.

Can I be disenrolled from the program even though I have not asked to be?
Yes. There are certain circumstances under which Fallon Health Weinberg-MLTC can disenroll you even though you have not asked us to do so. This is called an Involuntary Disenrollment.

There are certain circumstances when we are required by our contract with the New York State Department of Health to disenroll you. There are other times when, under our contract with the New York State Department of Health, we may choose to disenroll you.

We must disenroll you within five (5) business days from the date the Plan becomes aware that:

- You no longer reside in the service area (Erie and Niagara County);
- Need nursing home care, but are not eligible for institutional Medicaid;
- You have been absent from the service area for more than 30 consecutive days;
- You lose your right to receive benefits from the Medicaid program;
- You are hospitalized or enter an Office of Mental Health, OPWDD or Office of Alcohol and Substance Abuse residential program for 45 consecutive days or longer;
- You are assessed as no longer having a functional or clinical need for community-based long term care (CBLTC) services on a monthly basis;
- You have Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool;
- Are receiving Social Day Care as your only service;
- No longer require, and receive, at least one CBLTC service in each calendar month;
- You are incarcerated. The effective date of disenrollment shall be the first day of the month following incarceration; or
- You provide the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership

We may choose to disenroll you from Fallon Health Weinberg-MLTC if:

- You, your family members or other caregivers are abusive, disruptive, or uncooperative to such a degree that you jeopardize the provision of care. Fallon Health Weinberg-MLTC must make and document reasonable efforts to resolve the problems presented, and we must establish that your behavior is not related to the use of medical services or diminished mental capacity.
- You have failed to pay or make satisfactory arrangements to Fallon Health Weinberg-MLTC to pay the amount of money, as determined by the Local Department of Social Services, owed to the plan as spenddown/surplus within 30 days after the amount first becomes due. We will have made a reasonable effort to collect such amount, including making a written request for payment.

When will my disenrollment become effective?

For voluntary and involuntary disenrollment's Fallon Health Weinberg-MLTC will forward the documentation related to your disenrollment to the County Department of Social Services or the Department of Health designated entity for processing. For Medicaid recipients, the effective date of disenrollment and termination of Fallon Health Weinberg-MLTC benefits is determined by the date that notification is received in the Fallon Health Weinberg Office. Fallon Health Weinberg-MLTC will use the State's New York Medicaid Choice to determine the effective date of disenrollment. In most instances the effective date of disenrollment and termination of Fallon Health Weinberg-MLTC benefits will be the first day of the calendar month following the date that Fallon Health Weinberg-MLTC processed the disenrollment and receives notification from NY Medicaid Choice, provided the process is initiated prior to the 20th day of the month. If you continue to need community based long term care services, you be required to choose another plan or you will be automatically assigned (auto-assigned) to another plan.

Do I continue to receive service while my disenrollment is being processed?

Until your disenrollment becomes effective, we will continue to provide covered services according to your Plan of Care, and you must continue to use Fallon Health Weinberg-MLTC network providers.

Will my enrollment in the program ever end for any other reason?

Fallon Health Weinberg-MLTC has a contract with the New York State Department of Health to offer health care benefits and coordinate services. This contract is

subject to renewal on a periodic basis. If this contract is not renewed for some reason, your enrollment in the program will be terminated and assistance will be provided to secure another appropriate plan to cover benefits and coordinate your service needs.

Can I re-enroll in Fallon Health Weinberg-MLTC?

If you were involuntarily disenrolled, you may re-enroll in the program as long as the circumstances that were the basis for your disenrollment have changed.

In all cases, in order to re-enroll, you must meet the enrollment criteria at the time you wish to re-enroll and have your re-enrollment coordinated with the Department of Health designated entity (Maximus).

Do I have to pay a monthly fee to Fallon Health Weinberg-MLTC?

You do not pay anything unless the County Department of Social Services determines that you have a monthly spend down and/or surplus amount. You will have a monthly spend down and/or surplus amount if your monthly income exceeds the monthly amount of income that the Medicaid Program allows.

