healthfirst®
Health Insurance for New Yorkers

2025
Senior Health Partners
Member Handbook

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Welcome To Healthfirst's Senior Health Partners Managed Long Term Care Plan!

Welcome to Senior Health Partners Managed Long Term Care (MLTC) plan. The MLTC plan is specifically 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.

Senior Health Partners is a Healthfirst plan. Healthfirst is New York's largest not-for-profit health insurer. We have been offering affordable plans to New Yorkers for 30 years.

As a Senior Health Partners member, you will get services from providers who are in-network. The plan and your providers will help you stay in your home for as long as possible. You can access the Provider Directory at **healthfirst.org/find-a-doctor** or by calling Member Services and asking for a directory to be mailed to you.

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

Help From Member Services

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

There is someone to help you at Member Services:

Call 1-800-633-9717

For TTY, 1-888-542-3821 for English; 1-888-867-4132 for Spanish

Important Senior Health Partners Phone Numbers	
Care Team	1-800-633-9717
Quality Management Department	1-800-633-9717
Enrollment Unit	1-866-585-9280
Other Important Phone Numbers	
EyeMed (Vision Services)	TOLL FREE: 1-844-844-0883 Monday to Friday, 8am–6pm
DentaQuest (Dental Services)	1-800-508-2047 Monday to Friday, 8am–6pm
Independent Consumer Advocacy Network (ICAN)	1-844-614-8800
New York Medicaid Choice	1-888-401-6582
New York State Department of Health	1-866-712-7197
NYC Human Resources Administration	1-718-557-1399
NY Connects: Your Link to Long Term Services and Supports | Office for the Aging	800-342-9871
Westchester County Dept. of Social Services*	1-914-995-5000

*General Information for City Offices number

The State of New York has created a Participant Ombudsman Program called the Independent Consumer Advocacy Network (ICAN) to provide Participants/Members free, confidential assistance on any services offered by Healthfirst Health Plan, Inc. ICAN may be reached toll-free at 1-844-614-8800 or online at **icannys.org**. (TTY users call 711, then follow the prompts to dial 1-844-614-8800.)

Special services are available for people with special needs. If you have special needs, call us and we will help you find services (and providers) that will fit your needs. We also can provide materials in large print, braille, audio, or other formats if you ask us. We can help you get VCO (Voice Carry-Over) or TTY (Text Telephone Device) by dialing 1-888-542-3821 (English); 1-888-867-4132 (Spanish) to help make communication easier. This member handbook is also available in large print/CD.

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 New York (Manhattan), the Bronx, Kings (Brooklyn), Queens, Richmond (Staten Island), Nassau or Westchester counties,
3. Have Medicaid,
4. Have Medicaid only **and** are eligible for nursing home level of care,
5. Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, ***and***
6. Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the MLTC Plan for a continuous period of more than 120 days from the date of enrollment:
    a. Nursing services in the home
    b. Therapies in the home
    c. Home health aide services
    d. Personal care services in the home
    e. Adult day health care, (ADHC), which includes AIDS ADHC
    f. Private duty nursing; or
    g. Consumer Directed Personal Assistance Services (CDPAS)

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

New York Independent Assessor Program (NYIAP) - Initial Assessment Process

The New York Independent Assessment Process ("NYIAP") manages the initial assessment process. NYIAP will start the expedited initial assessments (requests where a quick turnaround time is needed) 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.

Senior Health Partners will use the CHA and PO outcomes to determine 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 who 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 Senior Health Partners about whether the plan of care meets your needs.

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

Enrollment

Enrolling in Senior Health Partners is voluntary. If you want to join, you (or someone on your behalf) can call Senior Health Partners. Your Medicaid eligibility must be reviewed and approved by the NYC Human Resources Administration or Local Department of Social Services. If you do not currently have Medicaid, we will help you apply for Medicaid coverage.

After confirming eligibility, we will give you a call to provide you with more information about the plan and will schedule a telephonic or in-home assessment for one of our registered nurses. We will also ask you for information about your healthcare needs.

