



VNS Health MLTC Member Handbook



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Welcome to VNS Health MLTC Managed Long Term Care Plan

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

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

Help From Your Care Team

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

There is someone from your Care Team to help you:
1-888-867-6555 (TTY: 711)

You can get important information about the program in the language you understand best. Please call us if you need this document in another language or other formats, such as large print, braille, or audio. You can get this information for free.

Eligibility for Enrollment in the MLTC Plan

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

- 1) Are age **18** and older,
- 2) Reside in the plan's service area which is Albany, Allegany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Dutchess, Erie, Fulton, Genesee, Greene, Herkimer, Kings (Brooklyn), Livingston, Madison, Monroe, Montgomery, Nassau, New York (Manhattan), Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming and Yates.

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- 3) Have Medicaid,
- 4) Have Medicaid only or are age 18-20 with both Medicaid and Medicare **and** are eligible for nursing home level of care,
- 5) Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, **and**
- 6) Need at least one of the following Community Based Long Term Services and Supports (CBLTSS) for a continuous period of more than 120 days from the date of enrollment, as well as the Minimum Needs Requirements listed below:
 - Community Based Long Term Services (CBLTSS):
 - Nursing services in the home
 - Therapies in the home
 - Home health aide services
 - Personal care services in the home
 - Adult day health care,
 - Private duty nursing; or
 - Consumer Directed Personal Assistance Services
 - Minimum Needs Requirements:
 - at least limited assistance with physical maneuvering with more than two activities of daily living (ADLs); or
 - individuals with a Dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one ADL

Note: Individuals enrolled in the MLTC program prior to September 1, 2025, will be granted MLTC Plan Legacy status and be assessed under previous criteria as long as they remain continuously enrolled. Individuals with MLTC Plan Legacy status will not be required to meet the Minimum Needs Requirements during reassessment.

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

New York Independent Assessor Program - Initial Assessment Process

Effective May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) is now known as the New York Independent Assessor Program

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(NYIAP). The NYIAP will manage the initial assessment process. NYIAP will start the expedited initial assessments at a later date. The initial assessment process includes completing the:

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

The NYIAP 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 NYIAP will complete a clinical appointment and PO a few days later.

VNS Health 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 NYIAP 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 VNS Health MLTC about whether the plan of care meets your needs.

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

Enrollment Process

A member of the Care Team will assist with scheduling an appointment with the enrollee in their home at a time that is convenient for them. The assessment nurse will use the NYIAP Community Health Assessment along with this visit to develop an initial Person Centered Service Plan (PCSP). Some assessments may be done via telehealth if an in-person visit is not possible.

The assessment nurse will ask the enrollee to sign an Authorization for Release of Health Information (a New York State Department of Health form) pursuant to

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HIPAA regulations. This will allow the plan to obtain information, input from doctors, and other health care providers. This information will give us important details about the enrollee's health needs so that we can provide the services that are best suited for them. We will protect the enrollee's confidential health information to the full extent of the law. During the assessment, Advanced Directives will be reviewed with the enrollee. Advance directives tell others what medical decisions to make if an enrollee cannot. Enrollee's may also name someone to speak on their behalf (called an agent). We feel advance directives are an important part of making sure that health care decisions reflect an enrollee's true wishes.

The complete assessment may take more than one home or telehealth visit to complete. During these visits, the assessment nurse will talk with the enrollee and their family about the program to make sure everyone understands how the plan works. This Member Handbook and the Provider Directory will be provided, and the plan's policies and procedures will be reviewed.

The assessment nurse and the care manager will also work with the enrollee, their family and health care professionals, to develop a PCSP to meet their needs and considers their cultural and beliefs as much as possible. The PCSP will be mailed to the enrollee and will include the services they will receive once they are a member of VNS Health MLTC for the period of time outlined in the plan. The enrollee will be asked to sign and return a copy to the plan. If their condition changes, their Care Team will work with them and their primary care provider (PCP) to modify the PCSP to continue to meet their long term care needs.

Enrollment in VNS Health MLTC is voluntary. The assessment nurse will ask the enrollee to sign an enrollment agreement. If after signing the enrollment agreement, they choose not to enroll in the program, the enrollee can withdraw it by noon on the 20th day of the month prior to the effective date of their enrollment. The enrollee must call us or contact us in writing. We will send an acknowledgment in writing confirming their withdrawal.