Fallon Health Weinberg-MLTC will send you a bill each month for the amount of your spend down and/or surplus, and you will have 30 days in which to make payment.

Can I be billed directly by a provider for covered services that have been provided to me under the plan?

Providers may not bill you directly for services provided to you. If this happens, please contact your Care Team as soon as possible and they will take care of the matter for you.

Information regarding the Members NY State Ombudsmen Service

You have the right to contact the members New York State Ombudsman Service, called ICAN (Independent Consumer Advocacy Network). This is an independent organization that provides free service for long-term care recipients in the state of New York. ICAN will answer your questions regarding Medicare, Medicaid, long-term care (for example, your home care or nursing home care) and your long-term managed care plan which is Fallon Health Weinberg-MLTC.

They can help you understand notices that you receive and other services including, but are not necessarily limited to:

- providing pre-enrollment support, such as unbiased health plan choice counseling and general program-related information,
- compiling member complaints and concerns about enrollment, access to services, and other related matters,
- helping members understand the Fair Hearing, 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, and
- Informing plans and providers about community-based resources and supports that can be linked with covered plan benefits.
- ICAN will assist anyone in a Medicaid managed care plan who needs long term care services (like home attendant, adult day care, or nursing home)
- They can assist people who are applying for Medicaid and need help enrolling in a Managed Long-Term Care (MLTC) or Medicaid Managed Care (MMC) plan.

You have the right to seek assistance from the Ombudsmen Program at any time and ICAN is able to talk with you, your friends, family members, and anyone else that is helping you with your medical decisions. You can reach ICAN to learn more about their services:

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

What are my rights as a Member?

As a Member you have the following rights:
Treatment provided with consideration, dignity, respect, and confidentiality. This treatment will be provided without discrimination.

Members have the right to:

- Receive medically necessary care
- Receive considerate, respectful and humane care from Fallon Health Weinberg-MLTC and its contractors at all times and in all circumstances.
- 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 privacy about your medical record and when you get treatment
- Not be discriminated against in the delivery of care and services based on race, ethnicity, national origin, color, religion, sex, age, sexual orientation, health status (mental or physical disability), marital status or source of payment.
- Receive care in a safe, clean and accessible environment.
- Be treated with dignity and respect with attention to privacy and confidentiality in all aspects of care.
- Not be required to perform services for Fallon Health Weinberg-MLTC
- Timely access to services.
- Freedom from harm including physical or mental abuse, neglect, corporeal punishment, involuntary seclusion, excessive medication, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the Member's medical symptoms.
- Designate a representative to exercise any, or all, of the rights to which they are entitled.
- Have all information provided in a culturally sensitive manner.
- Have information provided in a manner that is understood by the member and the member's representative and receive information in the needed language and have oral translation free of charge.
- You have the Right to appoint someone to speak for you about your care and treatment.

Have information disclosed before enrollment, at enrollment, and when there is a change in services. Disclosure must be in a manner that is accurate, easy to understand and supports informed decisions.

Members have the right to:

- Be fully informed, in writing, of the covered services provided by Fallon Health Weinberg-MLTC, including an explanation of those services provided through contract, and the procedures for obtaining needed care.
- Receive an enrollment agreement, and to have it explained in a manner that is understandable.
- Examine, or be assisted in examining, the results of the most recent review of Fallon Health Weinberg-MLTC by New York State Department of Health.
- Be informed of any changes in the organizational structure of Fallon Health Weinberg-MLTC.

Primary Care Physician

Members can choose a Primary Care Physician

Initiate disenrollment from the program at any time.

Access emergency health services when and where the need arises without prior authorization from Fallon Health Weinberg-MLTC.

- Members have the right to access emergency health care services without seeking prior approval.

Fully participate in all decisions that relate to treatment and care.

- Each Member has the right to be fully informed of his or her functional status, medical condition, and treatment options, and his or her right to participate in treatment decisions, and the development of their Plan of Care.
- You have the Right to get information necessary to give informed consent before the start of treatment.
- Members have the right to refuse medication, or any treatment. Fallon Health Weinberg-MLTC's clinical staff must inform the Member of the consequences of refusing medication, or treatment.
- Members have the right to receive an explanation of advance directives, and to establish them with the Plan's assistance if needed.
- Members have the right and are encouraged to express their opinions and participate as a member of their Care Team in the development of their Plan of Care and in the request for reassessment.
- Members have the right to expect reasonable advance written notice of any transfer to another treatment setting with a justification for the transfer.