Our Clinical Eligibility Nurse will confirm consent to let them assess your healthcare needs.

Our nurse will ask you to provide written consent that lets your healthcare providers give us your medical information, where applicable. Our Clinical Eligibility Nurse will conduct a telehealth or in-home assessment after the NYIAP assessment to:

- Identify your healthcare needs (also called an "initial assessment"); and
- Talk about services you may need.

After the initial assessment, our nurse will ask you to sign the Enrollment Agreement Transfer Attestation. By signing the Enrollment Agreement Transfer Attestation, you are agreeing to:

- The initial Person-Centered Service Plan (PCSP), described below, offered by Senior Health Partners.
- Receive all covered services from Senior Health Partners and our network providers.
- Comply with Senior Health Partners' terms and conditions, as described in this handbook.

Before your enrollment date, we may contact you to get more information to help create your plan of care. You should respond as soon as you can, so you can enroll as soon as possible and begin receiving services. After this, you will get your membership letter and a Senior Health Partners Member ID card. Your enrollment effective date will start on the first of the month following the successful completion of the enrollment process. After this, your Care Team will call you to further discuss your first PCSP and answer any questions you have. Your Care Team will also ask you, your provider, and your family/caregivers to help with any future changes in your PCSP.

Withdrawal of Enrollment

You can ask Senior Health Partners verbally or in writing to withdraw your application or enrollment agreement by noon (12pm) on the 20th day of the month before your enrollment date. If your request is received after the 20th of the month, you will be disenrolled from Senior Health Partners on the first day of the next month. You may also contact New York State Medicaid Choice directly to withdraw your application or enrollment agreement.

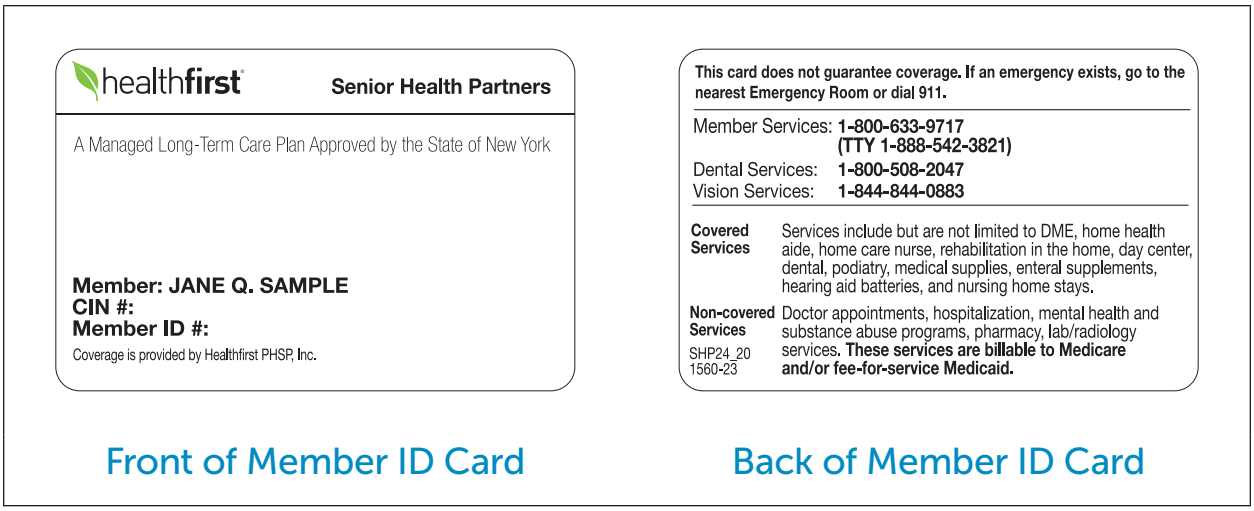
If you want to transfer to another MLTC Medicaid Plan, you can try Senior Health Partners for up to 90 days. You may leave Senior Health Partners and join another health plan at any time during that 90 day period. If you do not leave in the first 90 days, you must remain enrolled in Senior Health Partners for nine (9) 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 Senior Health Partners 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 (2) and six (6) 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. Senior Health Partners 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 Senior Health Partners.

