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

2021 Provider Manual

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Section 1 – Introduction

About Senior Whole Health of New York Medicaid Managed Long Term Care Plan

Senior Whole Health of New York (SHW of NY) Medicaid Managed Long Term Care Plan provides care and services, along with assistance with daily activities, to Medicaid-eligible adults 21 years or older who are also eligible for long-term care. SWH of NY serves members who reside in Bronx, New York, Queens and Westchester Counties.

SWH of NY is a subsidiary of Molina Healthcare, Inc., which provides managed health care services under Medicaid and Medicare programs and through the state insurance marketplaces.

SWH of NY Mission Statement

Our mission is to maximize the quality of life, health, security and independence of our members.

Purpose of this Manual

SWH of NY 's Provider Handbook ("Manual") is an extension of the provider participation agreement ("Agreement") between SWH of NY and all provider types including, but not limited to, physicians, hospitals and ancillary health care providers (hereinafter collectively and/or individually, as the context requires, referred to as "provider(s)").

This manual furnishes all such participating providers and their office staff with important information concerning SWH of NY's policies and procedures, claims submission and adjudication requirements, and guidelines used to administer SWH of NY Benefit Plans. This manual replaces and supersedes any and all other previous versions and is available on seniorwholehealthny.com or www.swhnyproviders.com. A paper copy may be obtained at any time upon written request to SWH of NY. Any capitalized terms not otherwise defined herein shall have the meaning as set forth in the Agreement.

When this Manual and Your Contract Differ

The Provider Manual is a supplemental document to, and an extension of, your contract with SWH of NY. It provides detailed information to answer many of the day-to-day operational questions about SWH of NY, our product, our members, and your relationship with us. In cases where your contract and this document differ, the contract takes precedence.

Section 2 – Compliance

Our Commitment

SWH of NY is committed to compliance with regard to member protections as well as regulatory and contractual relationships. The structure of our compliance plan remains steadfast, while our plan is constantly evolving. In addition to standard compliance oversight, we continually enhance the compliance plan by incorporating activities into our daily work that include: communication to enhance awareness, trainings and spot audits. These activities provide two important results. Primarily, it drives the culture at SWH of NY by establishing the expectation of compliance in our daily work and thus drives how we do business. Second, it allows us to assess our work and determine how we can consistently improve our processes.

Regulation for Fraud, Waste, and Abuse Training

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage - Prescription Drug (MA-PD) health plans like SWH to ensure participating providers complete Fraud, Waste, and Abuse training annually.

Providers who have met the fraud, waste and abuse certification requirements through enrollment in the Medicare program are deemed to have met the training and educational requirements for fraud, waste and abuse.

Providers who need to fulfill the training requirements should go to http://www.hcasma.org and click on Medicare Training. Healthcare Administrative Solutions (HCAS) has created this website, which includes an online training program to be completed by Providers.

SWH has implemented the following hotline where our employees and contracted providers can report suspected fraud, waste, and abuse anonymously.

- Molina Alert Line: 1-866-606-3889 or report online at: https://molinahealthcare.alertline.com
- Agreement to Abide by CMS Guidelines: Contracted Providers agree to comply with all Medicare and/or NY Medicaid guidelines as outlined in the Provider contract.

Regulation Compliance Information for all Contracted Providers

Because SWH of NY is a Medicare Advantage Special Needs Plan, SWH contracted providers are required to adhere to the following federal, state and Medicare Advantage provisions which are incorporated into SWH and Contracted Provider Agreements:

- Anti-discrimination/federal funds: SWH hereby notifies contracted providers that payments received under the agreements are from federal funds. Contracted providers are obligated to comply with all laws applicable to individuals and entities receiving federal funds, including without limitation:

I. The Civil Rights Act of 1964
II. The Age Discrimination Act of 1975
III. The Americans with Disabilities Act

- HIPPA: Each Party agrees to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and the implementing regulations under HIPAA and HITECH, as modified from time to time. Furthermore, SWH reserves the right to audit, no less than once every three (3) years, Contracted Provider's written information security program to determine such program meets the requirements of the security regulations issued under HIPAA and/or HITECH.
- Fraud and abuse prevention/whistleblower protection: In accordance with Section 6032 of the Deficit Reduction Act of 2005 ("DRA"), contracted providers shall comply with SWH's Fraud and Abuse Prevention Policy, as revised from time to time by SWH. Contracted providers shall make available to all employees and agents, and to the extent required by DRA, his or her contractors, a copy of SWH's Fraud and Abuse Prevention Policy including specific discussion of the provisions of SWH's Fraud and Abuse Prevention Policy in an employee handbook, if such agent or contractor has an employee handbook.
- False Claims Act and related state laws: The Federal False Claims Act (FCA) sets forth liability for any person who knowingly submits a false claim for payment to the government. As a recipient of federal funding from the Medicare program, Senior Whole Health and all of its employees and agents are bound by the FCA. SWH also receives funding from state Medicaid programs and is therefore subject to similar False Claims Act laws at the state level in both Massachusetts and New York. Collectively, these False Claims Act laws extend liability to anyone who knowingly makes a false assertion to get a false claim paid by the government or who causes another person to submit a false claim to the government. The False Claims Act also covers improper acts designed not to get money from the government but to avoid having to pay money to the government and for those who conspire to violate the law.
- Non-discrimination: Contracted providers shall provide services to members on the same basis as it provides services to all other patients; and contracted providers may only deny, limit or condition the provision of services to a member on the same grounds as they deny, limit or condition the provision of such services to others, subject to any applicable SWH policies or terms of our agreements. Contracted providers shall provide covered services to members in a culturally competent manner, including members with limited English proficiency, limited reading skill and members with diverse cultural and ethnic backgrounds.
- Medicare Advantage provisions: Contracted providers agree to comply with the provisions of Appendix A, which is expressly incorporated into agreements and is binding upon parties to agreements.
- Standard clauses: The New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts, (the "Standard Clauses") attached as Appendix B, are expressly incorporated into agreements and are binding upon the parties to agreements. All prior versions of the Standard Clauses incorporated into the agreements

are of no further effect. In the event of any inconsistent or contrary language between the Standard Clauses in Appendix B and any other part of the agreements, including but not limited to appendices, amendments and exhibits, parties agree that the provisions of the Standard Clauses shall prevail, except to the extent applicable law requires otherwise and/or to the extent provision of agreements exceed the minimum requirements of the Standard Clauses.

- Copays, coinsurance and deductibles: In accordance with 42 CFR §422.504(g)(1)(iii), effective January 1, 2010, should SWH be required to impose copays, coinsurance or deductibles (collectively "member expenses") for covered services for Medicare Part A and B services on members eligible for both Medicare and Medicaid ("dual eligible members"), the amount collected for member expenses may not exceed the amount that could be collected had Member otherwise been enrolled in original Medicare and Medicaid. Dual eligible members will not be responsible or billed for any member expenses for Medicare Part A and B services when the Medicaid program or SWH is responsible for paying member expenses. If the State is responsible for paying those amounts, contracted providers may accept SWH payment as payment in full or bill Medicaid.
- Interpretation: In the event of any inconsistency between the Provider Manual Compliance Section and the Agreements, all parties agree that the terms of the Provider Manual shall control. Except as modified by the terms of the Provider Manual Compliance Section, all terms, conditions and provisions of the Agreements shall remain in full force and effect.
- The contractor shall, upon contracting with a participating provider or subcontractor, provide the following information about the grievance and appeal system to participating providers and subcontractors:
    I. The right of the enrollee, or, with the enrollee's written consent, a provider or an authorized representative, to file grievances and appeals;
    II. The requirements and timeframes for filing a grievance or appeal
    III. The availability of assistance in the filing process
    IV. The right to request a State Fair Hearing after the contractor has made a determination on an enrollee's appeal that is adverse to the enrollee; and
    V. The fact that, when requested by the enrollee, benefits that the contractor seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.
- The contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an Enrollee's service authorization request, appeal, or grievance.
- Language interpreter services must be provided during scheduled appointments and scheduled encounters by a third-party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone and/or by video remote interpreter technology. The interpreter must

demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible.

New York DOH Standard Clauses for Managed Care Provider/IPA Contracts

Notwithstanding any other provision of the agreements, contracts or amendments (hereinafter the agreements) the parties agree to be bound by the following clauses which are hereby made a part of the agreements. Further, if the agreements are between an MCO and IPA, or between an IPA and an IPA, such classes must be included in IPA contracts with providers and providers must agree to such clauses.

Definitions for this section

Managed Care Organization (MCO): The person, natural or corporate, or any groups of such persons certified under Public Health Law Article 44 who enter into an arrangement, agreement or plan, or any combination of arrangements or plans which provide or offer a comprehensive health services plan.

Independent Practice Association (IPA): An entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions and, as appropriate, ancillary medical services and equipment by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. “IPA” may also include, for purposes of the agreements, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

Provider: Any physician, dentist, nurse, pharmacist and other health care professional, pharmacy, hospital or other entity engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

General terms and conditions

- Agreements are subject to the approval of the New York State DOH and, if implemented prior to such approval, the parties agree to incorporate into the agreements any and all modifications required by DOH for approval, or to terminate agreements if so directed by DOH, effective 60 days subsequent to notice, subject to Public Health Law §4403(6) (e). Agreements are the sole agreement between the parties regarding the arrangement established herein.
- Any material amendments to the agreements are subject to the prior approval of DOH, and any such amendment shall be submitted for approval at least 30 calendar days (or 90 calendar days if the amendment adds or materially changes a risk sharing arrangement that

is subject to DOH review) in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH (or New York City) as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