- Members have the right to be informed of the existence and purpose of the Member Advisory Committee in which he/she is encouraged to participate.
- Members have the right to express opinions and recommend changes to policies and procedures.
- You have the Right to be told where, when and how to get the services you need from the MLTC, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.

Communication with health care providers in confidence and to have information related to his or her care protected.

- Members have the right to have access to records, upon written request and may request copies of or changes to these records.
- Members have the right to have all records and information kept confidential.

Fair and responsive process for resolving differences including a rigorous internal review of complaints and an independent external review.

- Members have the right to present their concerns directly to the specific department involved, Care Team or staff member, whenever they feel a situation warrants such attention.
- Members have the right to voice concerns to staff or outside representatives without fear of reprisal, restraint, interference, coercion or discrimination by the Fallon Health Weinberg-MLTC staff.
- Exercise rights as a Member, including using the complaint and appeals processes and to receive uninterrupted care during this process.
- Members have the right to appeal any treatment decision of Fallon Health Weinberg-MLTC or its contractors.
- Members have the right to information regarding the New York State Department of Health’s complaint procedure, including contact information.
- The right to be informed of the complaint and appeal processes.
- Members have the Right to complain to the New York State Department of Health or Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- Members have the Right to seek assistance from the Member Ombudsman program.

What are my responsibilities as a Member?

As a Member, you have the following responsibilities. You have the responsibility to:

- Communicate openly and honestly with your physician and Care Team about health and care. You are responsible to ask questions and to consider consequences of non-compliance.
- Following the plan of care recommended by the Fallon Health Weinberg-MLTC staff with your input
- Share in care decisions and continue to be in charge of your own health.
- Receive all of your covered benefits through the Fallon Health Weinberg-MLTC and the provider network
- Complete self-care as planned, keeps appointments, and inform your Care Team of any need to change appointments.
- Except for non-covered and Medicare covered services, use network providers for non-emergency situations.
- Obtain prior approval from the plan before accessing services except for podiatry, dentistry, optometry, and audiology.
- Being seen by your physician if a change in your health status occurs
- Cooperating with and being respectful with the Fallon Health Weinberg-MLTC staff and not discriminating against MLTC staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status;
- Let your Care manager know if you plan to travel out of town. They will temporarily cancel the services you are receiving in your home and community.
- Read the Member Handbook and follow procedures as outlined to receive services.
- Help Fallon Health Weinberg-MLTC staff to maintain a safe home environment.
- Notify Fallon Health Weinberg-MLTC of any change in address, personal information or financial responsibilities.
- Pay the Medicaid spend-down/surplus amount.

Is there any information that must be made available to me if I request it?

Yes there is. The following information must be disclosed to you if you make a written request for it:

- Information regarding the structure and operation of Fallon Health Weinberg-MLTC
- A copy of the most recent annual certified financial statement of the plan including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant.
- Information related to Member complaints and appeals and aggregated information about complaints and appeals.
- Procedures for protecting the confidentiality of medical records.
- Written description of our Quality Management Plan.
- Individual health practitioner affiliations with participating hospitals and other facilities.
- Provider credentialing policies
- Specific clinical review criteria relating to a particular health condition and other information that Fallon Health Weinberg considers when authorizing services;
- Written application procedures and minimum qualification requirements for health care providers to be considered by Fallon Health Weinberg-MLTC

How will Fallon Health Weinberg-MLTC protect my confidentiality?

Your Care Team and all staff members will work diligently to protect and ensure that information about you remains confidential.

Fallon Health Weinberg-MLTC will permit only legally authorized representatives to inspect and request copies of your record as you consented to at enrollment.

To further protect your privacy, all requests for information will be reviewed and authorized by the Fallon Health Weinberg-MLTC Program Director.