Plan Member (ID) Card

Your Senior Health Partners identification card (Member ID card) will be mailed to you. You will receive your Senior Health Partners member ID Card within 14 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to always carry your ID card with you along with your Medicaid card. You need to show it to your provider. If your card becomes lost or stolen, please contact Member Services at 1-800-633-9717 (TTY, 1-888-542-3821 for English; 1-888-867-4132 for Spanish).



Front of Member ID Card

Back of Member ID Card

Services Covered By The Senior Health Partners MLTC Plan

Care Management Services

As a valued member of our plan, you will be assigned a care manager who is a healthcare professional – usually a NYS registered nurse or a social worker to help support and manage your care needs. The Care Management team may also consist of a behavioral health professional, Registered Dietitian, and/or a Care Coordinator. Your care management team will work with you, your family, your Primary Care Physician (PCP), and any other individuals you want involved in your care. Your care team members are available to you if you have any issues. They are here to help you decide what services are most important to help you remain safe at home. They will arrange appointments and coordinate with your care providers. Your care management team will also help you manage your chronic health conditions.

You, or anyone you choose to represent you, will work with your care management team to guide the development of a personalized Person-Centered Service Plan (PCSP). The PCSP will include your goals, objectives, and services you need to meet your healthcare needs. You will receive an in-person Care Management visit every six (6) months that includes a review of your needs and services. It is important that you work with your Physician to make sure that you get Doctor's Orders yearly and send to Healthfirst. This is needed for you to get Personal Care Services (PCS) and/or Consumer Directed Personal Care Services (CDPAS). You will receive a comprehensive assessment by a registered nurse annually, or if your condition changes.

To monitor your needs, it is important for your Care Management Team to talk to you monthly or more frequently if needed. If you have any questions, please feel free to call Member Services, who can address any questions you may have and, connect you to your Care Management team, if needed. Member services will respond to your calls 24 hours a day, seven days a week.

Additional Covered Services

Because you have Medicaid and qualify for MLTC, Senior Health Partners will arrange and pay for the extra health and social services described below. You may get these services so long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in Senior Health Partners' network. If you cannot find a provider in our plan, please contact Member Services, who will help you find another provider.

The following treatments and services must be approved (prior authorization is required) before you get them:

- **Outpatient Rehabilitation**
  (includes Physical, Occupational and Speech therapies)
- **Personal Care Services**
  (such as assistance with bathing, eating, dressing, toileting, and walking)
- **Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical, and speech therapies
- **Nutrition**
- **Medical Social Services**
- **Home Delivered Meals and/or meals in a group setting** such as a day care
- **Social Day Care**
- **Private Duty Nursing**
- **Dental**
  - Starting January 31, 2024, Senior Health Partners, Managed Long-Term Care (MLTC) plan will be covering crowns and root canals in certain circumstances so that you can keep more of your natural teeth. In addition, replacement dentures and implants will need a recommendation from your dentist to determine if they are medically necessary. This will make it easier for you to access these dental services. You must use an in-network dentist.
- **Social/Environmental Supports** (such as home maintenance tasks, homemaker/chore services, housing improvements, and respite care).
  - Home maintenance tasks and housing improvements do not include permanent and/or structural changes to someone's residence. These are not covered. Limitations and exclusions apply to social and environmental supports.
- **Personal Emergency Response System (PERS)**
- **Adult Day Health Care**
- **Nursing Home Care not covered by Medicare**
  (provided you are eligible for institutional Medicaid)
- **Audiology** (Hearing Services and Hearing Aids)

- Durable Medical Equipment (DME)
- Medical Supplies
- Prosthetics and Orthotics
- Optometry/Eyeglasses
- Consumer Directed Personal Assistance Services (CDPAS)
- Podiatry
- Respiratory Therapy

Starting January 1, 2025, you can connect to organizations in your community that provide services to help with housing, transportation, and care management at no cost to you, through a regional Social Care Network (SCN).