- Assignment of an agreement between an MCO and (1) an IPA, (2) an institutional network provider, or (3) a medical group provider that serves five percent or more of the enrolled population in a county; or the assignment of an agreement between an IPA and (1) an institutional provider or (2) a medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
- The provider agrees, or if the agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully, and to abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the provider at least 30 calendar days in advance of implementation, including but not limited to quality improvement/management or utilization management, including but not limited to precertification procedures, referral processes or protocols, and reporting of clinical encounter data, member grievances and provider credentialing.
- The provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, IPA agrees and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.
- If the provider is a primary care practitioner, the provider agrees to provide for 24-hour coverage and back-up coverage when unavailable. The provider may use a 24-hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
- The MCO or IPA that is a party to the agreement agrees that nothing within the agreement is intended to, or shall be deemed to, transfer liability for the MCO or IPA's own acts or omissions, by indemnification or otherwise, to a provider.
- Notwithstanding any other provision of the agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007 and Chapter 237 of the Laws of 2009 with all amendments thereto.
- To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, the agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:

I. The MCO will monitoring the performance of the provider or IPA under the agreement and terminate the agreement, and/or impose other sanctions, if the provider or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;

II. The provider or IPA agrees that the work it performs under the agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the provider or IPA's performance; and

III. The provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.

IV. The MCO and the provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.

V. The MCO shall not impose obligations and duties on the provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.

VI. The provider or IPA agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a Member of the MCO and for quality purposes at no cost to the MCO.

VII. The provider or IPA agrees, pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the award of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. The provider or IPA agrees to complete and submit the "Certification Regarding Lobbying," Appendix B-1 attached hereto and incorporated herein, if the Agreement exceeds $100,000.

VIII. The provider or IPA agrees, pursuant to 31 U.S.C. § 1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the provider/IPA for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the award of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. The provider or IPA agrees to complete and submit the "Certification Regarding Lobbying," Appendix B-1 attached hereto and incorporated herein, if the Agreement exceeds $100,000.

IX. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of a member of congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or

cooperative agreement, and the Agreement exceeds $100,000, the provider or IPA shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying" in accordance with its instructions.

X. The provider agrees to disclose to the MCO, on an ongoing basis, any managing employee that has been convicted of a misdemeanor or felony related to the person's involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).

XI. The provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE) and excluded individuals posted by the OMIG on its Website.

XII. The provider agrees to disclose to MCO complete ownership, control, and relationship information.

XIII. The provider agrees to obtain, for MCO ownership, information from any subcontractor with whom the provider has had a business transaction totaling more than $25,000 during the 12-month period ending on the date of the request made by SDOH, OMIG or DHHS. The information requested shall be provided to the MCO within 35 calendar days of such request.

- The parties to the agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.
- The provider agrees, or if the agreement is between the MCO and an IPA or an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act; the HIV confidentiality requirements of Article 27-F of the Public Health Law and Mental Hygiene Law § 33.13.

Payer/Risk Arrangements

- Enrollee non-liability: The provider agrees that in no event, including but not limited to nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of the agreement, shall the provider bill, charge or collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on the enrollee's behalf for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and the agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, the provider agrees that, during the time an enrollee is enrolled in the MCO, the provider will not bill the New York State Department of Health or the City of New York for covered services within the Medicaid Managed Care Benefit Package as set forth in the agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, the provider agrees that, during the time an enrollee is enrolled in the MCO, the provider will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copays, coinsurance amounts or permitted deductibles as specifically provided in

the Evidence of Coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that the provider advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the provider has not been given a list of services covered by the MCO, and/or the provider is uncertain as to whether a service is covered, the provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of the agreement for any reason and shall supersede any oral or written agreement now existing or hereafter entered into between provider and enrollee or person acting on his or her behalf.

- Coordination of Benefits (COB): To the extent otherwise permitted in the agreement, the provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus or Family Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

If the provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or IPA must provide notice to the provider at least 90 days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law § 4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association's current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of the agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.

The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) regulations contained in 42 CFR §438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under the agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

The parties agree that a claim for home health care services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a Member's inpatient hospital discharge, consistent with Public Health Law § 4903.

Additionally, the parties agree that where the contractor has previously recovered overpayments, by whatever mechanism utilized by the contractor, from a participating provider, said overpayment recovery shall not be recovered from that participating provider for any such previously recovered identifiable claims that are the subject of a further investigation, audit or action commenced by the agencies listed in Section 22.7bF(8) of Article VII of this Agreement.

The parties agree that where the contractor has recovered overpayments from a participating provider, the contractor shall retain said recoveries, except where such recoveries are made on behalf of OMIG or the Department as provided in Section F(6) of Article VII, or pursuant to a combined audit as provided in Section F(7) of Article VII of the agreement.