Only necessary information will be released to community agencies, hospitals, and long-term care facilities and only to ensure the continuity of your care. Information

will be copied or shared with these agencies only if you or your designee has signed a release that authorizes Fallon Health Weinberg-MLTC to provide medical, nursing and psychosocial information to that facility.

Any requests for information regarding your care that are received from law enforcement agencies, such as the police or district attorney's office, will be brought to the attention of the Program Director prior to providing any information to ensure that the proper authorization is obtained. Fallon Health Weinberg-MLTC will follow all federal and New York State laws regarding confidentiality, including those that relate to HIV testing results.

Quality Management

How does Fallon Health Weinberg-MLTC ensure that I receive the highest quality care?

Fallon Health Weinberg-MLTC ensures that you receive the highest quality care through our Quality Management Plan. Our Quality Management Plan manages and evaluates the quality and appropriateness of care and services, and identifies opportunities for continued improvement by ongoing assessments of:

- The quality of services provided
- The management of care including availability and continuity
- The identification and correction of operational and clinical practices and;
- The outcomes in clinical and non-clinical areas

Member Advisory Committee

Fallon Health Weinberg-MLTC has a Member Advisory Committee that meets four times per year. This Committee is made up of plan staff to include leadership, multiple providers and members/caregivers from the plan.

The purpose of this MAC is to discuss changes within the plan, updates to the provider network, problems with providers/plan and other issues raised by the committee.

If you would like to join the MAC please contact your Care Manager, social worker or our Member Services Department.

Fallon Health Website and Education

Members of Fallon Health Weinberg-MLTC will have numerous opportunities to be educated by the Care Team which include utilization of our website, 1:1 education, referrals to community education classes and when available Member Newsletters.

You can access our website at:

fallonweinberg.org

To access our Health Education areas follow the below instructions once at our web page:

- Choose “Our Plans” at the top of the page
- Choose any of the plans
- Choose at the bottom— “Resources for Caregivers”
- Scroll down to the Health Library and choose:
- “Go to the Healthwise® Knowledgebase”

Members/caregivers then can search for information on health, wellness, how to take a blood pressure etc.

Topics of education include:

- Asthma
- Immunization recommendations
- Injury Prevention
- Diabetes
- Hypertension
- Screening for Cancer
- HIV/AIDS
- Physical Fitness
- Cardiovascular Disease
- Hepatitis C

Advance Directives

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

Health Care Proxy

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

Veterans Information

It is the policy of the Fallon Health Weinberg-MLTC Program to establish, maintain support and facilitate utilization of Veteran Administration (VA) Services when available. Members can meet the criteria as below and should communicate this to the Care Team staff:

- Veteran of military service
- Spouse of a veteran
- Gold Star parent (Parent who lost son/daughter in the United States Armed Forces)

Your Care Team will coordinate services for the member including services provided under the VA system when applicable. This will include coordinating with the discharge team when a member utilizes a VA facility.

If a member is in need of long-term care services within a skilled nursing facility and requests to utilize the New York State Veterans' Home at Batavia the member will be informed that this is not in our network. Fallon Health Weinberg-MLTC will work with

the facility to accomplish the request as a non-par provider and authorize the facility provided beds are available, member meets eligibility and the facility will accept the member.

The Fallon Health Weinberg-MLTC member must meet the eligibility requirements of the facility and have entered active duty from the State of New York or be a New York State resident for one year prior to application for admission.

Other requirements are:

- The Veteran must have had an honorable discharge from the U.S. Armed Forces; and
- The Veteran must have had at least 30 days of active service;
- A spouse of an otherwise qualified Veteran, unless legally separated, may be admitted to a home if the spouse was married to an eligible Veteran for one year prior to application and requires skilled nursing care.
- A Veteran accompanied by their spouse both of whom require skilled nursing care will receive the highest priority for admission followed by “wartime” Veterans; “non-wartime” Veterans, spouses and un-remarried surviving spouses; and then Gold Star mothers and fathers.
- For a Veteran with a service connected disability rating at 70% or greater, the Department of Veterans Affairs will pay State Veterans Homes the full cost to provide skilled nursing to that Veteran

If a member chooses to contact the Skilled Nursing Facility they can be reached at:

New York State Veterans’ Home at Batavia
220 Richmond Avenue
Batavia, NY 14020
(585) 345-2049
www.nysvets.org

If a member needs to learn more about the benefits and services they may be eligible for as a Veteran, service member, or as a family member of a Veteran or service member, they can call the New York State Division of Veterans’ Affairs Help Line at 1.888.838.7697 (VETSNYS), to schedule an appointment with one of the Veterans Benefits Advisors.