- Through this SCN, you can meet with a Social Care Navigator who can check your eligibility for services that can help with your health and well-being. They will ask you some questions to see where you might need some extra support.
- If you qualify for services, the Social Care Navigator can work with you to get the support you need. You may qualify for more than one service, depending on your situation. These services may include:
    - Housing and utilities support:
        - Installing home modifications like ramps, handrails, and grab bars to make your home accessible and safe.
        - Repairing and fixing water leaks to prevent mold from growing in your home.
        - Sealing holes and cracks to prevent pests from entering your home.
        - Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
        - Helping you find and apply for safe and stable housing in the community.
    - 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, 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.

If you are interested, please call Senior Health Partners Member Services at **1-800-633-9717** (for TTY services call 1-888-542-3821 for English or 1-888-867-4132 for Spanish) and we will connect you to a SCN in your area. The Social Care Navigator will verify your eligibility, tell you more about these services, and help you get connected to them.

How to Obtain Covered Services

Most of the covered services that you get must be approved by your Care Team. The following services also require a doctor's order and must be approved by your Care Team: Consumer Directed Personal Assistance Services (CDPAS), home healthcare, nursing home care, rehabilitative therapies, respiratory therapy, durable medical equipment, prosthetics, orthotics, and social and environmental supports. On a yearly basis, you must complete and submit a doctor's order to Senior Health Partners for Personal Care Services and Consumer Directed Personal Assisted Services.

If you need help getting any covered service, talk to any member of your Care Team. They can schedule an appointment with the provider.

Emergency or urgent care services do not have to be ordered by your provider or approved by your Care Team.

To submit a prior approval request, you or your provider may call Senior Health Partners Member Services at **1-800-633-9717** (for TTY services call 1-888-542-3821 for English or 1-888-867-4132 for Spanish). You can also send your request in writing to:

Healthfirst Member Services
P.O. Box 5165
New York, NY 10274-5165

Limitations

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

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

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

Nursing Home Care is covered for individuals who are considered a permanent placement for at least three (3) months. After 90 days, your Nursing Home Care may be covered through regular Medicaid, and you will be disenrolled from Senior Health Partners.

Getting Care Outside the Service Area

If you will be out of the Senior Health Partners service area for a while (a few days or more), you must call your Care Team. We're available 24 hours a day, 7 days a week at: **1-800-633-9717** (TTY 1-888-542-3821 for English; 1-888-867-4132 for Spanish). Your Care Team can manage your care for up to 30 days while you are away. During that time, we can help you with any issues you have about your care, and with getting other services. If you are out of the Senior Health Partners service area for more than 30 days in a row (with or without telling us), we will have to start the disenrollment process. This will begin within five (5) business days of knowing you have been away from the service area for more than 30 days in a row.

Emergency Services

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

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

Transitional Care Procedures

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

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 the **Money Follows the Person (MFP)/Open Doors program**. 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 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 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 Senior Health Partners does not cover but may be covered by regular Medicaid. You can get these services from any provider who accepts Medicaid by using your Medicaid Benefit Card. Call Member Services at **1-800-633-9717** (for TTY services, call 1-888-542-3821 for English or 1-888-867-4132 for Spanish), if you have a question about whether a benefit is covered by Senior Health Partners or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

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

Certain Mental Health Services, including:

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

Certain Intellectual and Developmental Disabilities Services, including:

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

Other Medicaid Services including:

- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Family Planning
- Certain medically necessary ovulation-enhancing drugs, when criteria are met.
- Non-Emergency Medical Transportation
    - Non-emergency medical transportation is arranged by the New York State Department of Health Statewide Transportation Broker, Medical Answering Services (MAS). To arrange this transportation, please contact MAS at least 3 days before your medical appointment and provide the details of your appointment (date, time, address, the name of your provider and if you need a assistance getting to the vehicle) and your Medicaid identification number. You can contact MAS to schedule a trip or to file a complaint by:
        - Creating an online account at **medanswering.com** and booking a trip on the portal or
        - Members residing in New York City, Nassau, and Westchester counties should dial **1-844-666-6270**.
        - Members in all other counties should dial **1-866-932-7740**.