Medicaid must verify an enrollee's Medicaid eligibility prior to enrollment in VNS Health MLTC. After you signs the enrollment agreement, we will send your information to New York Medicaid Choice. The enrollment is official when it's confirmed by New York Medicaid Choice. In most cases, you will become a member of VNS Health MLTC on the first day of the month after the enrollment agreement is signed. We will confirm the actual enrollment effective date by telephone, usually a few days before plan membership begins. Your care manager will ensure that you get all the services that are outlined in your PCSP.

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Denial of Coverage

In addition to not meeting the criteria listed under the **Eligibility for Enrollment in the MLTC Plan**, your enrollment in the plan would be denied if:

- You are currently receiving care in a hospital or residential facility operated by the State Office of Mental Health, the Office of Alcoholism and Substance Abuse Services or the Office for People with Developmental Disabilities (OPWDD). Please note, an application to enroll in VNS Health MLTC may be accepted, but your enrollment may only begin upon discharge to your home in the community.
- You are currently enrolled in another Medicaid managed care program, a Day Treatment program sponsored by the OPWDD, or a Hospice program. If you terminate your participation in these programs, you can then be considered for enrollment in the plan.
- You were **involuntarily** disenrolled from the plan in the past, and the situation that led to your disenrollment has not been resolved.

Plan Member (ID) Card

You will receive your VNS Health MLTC identification (ID) card within 30 days of your enrollment effective date. Please verify that information on your card is correct. We encourage you to keep it with your Medicaid card so it is handy when you need it. If your card becomes lost or is stolen, please contact your Care Team or request a replacement through your online account, <http://vnshealthplans.org/account>. You can also download a temporary ID card from your online account.

Services Covered by VNS Health MLTC Plan

Care Management Services

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

Who is part of my Care Team?

- **Assessment nurse:** The first person you meet when you enroll is your assessment nurse. The assessment nurse will come to your home every

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12 months to talk to you and make sure that your health care needs are still being met and will share that information with your care manager.

- **Care manager:** Your care manager is the “captain” of your Care Team who:
 - Is a registered nurse or licensed social worker who coordinates everything involved in your Person Centered Service Plan (PCSP).
 - Is experienced in caring for people with long-term care needs.
 - Ensures that all of your health care and long-term care services are coordinated with all your health care professionals.
 - Arranges for services not covered by VNS Health MLTC, but is paid for by Medicare, Medicaid, or other insurance.

Your care manager will:

- ✓ Talk to you about your needs and preferences.
 - ✓ Work with you to develop a PCSP that meets your needs.
 - ✓ Coordinate with your other health care professionals (i.e., primary care physician, specialists, social workers and therapists) to make sure you receive the services you need.
 - ✓ Coordinate everything involved in your PCSP Plan.
 - Your PCSP is updated periodically, based on a comprehensive assessment of your health needs and upon a change in your condition. You play an important part in this process. If you feel you need a service that is covered by the plan, but is not in your PCSP, please talk to your care manager.
- **Social Worker:** The social worker can provide guidance and support with concerns that may be affecting your wellbeing. They can help connect you with public benefits, community-based resources and support services. Let your care manager know if you would like to speak with a social worker.

Your Care Team is just a phone call away when you need services, wish to request changes in your PCSP, or if you encounter any problems. They are here to help.

After Hour Care

If you need help after hours, on a weekend, or over a holiday, one of the registered nurses in our special after-hours unit will help you. Please call your Care Team, you will automatically be forwarded to a nurse in the after-hours

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unit.

These specially trained nurses will answer your questions regarding your medical condition. If they feel your condition is an emergency, they will be sure you get help as quickly as possible. They can also refer you to a hospital, contact your doctor and care manager, and follow up if there is a problem with an in-home provider or service.

Additional Covered Services

Because you have Medicaid and qualify for MLTC, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in VNS Health MLTC network. If you cannot find a provider in our plan, we will cover services you get from providers who are not part of the plan's network in the following scenarios:

- If you need medical care that Medicaid requires the plan to cover and the providers in the plan's network cannot provide this care, you must get a prior authorization from the plan before getting care from an out-of-network provider.
- If you are a new member and you are receiving long term care service from Medicaid. We will continue to cover these services from an out-of-network provider for at least 90 days after enrollment.