The Contractor shall require and have a mechanism in place for its participating or non-participating providers to report to the contractor when the participating or non-participating provider has received an overpayment, to return the overpayment within 60 days of the date of the identification of the overpayment, and to notify the contractor in writing of the reason for the overpayment.

OMIG or the Department shall have the right to request that the contractor recover an overpayment, penalty or other damages owed to the Medicaid program, including any interest, from its participating provider consistent with the requirements of Insurance Law § 3224-b. In such cases OMIG or the Department may charge the Participating Provider a collection fee as set forth in State Finance Law, in an amount to be determined by OMIG or the Department in its sole discretion. The Contractor shall remit, on a monthly basis, to the Department all amounts collected from the participating provider. Upon collection of the full amount owed to the Medicaid program, the contractor may retain the collection fee to account for the contractor's reasonable costs incurred to collect the debt. The contractor shall report the amounts recovered in its Quarterly Provider Investigative Report in accordance with Section F(3)(t) of Article VIII of the agreement. OMIG will only request that the contractor recover an overpayment, payment or other damage where there has been a final determination. For purposes of this section, a final determination is defined as:

- A Notice of Agency Action issues by OMIG pursuant to 18 NYCRR Part 515; ii.) a Notice of Agency Action issued by OMIG pursuant to 18 NYCRR Part 516;
- A Final Audit Report issued by OMIG pursuant to 18 NYCRR Part 517; iv.) a stipulation of settlement or repayment agreement resolving any outstanding audit, investigation, or review; or
- An Administrative Hearing Decision issued by the Department pursuant to 18 NYCRR Part 519: however, only a timely request for an administrative hearing, as defined in 18 NYCRR 519.7, shall delay OMIG's request pending a decision.

Consistent with 18 NYCRR § 517.6(g) OMIG may enter into an agreement with the contractor to conduct a combined audit or investigation of the contractor's participating

provider, non-participating provider, or subcontractor. Such agreement shall be executed by the parties prior to the commencement of the audit or investigation. The portion of any recoveries as a result of a combined audit or investigation that is not owed to the federal government shall be shared between the contractor and OMIG as provided for in the combined audit or investigation agreement. In no event shall the contractor share in any recovery which results from the referral of a pending investigation of a credible allegation of fraud by the State to the New York State Office of the Attorney General or other law enforcement organization pursuant to 42 C.F.R. § 455.23 and other pertinent authority.

Records Access

- Pursuant to appropriate consent/authorization by the enrollee, the provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, including Quality Assurance Reporting Requirements ("QARR"), payment processing and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/manager analysis and recovery of overpayments due to fraud and abuse. The provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The provider shall provide copies of such records to DOH at no cost. The provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
- When such records pertain to Medicaid or Family Health Plus reimbursable services, the provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the US DOH, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of the agreement regardless of the reason.
- The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within the agreement. This provision shall survive the termination of the agreement regardless of the reason.
- The MCO and the provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA

agrees to require the providers with which it contracts to agree as provided above. If the agreement is between an IPA and a provider, the provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

Termination and Transition

Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional provider or medical group provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 calendar days after receipt of notice by either party, provided, however, that termination by the MCO may be effected on less than 45 calendar day's notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

If the agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days' notice of its decision to not renew the Agreement.

If the agreement is between an MCO and an IPA and the agreement does not provide for automatic assignment of the IPA's provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree and IPA's providers agree that the IPA providers shall continue to provide care to the MCO's enrollees pursuant to the terms of the agreement for 180 calendar days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever occurs first. This provision shall survive termination of the agreement regardless of the reason for termination.

- Continuation of treatment: The provider agrees that, in the event of MCO or IPA insolvency or termination of this contract for any reason, the provider shall continue to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract to an enrollee confined in an inpatient facility until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term "provider" shall include the IPA and the IPA's contracted providers if the agreement is between the MCO and an IPA. This provision shall survive termination of the agreement.
- Notwithstanding any other provision herein, to the extent that the provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the agreement when the provider has been terminated or suspended from the Medicaid Program.

- In the event of termination of the agreement, the provider agrees and, where applicable the IPA agrees, to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

Arbitration

- To the extent that arbitration or alternative dispute resolution is authorized elsewhere in the agreement, the parties to the agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation along with copies of all decisions.

IPA-specific provisions

- Any reference to IPA quality assurance (QA) activities within the agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

The undersigned certifies, to the best of his or her knowledge, that:

- ❑ No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- ❑ If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement, and the agreement exceeds $100,000, the provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Section 3 – Quick Reference Information

The Provider Relations team is your contact for most communications with us. If a representative can't help you directly, you'll be connected to the department best able to handle your question or concern.