Services Not Covered By Senior Health Partners OR Medicaid

You must pay for services that are not covered by Senior Health Partners or by Medicaid if your provider tells you in advance that these services are not covered AND you agree to pay for them.

Examples of services not covered by Senior Health Partners or Medicaid:

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

If you have any questions, call Member Services at **1-800-633-9717**. For TTY services, call 1-888-542-3821 for English or 1-888-867-4132 for Spanish.

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 may call Senior Health Partners' Member Services at **1-800-633-9717** (for TTY services call 1-888-542-3821 for English or 1-888-867-4132 for Spanish). You can also send your request in writing to:

Healthfirst Member Services
P.O. Box 5165
New York, NY 10274-5165

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 Senior Health Partners' Utilization Management Department before you receive them or in order to be able to continue receiving them. You or someone you authorize can ask for this. The following treatments and services must be approved before you get them:

- Outpatient Rehabilitation (includes Physical, Occupational and Speech therapies)
- Personal Care Services (such as assistance with bathing, eating, dressing, toileting, and walking)
- Home Health Care Services Not Covered by Medicare including nursing, home health aide, occupational, physical, and speech therapies
- Nutrition
- Medical Social Services
- Home-Delivered Meals and/or meals in a group setting such as a day care
- Social Day Care
- Private Duty Nursing
- Dental
    - Starting January 31, 2024, Senior Health Partners, Managed Long-Term Care (MLTC) plan will be covering crowns and root canals in certain circumstances so that you can keep more of your natural teeth. In addition, replacement dentures and implants will only need a recommendation from your dentist to determine if they are medically necessary. This will make it easier for you to access these dental services. You must use an in-network dentist.
- Social/Environmental Supports (such as home maintenance tasks, homemaker/chore services, housing improvements, and respite care).
    - Home maintenance tasks and housing improvements do not include permanent and/or structural changes to someone's residence. These are not covered. Limitations and exclusions apply to social and environmental supports).
- Personal Emergency Response System (PERS)
- Adult Day Health Care
- Nursing Home Care not covered by Medicare (provided you are eligible for institutional Medicaid)
- Audiology (Hearing Services and Hearing Aids)
- Durable Medical Equipment (DME)
- Medical Supplies
- Prosthetics and Orthotics
- Optometry/Eyeglasses
- Consumer Directed Personal Assistance Services (CDPAS)
- Podiatry
- Respiratory Therapy

To get an authorization, you or your provider must call Member Services at **1-800-633-9717** (for TTY services call 1-888-542-3821 for English or 1-888-867-4132 for Spanish), or write to us at:

Healthfirst Utilization Management
P.O. Box 5166
New York, NY 10274-5166

Concurrent Review

You can also ask Senior Health Partners' Utilization Management Department for an increase in the services that you are getting now. This is called **concurrent review**. This can be done by contacting Member Services: **1-800-633-9717** (for TTY services call 1-888-542-3821 for English or 1-888-867-4132 for Spanish).

Retrospective Review

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

What happens after we get your service authorization request?

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

We may decide to deny a service authorization request or to approve it for an amount that is less than what you requested. These decisions will be made by a qualified healthcare 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 decisions 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 business day from 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 business day from 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 business 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 authorize 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 **1-800-633-9717** (for TTY services call 1-888-542-3821 for English or 1-888-867-4132 for Spanish) or writing.

You or someone you authorize can file a complaint with Senior Health Partners if you don't agree with our decision to take more time to review your request. You or someone you authorize 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 Senior Health Partners denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends, or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions." An action is subject to appeal. (See ***How do I File an Appeal of an Action?*** below for more information.)