Money Follows the Person/Open Doors

Service and supports are available through New York States program called *Money Follows the Person (MFP)/Open Doors. MFP/Open Doors* is a program that can help enrollees/members move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP if they:

- 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 enrollees/members in the nursing home and talk with them about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help enrollees by:

- Giving them information about services and supports in the community
- Finding services offered in the community to help enrollees live independently
- Visiting or calling enrollees/members after they move to make sure that they have what they 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.

Cultural and Linguistic competency

Fallon Health Weinberg-MLTC honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We work to 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.

Conclusion

Fallon Health Weinberg-MLTC offers you the opportunity to live safely and independently in the comfort of your own home. A team of health care professionals will work closely with you and your Primary Care Physician in developing a Plan of Care designed especially to meet your health care needs.

If you have any questions about Fallon Health Weinberg-MLTC or any questions about this Member Handbook, please call the number listed below. A Fallon Health Weinberg-MLTC Care Team or staff member will be able to help you.

1-866-882-8185 (toll free)
1-716-250-3100
(TTY users call 711)
fallonweinberg.org

Definitions

Action – An activity of a Contractor or its subcontractor that results in a denial or limited authorization of a requested service (including the type or level of service); a restriction, reduction, suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; determination that a requested service is not a covered benefit (does not include requests for services that are paid for fee-for-service outside the plan); or failure to act within the timeframes for resolution and notification of determinations regarding complaints, appeals, and complaint appeals, as provided in the applicable law.

Adult Day Health Care – Sometimes referred to as Medical Day, is care and service provided in a residential health 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 planned
- Dental pharmaceutical
- Ancillary services

Appeal – Request for a review of an action taken

Applicant – An applicant is an individual who has expressed a desire to pursue enrollment in a MLTC.

Audiology/hearing aids – Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.

Benefit package – Medical and health related services identified which members are entitled to receive. Also known as Covered Services.

Care Plan – Sometimes referred to as Plan of Care, is a written description in the care management record of member specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to a member in order to achieve such goals. The care plan is based on assessment of the members health care needs and developed in consultation with the member and his/her informal supports. Effectiveness of the care plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which inter-relate with the covered services identified on the care plan and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the care plan or elsewhere in the Clinical electronic Record.

Care Management – A process that assists members to access necessary covered services identified in the care plan. It also provides referral and coordination of other services in support of the care plan. Care management services will assist members to obtain needed medical, social, educational, psychosocial, financial and other services in support of the care plan irrespective of whether the needed services are covered benefits under FHW MLTC.

CMS – U.S. Centers for Medicare and Medicaid Services

Community Based Long Term Care Services (CBLTCS) – health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. CBLTCS is comprised of services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, Personal Care Services.

Consumer Directed Personal Assistance Services (CDPAS) – Personal care services, home health aide services or skilled nursing tasks received by a consumer directed personal assistant under the instruction, supervision and direction of you or your designated representative. You may request a consumer directed personal assistant at the time of enrollment, assessment or reassessment or when in receipt of personal care, home care or skilled nursing services. CDPAS is intended to permit chronically ill or physically disabled individuals greater flexibility and freedom of choice in getting such services.