Contact	Information
Provider Relations Number	1-877-353-9819 Monday – Friday, 9 a.m. - 5 p.m.
Provider Relations Email	SWHProviderRelationsNY@magellanhealth.com
Member Care Coordination	Contact Member Services at 1-877-353-0185
Clinical Services	1-877-635-3101
Secure Email	If you'd like to email protected health information (PHI) and don't have a secure email service, call Provider Relations.
FAX	1-855-818-4873 Attn: Provider Relations
Mail	Senior Whole Health of New York Attn: Provider Relations 15 MetroTech, 11th Floor Brooklyn, NY 11201
Member After-hours line	1-866-211-1777 for member-specific, urgent matters

How to Contact SWH of NY Sub-contracted Vendors

We use vendors to administer certain benefits.

- **Dental**
  DentaQuest: 1-855-343-4272
- **Vision**
  Vision Service Plan (VSP): 1-800-877-7195
- **Transportation**
  Logisticare: 1-855-558-1638

Section 4 – Referrals & Authorizations

Referrals and Authorizations
SWH of NY processes all service determination requests in accordance with NYS and federal regulatory guidelines.

An authorization is a notification to Senior Whole Health of the need for a specialty service that, in addition to eligibility and benefit coverage, requires review by SWH for medical necessity. Upon review, SWH will issue an Authorization Number for billing purposes.

Authorizations are required for non-par specialty physicians and for some service types. Refer to the Authorization Grid in the Appendix to determine if a particular service requires an authorization. Examples of services requiring authorization include hospitalization, home health care, or non-emergency transportation.

Referral is a communication by a member's primary care provider (PCP) for the need for services from a specialty provider. Senior Whole Health does not require referrals for network specialists. Please refer to the SWH Provider Directory.

Non-participating provider authorizations
Referrals to non-participating providers require an authorization. The SWH of NY provider directory is available at www.SWHNYMembers.com.

To request services from a non-participating provider, complete and fax the SWH of NY Authorization Form to the confidential clinical fax line at 1-855-818-4871. See Appendix for copy of form. You may also call Member Services at 1-877-353-0185. After the referral or authorization is approved, SWH of NY will send written confirmation to the specialist or facility in writing via mail or fax. Non-participating specialists or facilities can check the status of a referral or authorization or request a copy of a referral by calling Senior Whole Health at 1-877-635-3101.

Durable medical equipment (DME) authorizations
SWH of NY requires prior authorization for DME rental or purchase with a line item charge over $500.00. Examples include but are not limited to:

Home Health Authorizations

All home health services require authorization. A provider, family member, significant other or PCP may initiate a request for home health or medical social services. The SWH of NY Nurse Care Manager (NCM) may also determine that a member would benefit from these services in order to improve, maintain or sustain current functioning. The NCM will communicate this need to the member's PCP.

To request authorization for home health services, fax the SWH of NY Authorization Form to the confidential clinical fax line at 1-855-818-4871. A copy of the form can be found in the Appendix. Requests may also be called in to Member Services at 1-877-353-0185.

Other services requiring authorization

Refer to the Authorization Grid in the Appendix to determine if a particular service requires an authorization.

Retroactive authorizations

To request a retroactive authorization for any service for which authorization is required, fax the SWH Authorization Form to the confidential clinical fax line at 1-855-818-4871. You may also call Member Services at 1-877-353-0185. SWH requires a detailed explanation of why the authorization is needed on a retroactive basis.

Inpatient (acute hospital) authorizations

Authorizations for elective inpatient stays should be obtained prior to admission. Senior Whole Health requires treating providers to notify us within 24 hours of emergency or urgent admission. Contact Member Services at 1-877-353-0185 for all inpatient admissions. When leaving a recorded message, please include caller name, phone number, member name, member SWH ID number and date of admission. A SWH clinical staff person will return the call.

A reference number will be generated upon notification of inpatient admissions. Authorization numbers require clinical information. Authorizations will not be given and denials will be issued if clinical information is not received from the provider.

Pharmacy authorizations

SWH of NY covers glucose testing supplies. A small number of may require prior authorization.

Utilization Management

SWH of NY adopts evidence-based clinical practice guidelines to assist practitioners in making decisions about appropriate health care for specific clinical issues. The clinical practice guidelines address preventive medical services, acute or chronic medical services Specific clinical practice guidelines form the clinical bases for SWH of NY disease management programs. The guidelines are reviewed at least every two years. When guidelines are updated, practitioners are notified by SWH of NY.

SWH of NY Health criteria

SWH of NY applies objective and evidence-based criteria taking into account individual circumstances and the local delivery system when determining medical appropriateness of health care services during the utilization management process. Criteria used by SWH are stated in notices of denial of medical coverage. Criteria can be obtained upon request by contacting Utilization Management staff within Clinical Services at 1-888-794-7268.

SWH of NY clinical staff that make utilization management decisions annually affirm that:

- Utilization management decisions are based only on appropriateness of care and service and existence of coverage
- SWH of NY does not specifically reward providers for issuing denials of coverage
- Financial incentives do not encourage decisions that result in underutilization

Utilization management inquiries

Utilization Management staff within Clinical Services is available from 8 a.m. to 8 p.m., 7 days a week. You can call us toll free at 1-888-794-7268 to get information about the UM process and authorization of care. After hours communication can be faxed to 617-494-5554 and we will respond the following day.