Timing of Notice of Action

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

Contents of the Notice of Action

Any notice we send to you about an action will:

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

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

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

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

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on the notice. If we are reducing, suspending, or terminating 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 **1-800-633-9717** (for TTY services call 1-888-542-3821 for English or 1-888-867-4132 for Spanish) or writing to:

Senior Health Partners Plan
Attn: Appeals and Grievances
P.O. Box 5166
New York, NY 10274-5166

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, we must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice 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 best interest. During our review you will have a chance to present your case in person and in writing. We will also send you your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal. This notice 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 best 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 written notice of our decision to deny your request for a *fast track* appeal within 2 days of receiving your request.

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

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

Note: **You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.** If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

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

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

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

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

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

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

- Online Request Form:
  Request Hearing | Fair Hearings | OTDA (**ny.gov**)
- Mail a Printable Request Form:
  NYS Office of Temporary and Disability Assistance Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023
- Fax a Printable Request Form: 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 – 5 Beaver Street, New York, NY 10004
Albany – 40 North Pearl Street, Albany, New York 12243

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

State External Appeals

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

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

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

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

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

Complaints and Complaint Appeals

Senior Health Partners 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 Senior Health Partners staff or a healthcare 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: **1-800-633-9717** (for TTY services call 1-888-542-3821 for English or 1-888-867-4132 for Spanish) or write to:

Senior Health Partners Plan
Attn: Appeals and Grievances
P.O. Box 5166
New York, NY 10274-5166

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

What is a Complaint?

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

The Complaint Process

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

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

2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

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

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision, we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal orally or in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including healthcare professionals for complaints involving clinical matters, who were not involved in the initial compliant 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 Senior Health Partners. This support includes unbiased health plan choice counseling and general plan related information. Contact ICAN to learn more about their services:

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

Disenrollment From Senior Health Partners 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 Senior Health Partners at any time for any reason.

To request disenrollment, call **1-800-633-9717** (TTY 1-888-542-3821 for English: 1-888-867-4132 for Spanish) 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 Senior Health Partners 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 Senior Health Partners 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 Senior Health Partners is best for you.
- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the State.

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

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

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

Involuntary Disenrollment

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

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

- No longer Medicaid eligible.
- Permanently move out of Senior Health Partners' service area.
- Out of the plan's service area for more than 30 days in a row.
- 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) days in a row 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.
- Incarcerated.
- Providing the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.
- Enrollee refused to cooperate or was unable to be reached to complete the required assessment.

We Can Ask You to Leave Senior Health Partners if you:

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

Before being involuntarily disenrolled, Senior Health Partners 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

Senior Health Partners 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

Senior Health Partners 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 to assist you with exercising your rights.

Member Rights

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the Right to get information in a language you understand; you can get oral translation services free of charge.
- You have the Right to get information necessary to give informed consent before the start of treatment.
- You have the Right to be treated with respect and dignity.
- You have the Right to request and 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 healthcare, 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 (including gender identity and status of being transgender), 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 Senior Health Partners.
- Using Senior Health Partners network providers for covered services to the extent network providers are available.
- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies; Being seen by your physician, if a change in your health status occurs.
- Sharing complete and accurate health information with your health care providers.
- Informing Senior Health Partners 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 Senior Health Partners staff (with your input).
- Cooperating with and being respectful with the Senior Health Partners staff and not discriminating against Senior Health Partners staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation, or marital status.
- Notifying Senior Health Partners within two business days of receiving non-covered or non-pre-approved services.
- Notifying your Senior Health Partners health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- Informing Senior Health Partners 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.

- **Do Not Resuscitate Order (DNR):** a medical order written by a doctor which instructs health care providers not to perform cardiopulmonary resuscitation (CPR) or other lifesaving emergency procedures if your heartbeat or breathing stops. These are arranged with your doctor prior to an emergency.
- **Health Care Proxy:** a form which lets you appoint a health care agent to make health care decisions for you if you are unable to make decisions for yourself. In order for the health care proxy to become effective, a doctor must decide that you are not able to make your own health care decisions.