• Outpatient Rehabilitation

- **Physical Therapy** – covers evaluation and treatment for injuries and diseases that change your ability to function, or to maintain current function or slow decline, when your doctor or other health care provider certifies your need for it. Prior authorization may be required.
- **Occupational Therapy** – covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) to maintain current capabilities or slow decline when your doctor or other health care provider certifies you need it. Prior authorization may be required.
- **Speech Therapy** – covers evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, or to maintain current function or slow decline, when your doctor or other health care provider certifies you need it. Prior authorization may be required.

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- **Personal Care** (such as assistance with bathing, eating, dressing, toileting and walking) – We will coordinate the provision of personal care to help you with such activities as personal hygiene, dressing and eating, and home-environment support. Personal care services must be medically necessary. Prior authorization is required.
- **Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical and speech therapies. We coordinate the provision of home care services including care from nurses, social workers, physical therapists, occupational therapists and speech therapists. These services are provided to help maintain, rehabilitate, guide and/or support your health. The staff provide these services based on your Person Centered Service Plan (PCSP), and all services are provided in your home. Prior authorization is required.
- **Nutrition** – We can provide nutrition services from a registered dietitian who will assess your dietary needs and make recommendations to ensure that your diet is consistent with your health and personal needs. Prior authorization is required.
- **Medical Social Services** – Medically necessary assessment, arranging and providing aid for social problems related to maintaining an individual at home. Prior authorization is required.
- **Home Delivered Meals and/or meals in a group setting such as a day care** – We can provide you with home-delivered or congregate meals provided in accordance with your plan of care. Typically, one or two meals are provided per day for individuals who are unable to prepare meals and who do not have personal care services to assist with meal preparation. Prior authorization is required.
- **Social Day Care** – Social day care is a structured program that provides you with socialization, personal care and nutrition in a protective setting. You may also receive services such as enhancement of daily living skills, transportation, and caregiver assistance. If interested, your care manager can arrange for you to attend a social day care facility. Prior authorization is required.
- **Private Duty Nursing** – Continuous skilled nursing care is provided in your home by licensed registered professional or licensed practical nurses. Prior authorization may be required.

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- **Dental** – You can receive **preventive and basic dental care services** from any dentist listed in your Provider Directory without prior approval. You do not need an authorization to see your in-network dentist for a check-up twice a year and basic dental services. We cover crowns and root canals in certain circumstances so that you can keep more natural teeth. In addition, replacement dentures and implants will only need a recommendation from your dentist to determine if they are necessary. If you need a more complex dental service, it will require authorization in advance. Your dentist will obtain these authorizations for you. We can help you select a dentist, and/or schedule an appointment.
- **Social/Environmental Supports** (such as chore services, home modifications or respite) – In the event you require it, we can provide you with social and environmental support 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, pest control, housing modifications to improve your safety, and respite care. Prior authorization is required.
- **Personal Emergency Response System** – PERS is an electronic device that enables members to secure help in the event of an emergency (including a physical, emotional or environmental emergency). Such systems are usually connected to a member’s phone and deliver a signal to a response center once a “help” button is activated. In the event of an emergency, the signal is received and appropriately acted on by our contracted response center. Prior authorization is required.
- **Adult Day Health Care** – We can arrange for you to receive adult day health care in a residential health care facility or state-approved site supervised by a physician. The services provided at adult day health care include medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities, dental, pharmaceutical, and other services. You must not be homebound and must require certain preventive or therapeutic services to attend an Adult Day Health Care center. Prior authorization is required.
- **Nursing Home Care not covered by Medicare (provided you are eligible for institutional Medicaid)** – Although we do our best to meet your needs at home, there may be times when it is more appropriate for you to receive care in a nursing home. Admission to one of our participating nursing homes is made on an individual basis. The decision to receive care in a nursing home must be made by you, your doctor, your family, and your care manager. There are two types of nursing home stays. They are short-term or

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rehabilitation stays following hospitalization and long-term stays for ongoing care. No prior hospital stay is required.