DHHS – Department of Health and Human Services of the United States

Durable Medical Equipment (DME) – Medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula and hearing aid batteries. DME are devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition and which have the following characteristics:

- Can withstand repeated use for a protracted period of time
- Are primarily and customarily used for medical purposes
- Are generally not useful in the absence of an illness or injury
- Are not usually fitted, designed or fashioned for a particular individuals use
- Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and devices, DME or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value
- Prosthetic appliances and devices are appliances and devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body
- Orthopedic footwear are shoes, shoe modification or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.
- 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
    a. Individuals who are fed via nasogastric, jejunostomy, or gastrostomy tubes
    b. Individuals with rare inborn metabolic disorders

Emergency Transportation – Transportation by ambulance as a result of an emergency condition

Home health aide – (HHA) a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to an Enrollee with health care needs in his home. This is a higher level aid than a Personal Care Aid. This service usually requires that other skilled service, i.e. RN, PT are involved in the Plan of Care.

Hospice – a coordinated program of home and inpatient care that provides non-curative medical and support services for persons certified by a physician to be terminally-ill with a life expectancy of twelve (12) months or less. Hospice programs provide patients and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement. Hospices are organizations that must be certified under PHL Article 40. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangement to the extent permitted by federal and state requirements. All services must be provided according to a written Plan of Care that reflects the changing needs of the patient/family.

Institutional Long-Term Services and Supports (ITLSS) – Residential Health Care Facility (Nursing Home) services as included in the Benefit Package when medically necessary.

LDSS – Local Department of Social Services (sometimes referred to as DSS)

Long Term Placement (Permanent Placement) Status – means the status of an individual in a Residential Health Care Facility (RHCF) when the entity designated by the State determines that the individual is not expected to return home based on medical evidence affirming the individual's need for long term (permanent) RHCF placement.

MCO – Managed Care Organization

Meals – Home delivered and congregate meals provided in accordance with each individual member's Plan of Care

Medically Necessary – Necessary to prevent, diagnose, correct or cure conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere with such members capacity for normal activity, or threaten some significant handicap.

Medical social services – assessing the need for, arranging for and providing aid for social problems related to the maintenance of a patient in the home where such services are performed by a qualified social worker and provided within a Plan of Care. These services must be provided by a qualified social worker

NAMI – The amount of net available monthly income determined by the Department that a nursing home resident must pay monthly to FHW MLTC in accordance with the requirements of the medical assistance program.

New York State of Health (NYSoH) – an office located within the New York State Department of Health that functions as the state's official health insurance marketplace. The NYSoH was established in accordance with the Patient Protection and Affordable Care Act of 2010. NYSoH provides a web portal through which individuals may apply for and enroll in Medicaid and other government sponsored health insurance, or purchase standardized health insurance that is eligible for federal subsidies.

Nursing Services – Intermittent, part time and continuous nursing services provided in accordance with an ordering physicians treatment plan as outlined in the physicians recommendation. Nursing services must be provided by RNs and LPNs in accordance with the Nurse Practice Act. Nursing services include care rendered directly to the individual and instructions to his/her family or caretaker in the procedures necessary for the patients treatment or maintenance.

Nutrition – the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake within the patient's home environment and cultural considerations, nutritional education regarding therapeutic diets as part of the treatment milieu, development of a nutritional treatment plan, regular evaluation and revision of nutritional plans, provision of in-service education to health agency staff as well as consultation on a specific dietary problems of patients and nutrition teaching to patients and families. These services must be provided by a qualified nutritionist.

Occupational Therapy (OT) – Rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration or the member to his/her best functional level.

Medicaid coverage of OT provided in a setting other than a home is limited to 20 visits per calendar year, although this can be increased under the direction/approval by the care manager/team.

Ophthalmic Dispenser – Fills a prescription of an optometrist or ophthalmologist and supplies eyeglasses or other vision aids upon the order of a qualified practitioner. Coverage includes the replacement of lost or destroyed eyeglasses. The replacement of a complete pair of eyeglasses should duplicate the original prescription and frames. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts should duplicate the original prescription and frames. Repairs to and replacement of frames and/or lenses must be rendered as needed. Eyeglasses do not require changing more frequently than every two years unless medically indicated, such as a change in correction greater than ½ diopter, or unless the glasses are lost, damage or destroyed.