Section 5 – Claims

Claims Contact Information

Claims Department: 1-866-233-4773 Monday through Friday, 8:30 a.m. – 5 p.m.

Billing procedures

The information provided here enables providers to comply with the policies and procedures governing Senior Whole Health.

Senior Whole Health pays clean claims submitted for covered services provided to eligible members. In most cases, we pay clean claims within 30 business days. A remittance advice is provided for all claim payments. The remittance advice addresses paid and denied, but not pended claims. SWH accepts both electronic and paper claims. All claims received must comply with the Health Information Portability and Accountability Act (HIPAA). Industry standard diagnosis codes and procedure codes are required.

A clean claim must be submitted within 90 calendar days of the date of service or discharge and/or within your specific contract terms. When a member's care is ongoing, a claim must be submitted within 90 calendar days after the last day of the month. SWH requests that the provider bill every 30 calendar days. The final bill must be received within 90 calendar days of the last date of service. Interim billing may be used for inpatient hospital admissions, skilled nursing facility admissions, hospice admissions and other types of ongoing care.

Claims should be billed in accordance with CMS's Correct Coding Initiative (CCI) guidelines. SWH processes claims utilizing CCI-based claims edit software and may deny services that do not conform to CCI guidelines. Because SWH coverage includes Medicaid as well as Medicare services, overrides allow some services typically denied by Medicare to be paid by SWH.

Providers may inquire on the status of a claim by calling the Claims Department. It is requested that providers allow at least 30 days from the date the claim was sent to SWH before making a claims status inquiry telephone call. When modifiers are utilized in billing and effect pricing, it is important to place those pricing modifiers in the 1st and 2nd modifier positions on the claim (paper and EDI transactions). All other modifiers can follow thereafter.

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe (untimed CPT/HCPCS), the provider enters '1'in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the CPT/HCPCS code definition (often once per day).

Example: A beneficiary received a speech-language pathology evaluation represented by HCPCS-untimed code 92506. Regardless of the number of minutes spent providing this service, only one unit of service is appropriately billed on the same day.

Several CPT codes used for therapy modalities, procedures, tests and measurements specify that the direct (one-on-one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on any single calendar day using CPT codes and the appropriate number of 15-minute units of service.
Example: A beneficiary received occupational therapy (HCPCS-timed code 97530, which is defined in 15-minute units).

Clean Claims

Unless prohibited by federal law or CMS, SWH may deny payment of any claim that fails to meet submission requirements for a clean claim or failure to submit timely. SWH defines a **clean claim** as: a claim that has no defect, impropriety or lack of substantiating documentation; requires no further documentation, information or alteration in order to be processed and paid timely; and which complies with standard CMS coding guidelines and/or other government program requirements where applicable.

To be considered a clean claim by SWH, all claims must be submitted on the appropriate claim form — electronic format, CMS-1500\UB-04 or alternative, and have the required fields completed. Electronically submitted claims must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions.

The following are considered non-clean claims:
CMS-1500/837P claims — measured by the "from" date of service
UB-04 claims/837 claims — measured by the "thru" date of service

Required Information on Claims

Member information:

- Member name
- Member date of birth
- Member ID number

Provider Information:

- Servicing provider name
- Servicing provider address
- Servicing provider NPI number
- Billing provider group name and address
- Billing provider NPI number
- Billing provider federal tax id number (TIN)
  *TIN and NPI combination must match the W-9 information on file with SWH of NY

Claim Information:

- Servicing provider name

- Date of service (from xx/xx/xx to xx/xx/xx)
- Valid diagnosis codes (ICD-9 or ICD-10)
- Place of service/bill type
- Procedure code (CPT-4, HCPCS, or Successors) and/or revenue code
- Modifier (as required)
- Units (properly measured: per visit, per minute, etc.
- Total billed charged

Non-clean Claims

A **non-clean claim** is a claim that requires corrected data and addition information or investigation for processing. The following are considered to be non-clean claims:

- Claims to be investigated for coordination of benefits, subrogation or worker's compensation
- Claims that require medical records for processing
- Claims that include billing for non-covered services
- Claims that include billing for unlisted procedures
- Claims lacking any of the required elements of a clean claim

Electronic Data Interchange (EDI) Claims

Independence Care Systems accepts electronic claims through Electronic Data Interchange (EDI) as its preferred method of claim submission. All files submitted to Senior Whole Health must be in the ANSI ASC X12N format, version 5010A, or its successor version.

Claims submitted via EDI must comply with HIPAA transaction requirements. EDI claims are to be sent via clearing house. Senior Whole Health works specifically with Emdeon. In order for claims to be routed to Independence Care Systems, please be sure to include our payer ID 83035. This pin is the identifier at the clearinghouse to route claims directly to the Claims Operations Department.