- **Audiology/Hearing Aid** – Medicaid hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts. Prior authorization is required.
- **Durable Medical Equipment (DME)** – Medicaid covered durable medical equipment, including devices and equipment other than prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use. DME must be ordered by a qualified practitioner. Medical/surgical supplies, enteral/parenteral formulas and supplements, and hearing aid batteries must be ordered by a qualified practitioner. Prior authorization may be required for certain items.
- **Medical Supplies** – Items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment, or orthopedic footwear which have been ordered by a practitioner in the treatment of a specific medical condition and which are usually: consumable, non-reusable, disposable, for a specific rather than incidental purpose, and generally have no salvageable value. Prior authorization is required.
- **Prosthetics and Orthotics** – Prosthetics are appliances and devices that replace any missing part of the body. Orthotics are appliances and devices used to support, align, prevent, or correct the function of movable part of the body. Prior authorization is required.
- **Optometry/Eyeglasses** – Optometry includes the services of an optometrist and an ophthalmic dispenser. You may receive one routine eye exam without prior approval every two years at a vision provider listed in your Provider Directory. Prior authorization may be required for certain services.
- **Consumer Directed Personal Assistance Services (CDPAS)** is a self-directed home care model available to Medicaid eligible consumers who are

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chronically ill or physically disabled and in need of home care services. Consumers who are in need of personal care, home health aide and/or skilled nursing services may receive these services from a consumer directed personal care assistant under the direction of the enrollee or enrollee's designated representative. Your care manager can help determine the level of assistance with personal care services, home health aide services and/or skilled nursing services you are eligible to receive. To find out more about CDPAS and determine if it is right for you, please speak with your care manager. Prior authorization is required.

- **Podiatry** – Diagnosis and the medical or surgical treatment of injuries and diseases of the feet. Routine foot care for members with certain medical conditions affecting the lower limbs. Prior authorization is required.
- **Respiratory Therapy** – Preventive care and treatment of heart and lung disorders. Prior authorization is required.

Limitations

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

1. tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube;
2. individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means; **and**
3. under certain conditions, adults who have HIV, AIDS, or HIV-related illness, or other disease or condition, may be eligible for additional oral nutrition.

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

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

Getting Care outside the Service Area

You must inform your care manager when you travel outside your coverage

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area. Should you find yourself in need of services outside your coverage area, your Care Manager should be contacted to assist you in arranging services.

Emergency Service

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

If you are hospitalized, a family member or other caregiver should contact VNS Health MLTC 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 VNS Health MLTC so that we may work with them to plan your care upon discharge from the hospital.

Health Related Social Needs (HRSN) Screening and Services

As of **January 1, 2025**, you can receive screenings and referrals to existing local, state and federal services through regional Social Care Networks (SCNs). If you are eligible, these local groups can connect you to services in your community that help with housing, transportation, education, employment, and care management at no cost to you.

- After screening through this SCN, you and any interested member(s) in your household can meet with a Social Care Navigator who can confirm eligibility for services that can help with individual health and well-being. They may ask you or members in your household for supporting documentation to determine where extra support may be needed.
- If you or any member(s) in your household qualify for services, the Social Care Navigator can work with you to get the support needed. You may qualify for more than one service, depending on individual eligibility. These services include:
 - Housing and utilities support:
 - Installing home modifications like ramps, handrails, grab bars, pathways, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, and non-skid surfaces to make your home accessible and safe.
 - Mold, pest remediation, and asthma remediation services.

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- Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
- Providing small refrigeration units needed for medical treatment.
- Helping you find and apply for safe and stable housing in the community which may include assistance with rent and utilities.

NOTE: Some housing services may be covered by your plan. Therefore, some housing services will require coordination between the Social Care Navigator and your health plan’s care manager.

- Transportation services:
 - Helping you with access to public or private transportation to places approved by the SCN such as going to a job interview, parenting classes, housing court to prevent eviction, local farmers’ markets, and city or state department offices to obtain important documents
- Care management services:
 - Getting help with finding a job or job training program, applying for public benefits, managing your finances, and more.
 - Getting connected to services like childcare, counseling, crisis intervention, health homes program, and more.

Getting in Contact with an SCN in your area:

1. You may call us at 1-888-867-6555 (TTY: 711) and we will connect you to a SCN in your area.
2. You may call the SCN within your county and request a screening or more information. See the SCN contact information in the chart below.
3. You may also visit their website to begin a self-screening.

Once connected with the SCN, a Social Care Navigator will confirm your eligibility by asking questions, requesting supporting documentation (if necessary), tell you more about eligible services, and help you get connected to them.