Optometry – Services of an optometrist and an ophthalmic dispenser, and includes eyeglasses; medical necessary contact lenses and polycarbonate lenses, artificial eyes and low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the members condition. Examinations which include refraction are limited to every two years unless otherwise justified. If FHW MLTC does not provide upgraded eyeglass frames or additional features (such as scratch coating, progressive lenses or photo-gray lenses) as part of the vision benefit, FHW MLTC cannot apply the cost of its covered eyeglass benefit to the total cost of the eyeglasses the member wants and bill the difference to the member. Example: If FHW MLTC covers only standard bifocal lenses and the member wants no-line bifocal lenses, the member must choose between taking the standard bifocal or paying the full price of the no-line bifocal lenses (not just the difference between the cost of the bifocal lenses and the no-line lenses). The member may pay for upgraded lenses as a private customer and FHW MLTC pay for the frames or member may choose upgrade frames and pay privately. Members must be informed of this by the vision provider at the time that the glasses are ordered.

Participating Provider (Par Provider) – A provider of care and/or services than has an executed contracted provider agreement with FHW MLTC.

Personal Emergency Response System (PERS) – An electronic device which enables certain high risk members to secure help in the event of a physical, emotional or environmental emergency.

Personal care – some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care must be medically necessary, ordered by the Enrollee's physician and provided by a qualified person, in accordance with a Plan of Care. Many times referred to as PCA.

Person Centered Service Plan (or Plan of Care) – a written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to an Enrollee in order to achieve such goals. The person-centered individual service plan is based on assessment of the member's health care needs and developed in consultation with the member and his/her informal supports. The plan includes consideration of the current and unique psycho-social and medical needs and history of the Enrollee, as well as the person's functional level and support systems. Effectiveness of the person-centered service plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which interrelate with the covered services identified on the plan and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the person-centered service plan or elsewhere in the care management record.

Physical Therapy (PT) – Rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration or the member to his/her best functional level. Medicaid coverage of PT provided in a setting other than a home is limited to 20 visits per calendar year, although this can be increased under the direction/approval by the care manager/team.

Podiatry – Services by a podiatrist which must include routine foot care when the members physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet is not covered in the absence of pathological condition.

Potential Enrollee – A Medicaid recipient who is eligible to voluntarily elect to enroll in a managed long term care plan, but is not yet an Enrollee of the managed long term care plan.

Private duty nursing services – are medically necessary services provided to Enrollees at their permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies (CHHAs).

Provider – A person or entity with whom Fallon Health Weinberg-MLTC has entered into a written Provider Contract

Respiratory therapy – the performance of preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel. These services must be provided by a qualified respiratory therapist

Same Day Complaint – A complaint that is resolved by Fallon Health Weinberg-MLTC to the satisfaction of the member/caregiver the same day the complaint is lodged.

Social and Environmental Supports – Services and items that support the medical needs of the member and are included in the members Plan of Care. These services and items include but are not limited to the following:

- Home maintenance tasks
- Homemaker/chore services
- Housing improvement
- Respite care

Social day care – is a structured program which provides functionally impaired individuals with socialization; supervision and monitoring; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.

Social services – Information, referral, and assistance with obtaining or maintain benefits which include financial assistance, medical assistance, food stamps, or other support programs provided by the LDSS, Social Security Administration, and other sources. Social services also involves providing supports and addressing problems in a members living environment and daily activities to assist the member to remain in the community.

Speech-language Pathology (ST) – Rehabilitation services provided by a licensed and registered speech-language pathologist for the purpose of maximum reduction of physical or mental disability and restoration or the member to his/her best functional level. Medicaid coverage of ST provided in a setting other than a home is limited to 20 visits per calendar year, although this can be increased under the direction/approval by the care manager/team

Surplus amounts – shall mean the amount of medical expenses the Department determines a “medically needy” individual must incur in any period in order to be eligible for medical assistance (as currently described in 18 NYCRR 360-4.8). Surplus amounts are also referred to as a spenddown.

Transportation – Transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the members condition for the member to obtain necessary medical care and services as directed under the member’s Plan of Care. Ambulette vendors must be approved providers under NY state Medicaid.

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