    - Your appointed agent will make decisions for you, in accordance with your instructions or what they think is in your best interest after you lose the ability to make medical decisions.
    - For more information on health care proxies, see the following New York State resources:
        - "Deciding About Health Care: A Guide for Patients and Families", 1503.pdf **www.health.ny.gov/publications/1503.pdf**
        - Health Care Proxy: Appointing Your Health Care Agent in New York State: 1430.pdf **www.health.ny.gov/publications/1430.pdf**
- **A Living Will:** a document in which you declare your health care wishes in the event you become unable to make medical decisions, especially about end-of-life care. In your living will, you are able to include a statement about your beliefs, values, general care goals, and treatment wishes. There is no template Living Will form in New York.

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

If you already have an advanced directive, please share a copy with your care manager keep a copy for yourself, give a copy to the person you chose to make medical decisions for you, give a copy to your doctor and bring a copy with you if you go to the hospital.

Your doctor or someone on your Healthfirst Care Team can help answer any additional questions you may have. We can also help you find a provider who supports your wishes.

Medicaid Spend-Down and NAMI

Some Senior Health Partners members have too much income to qualify for Medicaid. This is called a surplus or excess income. Some people may qualify for Medicaid if they spend the surplus on medical bills, otherwise known as a "spend-down." The spend-down amount paid to Senior Health Partners depends on your Medicaid eligibility and the monthly surplus program.

Some Senior Health Partners members that have too much income to qualify for Medicaid and are a nursing home resident will have to pay a Net Available Monthly Income known as "NAMI." This amount paid to Senior Health Partners depends on your Medicaid eligibility and the monthly surplus program.

If you are eligible for:	You will pay:
Medicaid (no monthly spend-down or NAMI)	Nothing to Senior Health Partners
Medicaid (with monthly spend-down or NAMI)	A monthly spend-down or NAMI to Senior Health Partners, as determined by New York City Human Resources Administration (HRA) or Local District of Social Services (LDSS).

If you are eligible for Medicaid with a spend-down and your spend-down changes while you are a Senior Health Partners member, your monthly payment will be adjusted.

Senior Health Partners will make an effort to notify you payment is due. If you don't pay the Medicaid spend-down (or NAMI) within 30 days after the first of the month the payment is due, we may disenroll you.

Information Available on Request

- Information regarding the structure and operation of Senior Health Partners.
- Specific clinical review criteria relating to a particular health condition and other information that Senior Health Partners 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 Senior Health Partners certified financial statement; policies and procedures used by Senior Health Partners to determine eligibility of a provider.

Electronic Notice Option

Senior Health Partners 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 to you through Healthfirst and our vendors can send these notices to you through **MyHFNY.org**. To get notices on **MyHFNY.org**, you need to have or create a member account on **MyHFNY.org**. When a new notice is available for you on **MyHFNY.org**, you will receive an email at the address that you provided us. You can then view your notices using Adobe Acrobat Reader on your computer or on a smartphone using a PDF reader app. There are no fees to create a member account on **MyHFNY.org**.

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

Phone: **1-800-633-9717**

Online: **MyHFNY.org**

Mail* Senior Health Partners: 100 Church Street, 17th Floor New York, NY 10007

*When sending a letter in the mail, please include your member ID, your email address, and how you want to get notices normally sent by mail and by phone. You can use the Electronic Notice Request Form, but it is not required.

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.).

Senior Health Partners will let you know by mail that you have asked to get notices electronically.

Quality Assurance and Improvement Program

Senior Health Partners has a Quality Management System to track and measure the quality of care and service. This detailed system must meet the New York State health and long-term care quality assurance standards.

Our Quality Management System finds opportunities for Senior Health Partners to improve:

- Quality of service given.
- Management of care (including availability, access, and continuity).
- Operational and care management practices.
- Results in clinical, non-clinical (including member experience), and functional areas.

The quality management system includes a plan to look for areas where improvement is needed, a process for the continuous improvement of performance, a review of the credentials of all providers providing care or service, maintenance of health information records, and review of service use. We welcome your suggestions about quality improvement.

Healthfirst Locations

We make it easy for you to contact us—over the phone, online, and in person. Visit one of our convenient community offices, our virtual community office online, and on social media.