SCN	Counties	Phone number
Public Health Solutions	Manhattan, Queens, Brooklyn	888-755-5045
	https://www.wholeyou.nyc/	
Health Equity Alliance of Long Island	Nassau, Suffolk	516-505-4434
	https://healiny.org/	

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SCN	Counties	Phone number
Somos Healthcare Providers, Inc.	Bronx	833-SOMOSNY (833-766-6769)
	https://www.somoscommunitycare.org/social-care-network/	
Staten Island Performing Provider System	Richmond	917-830-1140
	https://statenislandpps.org/social-care-network/	
Hudson Valley Care Coalition, Inc.	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	800-768-5080
	https://hudsonvalleycare.org/services/hudson-valleys-social-care-network/	
Healthy Alliance Foundation Inc.	Albany, Columbia, Greene, Rensselaer, Montgomery, Saratoga, Schenectady, Schoharie	518-520-3211
	Cortland, Herkimer, Madison, Oneida, Onondaga, Oswego	315-505-2290
	Fulton, Warren, Washington	518-656-8312
	https://www.healthyalliance.org/member/	
Forward Leading IPA	Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates	315-264-9991
	https://forwardleadingipa.org/welinkcare	
Care Compass Collaborative	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins	607-352-5264
	https://carecompasscollaborative.org/social-care-network/	
Western New York Integrated Care Collaborative Inc.	Cattaraugus, Chautauqua, Erie, Niagara	716-431-5100
	https://wnyscn.org/	

Transitional Care Procedures

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

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

Money Follows the Person (MFP)/Open Doors

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

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

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

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

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

Medicaid Services Not Covered by Our Plan

There are some Medicaid services that VNS Health MLTC 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 your Care Team at 1-888-867-6555 (TTY: 711) if you have a question about whether a benefit is covered by VNS Health MLTC or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Non-Emergency Medical Transportation Services

This service will be arranged by the New York State Department of Health Statewide Transportation Broker, known as Medical Answering Services (MAS).

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
Monday – Friday, 9 am – 5 pm

To arrange non-emergency medical transportation, you or your provider must contact MAS at <https://www.medanswering.com/> or call 844-666-6270 (Downstate) or 866-932-7740 (Upstate), Monday – Friday, 7 am – 6 pm. If possible, you or your medical provider should contact MAS at least three days before your medical appointment and provide the details of your appointment (date, time, address, and name of provider) and your Medicaid identification number.

To learn more about these services, visit Department of Health Transportation Webpage:
www.health.ny.gov/health_care/medicaid/members/medtrans_overview.htm.

Pharmacy

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

Certain Mental Health Services, including:

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

Certain Intellectual and Developmental Disabilities Services, including:

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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Other Medicaid Services including:

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

Services Not Covered by VNS Health MLTC or Medicaid

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

If you have any questions, call your Care Team at the number below.

Service Authorizations, Actions and Action Appeals

When you ask for approval of a treatment or service, it is called a **service authorization request**. To submit a service authorization request, you or your provider must call our toll-free number at 1-888-867-6555 or send your request in writing to:

VNS Health MLTC
Health Plans - Medical Management Department
220 East 42nd Street
New York, NY 10017

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

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from VNS Health MLTC before you receive them or in order to be able to continue

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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receiving them. You or someone you trust can ask for this.

Requests for new or additional covered services may be obtained through your Care Team by you, your designated representative, or your provider. Requests can be made verbally or in writing. In some cases, you may need a referral or an order from your doctor to obtain these services. Your Care Team will assist you in obtaining authorization for covered services requiring prior authorization and any required documentation, if needed. The following treatments and services must be approved **before** you get them:

- Personal Care
- Home Health Care Services
- Nutrition
- Medical Social Services
- Home Delivered Meals and/or meals in a group setting such as a day care
- Social Day Care
- Private Duty Nursing
- Social/Environmental Supports
- Personal Emergency Response System (PERS)
- Adult Day Health Care
- Nursing Home Care not covered by Medicare
- Audiology
- Durable Medical Equipment (DME)
- Medical Supplies
- Prosthetics and Orthotics
- Consumer Directed Personal Assistance Services (CDPAS)
- Podiatry
- Respiratory Therapy

Concurrent Review

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

Retrospective Review

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
Monday – Friday, 9 am – 5 pm

What happens after we get your service authorization request?

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

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

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

Timeframes for prior authorization requests

- **Standard review:** We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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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 1-888-867-6555 (TTY: 711) 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?** Which explains how to make an appeal if you do not agree with our decision.