Type	Format	Submit To
EDI – Professional claims	HIPAA-compliant 837-p format	EDI Payer ID: SWHNY
Paper	CMS-1500 or UB-04	Senior Whole Health of NY PO Box 22637 Long Beach, CA 90801
Paper – Claims requiring additional documentation	CMS-1500 or UB-04 and any additional documentation	Senior Whole Health of NY PO Box 22637 Long Beach, CA 90801
EDI Support: If you're currently submitting via Emdeon, you should have a login for ON 24/7		

Type	Format	Submit To
website. If not, ON 24/7 is a web-based system that allows customers to submit service requests and check on the status of those requests 24 hours a day, 7 days a week. Please contact Emdeon directly at 1-888-363-3361 or visit the ON 24/7 site at https://clientsupport.emdeon.com/Login.aspx		

The bill frequency in CLM05-3 indicates the claim is an original, a replacement or a void. For example, a value of "7" represents a replacement claim and value "8" represents a void claim.

Claim frequency codes accepted:

1 Indicates the claim is an original claim

7 Indicates the new claim is a replacement or corrected claim (to the original claim). The information present on the claim represents a complete replacement of the previously issued claim.

8 Indicates the claim is a voided/canceled claim

*For a replacement or void, the payer assigned claim number for the last known claim being replaced is sent in Loop 2300, REF02 where REF01 is equal to F8.

Paper Claims Submissions

SWH of NY accepts submissions of properly coded claims from providers by EDI or standard paper claims. The provider acknowledges and agrees that each claim submitted for reimbursement reflects the performance of a covered service that is fully and accurately documented in the member medical record prior to the initial submissions of any claims. No reimbursement or compensation is due should there be a failure in such documentation.

All providers are encouraged to submit electronic claims whenever possible. SWH recognized, however, that some providers may choose to submit for reimbursement using industry-standard paper claim forms. If the provider does submit the paper claim forms, CMS-1500 and UB-04 are acceptable.
All paper claims must be submitted on original, red ink on white paper claim forms. Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.

All information must be aligned within the data fields and must form must:

- Be typed (do not print, hand-write, or stamp any extraneous data on the forms)
- Be in a large, dark ink font such as PICA or ARIAL and in a 10, 11 or 12 point type
- Be in capital letters
- Have all required fields populated in order to be considered a clean claim
- Have all fields completed completely and accurately
- Submitted in a 9"x 12"or larger envelope
- Contain correct National Provider Identifier (NPI) and member's ID number

The typed information must not have:

- Broken characters
- Incorrect NPI
- Incorrect member ID number

Replacement submissions

Replacement and void claims should be submitted electronically using industry-standard claim frequency codes. Providers may submit a corrected claim via EDI to correct a claim that was previously submitted and processed (both paid and denied).

The typed information includes:

- The original claim number
- An indication of the item(s) needing correction
- Submission within 30 days from the original claims Remittance Advice (RA) date

The typed information must not have:

- Handwritten changes
- Correction fluid

A replacement is sent when an element of data on the claim was either not previously sent or needs to be corrected. Examples include incorrect dates of service or units. To qualify for a replacement, certain identifying information must remain the same. If these values change, the period claim must be voided and a new claim sent with the appropriate frequency.

Enter claim frequency type code (billing code), in the 2300 loop in the CLM*0503. Enter the original claim number in the 2300 loop in the REF*F8.*

Void submissions

When identifying elements change, a void submission is required to eliminate the previously submitted claim. The entire claim must match the original with the exception of the claim frequency code, condition code and the payer assigned claim number.

Examples: Incorrect provider, patient, payer, insured or statement period on an institutional claim or patient did not want insurer to be billed for services

Correcting/void — paper HCFA-1500 claims

For professional claims, the provider must include the original claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified.

Claim Form: CMS 1500
Box Number: 22
Title: Medicaid resubmission and/or original reference number

Instructions: When resubmitting a claim, enter the appropriate claim frequency code left justified in the left-hand side of the field:

7= Replacement of prior claim
8= Void/cancel of prior claim

Correcting/void —paper UB04 claims

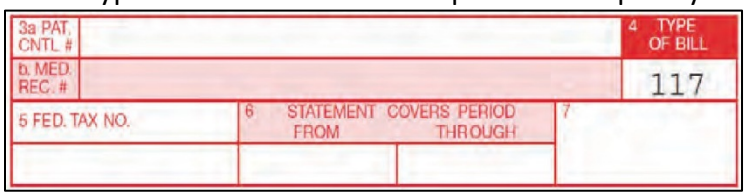
For institutional claims, the provider must include the original claim number and bill frequency code per industry standards.

Claim form: UB04
Box number: 4
Title: Type of bill
Instructions: When resubmitting a claim, enter the appropriate claim frequency code in the 3rd position of the type of bill.