Community Offices Near You

Bronx

Fordham
412 E. Fordham Road
(entrance on Webster Avenue)

Parkchester
112 Hugh J. Grant Circle
(between Cross Bronx Expressway and Virginia Avenue)

Brooklyn

Bensonhurst
2236 86th Street
(between Bay 31st and Bay 32nd Streets)

Brighton Beach
314 Brighton Beach Avenue
(between Brighton 3rd and Brighton 4th Streets)

Crown Heights
263 Utica Avenue
(between Eastern Parkway and Lincoln Place)

Flatbush
2166 Nostrand Avenue
(between Avenue H and Hillel Place)

Sunset Park

- 5202 5th Avenue
  (corner of 5th Avenue and 52nd Street)
- 5324 7th Avenue
  (between 53rd and 54th Streets)

Manhattan

Chinatown

- 128 Mott Street
  Room 407
  (between Grand and Hester Streets)
- 28 E. Broadway (between Catherine and Market Streets)

East Harlem
116 E. 116th Street
(between Park and Lexington Avenues)

Washington Heights
1467 St. Nicholas Avenue
(between W. 183rd and W. 184th Streets)

Queens

Elmhurst
40-08 81st Street (between Roosevelt and 41st Avenues)

Flushing
39-06 Main Street
(between Roosevelt and 39th Avenues)

Jackson Heights
93-14 Roosevelt Avenue
(between Whitney Avenue and 94th Street)

Jamaica
161-21 Jamaica Avenue
(corner of Jamaica Avenue and 162nd Street)

Richmond Hill
122-01 Liberty Avenue
(between 122nd and 123rd Streets)

Ridgewood
56-29 Myrtle Avenue
(entrance on Catalpa Avenue)

Long Island

Nassau County

Hempstead
242 Fulton Avenue
(between N. Franklin and Main Streets)

Suffolk County

Bay Shore
South Shore Mall
1701 Sunrise Highway
(in the JCPenney Wing)

Hampton Bays
Bravo Hamptons Food Supermarkets
39 West Montauk Highway
(between Ponquogue Avenue and Springville Road)

Lake Grove
Smith Haven Mall
313 Smith Haven Mall
(in the Sears Wing)

Patchogue
99 West Main Street
(between West and Havens Avenues)

Orange County

Newburgh
Crossroads Plaza
50 NY Route 17K

Westchester County

Yonkers
13 Main Street
(between Warburton Avenue and N. Broadway)

Go to **healthfirst.org/locations** for our hours of operation, and visit **HFVirtualCommunityOffice.org** to connect with a Healthfirst representative in your area.

healthfirst
Health Insurance for New Yorkers

Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. **Healthfirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

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

If you need these services, call **Healthfirst** at 1-866-305-0408.
For TTY services, call 1-888-542-3821.

If you believe that **Healthfirst** has not given you these services or has treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **Healthfirst** by:

- **Mail**: Healthfirst Member Services, P.O. Box 5165, New York, NY 10274-5165
- **Phone**: 1-866-305-0408 (for TTY services, call 1-888-542-3821)
- **Fax**: 1-212-801-3250
- **In person**: Visit a Healthfirst Community Office. Locations and hours are available at Healthfirst.org/CommunityOffices

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- **Web**: Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **Mail**: U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- **Phone**: 1-800-368-1019 (TTY 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).	Spanish
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 1-866-305-0408 (TTY: 1-888-542-3821).	Chinese
ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (TTY: 1-888-542-3821).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY: 1-888-542-3821). 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY: 1-888-542-3821).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408 (TTY: 1-888-542-3821).	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408 (TTY: 1-888-542-3821).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY: 1-888-542-3821).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-866-305-0408 (TTY 1-888-542-3821).	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY: 1-888-542-3821).	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408 (TTY: 1-888-542-3821).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 1-866-305-0408 (TTY: 1-888-542-3821).	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY: 1-888-542-3821).	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408 (TTY: 1-888-542-3821).	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-866-305-0408 (TTY 1-888-542-3821)۔	Urdu

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