What is an Action?

When VNS Health 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

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that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the involved issues of medical necessity or whether the treatment or service in question was experimental or investigational; **and**
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

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

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

If we are reducing, suspending, or terminating an authorized service the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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suspending or terminating and authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 1-888-867-6555 (TTY: 711) or writing to:

VNS Health
Health Plans – Grievance & Appeals
PO Box 445
Elmsford, NY 10523

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

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

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

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

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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person and in writing. We will also send you your records that are part of the appeal review.

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

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

Fast Track Appeal Process

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

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

If the Plan Denies My Appeal, What Can I Do?

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

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

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under **“How Long Will It Take the Plan to Decide My Appeal of an Action?”** above, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice.

If we are reducing, suspending or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

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

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

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

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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- Request by Telephone:

Standard Fair Hearing line – 1 (800) 342-3334

Emergency Fair Hearing line – 1 (800) 205-0110

TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:

New York City

14 Boerum Place, 1st Floor

Brooklyn, New York 11201

Albany

40 North Pearl Street, 15th Floor

Albany, New York 12243

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

otda.ny.gov/hearings/request

State External Appeals

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

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

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

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called a fast track external appeal. The external appeal reviewer will decide a fast track appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)

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Complaints and Complaint Appeals

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

There will be no change in your services or the way you are treated by VNS Health 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: 1-888-867-6555 (TTY: 711) or write to:

VNS Health
Health Plans – Grievance & Appeals
PO Box 445
Elmsford, NY 10523

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

What is a Complaint?

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

The Complaint Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process must be completed within 7 days of the receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review

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period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

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

How do I Appeal a Complaint Decision?

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

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

Participant Ombudsman

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

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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Disenrollment from VNS Health MLTC Plan

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

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

Voluntary Disenrollment

You can ask to leave the VNS Health MLTC plan at any time for any reason.

To request disenrollment, call 1-888-867-6555 or you can write to us. The plan will provide you with written confirmation of your request. We will include a voluntary disenrollment form for you to sign and send back to us. It could take up to six weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require CBLTSS, like personal care, you must join another MLTC plan, Medicaid Managed Care plan or Home and Community Based Waiver program, in order to receive CBLTSS.

Transfers

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

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving VNS Health 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.

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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To change plans: Call New York Medicaid Choice at 1-888-401-6582. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. VNS Health 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 VNS Health MLTC.

Involuntary Disenrollment

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

You Will Have to Leave VNS Health MLTC if you are:

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

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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- Incarcerated.
- Providing the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

We Can Ask You to Leave VNS Health MLTC if you:

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

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

Cultural and Linguistic Competency

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

Member Rights and Responsibilities

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

Member Rights

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.

Questions? Call your Care Team: 1-888-867-6555 (TTY: 711)
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- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the Right to get information in a language you understand; you can get oral translation services free of charge.
- You have the Right to get information necessary to give informed consent before the start of treatment.
- You have the Right to be treated with respect and dignity.
- You have the Right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the Right to take part in decisions about your health care, including the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the Right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the Right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services.
- You have the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

- Receiving covered services through VNS Health MLTC.
- Using VNS Health MLTC network providers for covered services to the extent network providers are available.

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

Advance Directives

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

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

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your Care Manager.

Information Available on Request

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

Electronic Notice Option

VNS Health MLTC and our vendors can send you notices about service authorizations, plan appeals, complaints and complaint appeals electronically, instead of by phone or mail. We can also send you communications about your member handbook, our provider directory, and changes to Medicaid managed care benefits electronically, instead of by mail.

We can send you these notices by emailing you when a notice is available on the portal. The email will have a link that will take you to the portal. From there, you can log in and see your notices. To use this option, you will need access to the internet, a web browser and access to your email.

If you want to get these notices electronically, you must ask us. To ask for electronic notices contact us by phone, online, or mail:

Phone 1-888-867-6555 (TTY: 711)
Online memberdocs.vnshealthplans.org
Mail VNS Health
Health Plans – Electronic Notice
PO Box 18023
Hauppauge, NY 11788

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When you contact us, you must:

- Tell us how you want to get notices that are normally sent by mail,
- Tell us how you want to get notices that are normally made by phone call, and
- Give us your contact information (mobile phone number, email address, fax number, etc.).

VNS Health MLTC will let you know by mail that you have asked to get notices electronically.

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