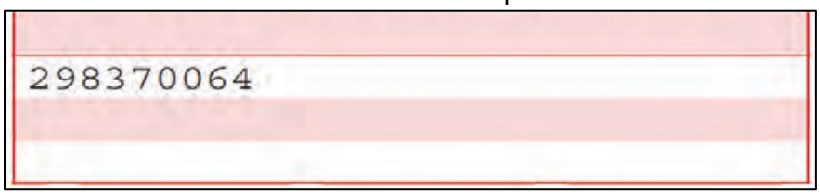
7= Replacement of prior claim
8= Void/cancel of prior claim

Example:

Box 4-Type of bill: 3rd character represents frequency code



Box 80: Place the claim number of the prior claim



Claims Appeals:

A claim appeal is a provider's written notice to SWH of NY challenging, contesting, appealing or requesting reconsideration of a claim or a bundled group of substantially similar multiple claims that are individually numbered that have denied or adjusted. Claims must be submitted in writing to the SWH of NY Claims Department. Use the SWH of NY Claims Appeal Form.

All provider appeals must include:

- Provider's tax ID number
- Provider's contact information (an individual person's name and phone number)
- Clear identification of the appeal item
- The remittance advice (or member name, date of service, CPT or HCPC code and original

claim number)
- Authorization number (if authorization was required)
- A clear explanation of the basis upon which the provider believes the payment amount (denial or adjustment), request for additional information, request for reimbursement for underpayment of claim, or other SWH action is incorrect

When submitting multiple batches of claim appeals:

- Sort appeals by similar issue or by individual member name
- Provide cover sheet for each batch
- Number each cover sheet
- Provide a cover letter that gives a summary description of all the batches

Claims appeals mailing address:
Senior Whole Health
Claims Operations Department
15 MetroTech Center, 11th Floor
Brooklyn, NY 11201

Incomplete Provider Appeals

Provider appeals that do not include all required information as listed above will be returned to the submitter for completion. Appeals will be closed if complete information, as requested, is not received within 30 calendar days of the request for additional information.

Payment disputes:

- Seeking resolution of a billing determination (adjusted, denied, paid incorrectly or overpaid)
- Disputing a request for recovery of overpayments

The following are not claims appeals:

- Those seeking resolution of a contractual issue
- Payment disputes wherein the provider believes SWH of NY is paying an amount that is different than what was contractually agreed on. These should be directed to Provider Relations at 617-494-5353.
- An appeal made by a provider on behalf of a specific member are considered member appeals. Member appeals should be directed to the Quality Department at 617-494-5353. See **Section 7 — Membership and eligibility** for more information on filing member appeals.

Incomplete or incorrect claims:

If a claim is found to be incomplete or incorrect, it will be denied and the denial reason code will appear on the remittance advice. For example, an NPI number and provider name may not match, or a quantity may not have been specified when one was required. The claim may be resubmitted with the requested information.

Senior Whole Health does not discriminate or retaliate against a provider because the

provider has filed an appeal.

Prompt Payment Rules

SWH will follow Medicare guidelines regarding prompt payment rules according to Section §422.520 Prompt Payment by MA organization. (a) Contract between CMS and the MA organization. (1) The contract between CMS and the SWH specifies that we must pay 95% of clean claims within 30 days of receipt if they are: submitted by or on behalf of an enrollee of an MA private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider. (2) SWH will pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B). (3) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request.

Section 6 – Membership & Eligibility

Eligibility Inquiries

SWH of NY recommends that providers confirm member eligibility prior to every scheduled service. For emergency services, providers should verify eligibility as soon as possible following provision of the service.

To confirm eligibility, call Member Services at 1-877-353-0185 Monday through Friday from 8 a.m. to 5 p.m.

SWH of NY Eligibility

In order to quality for membership in Senior Whole Health of New York Managed Long Term Care Plan, an individual must:

- ✓ Be eligible for New York State Medicaid and be 21 years of age or older.
- ✓ Reside in the SWH of NY service area for at least six months each calendar year. The service area includes Bronx, Kings, New York, Queens and Westchester Counties.
- ✓ Their health care needs can be safely met in their home and/or community
- ✓ Assessed as requiring at least one (1) of the following long-term care services and care management for a continuous period of more than 120 days from the date of enrollment:
    - ✓ Nursing services in the home
    - ✓ Therapies in the home
    - ✓ Home health aide services
    - ✓ Adult day health care
    - ✓ Personal care services in the home
    - ✓ Private duty nursing
    - ✓ Consumer-Directed Personal Assistance Services

A SWH of NY Outreach Representative will further assess eligibility and assist the applicant with enrollment.

*Individuals diagnosed with end stage renal disease (ESRD) are not eligible to join.

Referring Prospective Members

Participating providers who wish to communicate with their patients about managed care options must direct patients to the State's Enrollment broker for education on all plan options. Participating providers shall not advise patients in any manner that could be construed as steering towards any managed care product type. Participating providers are prohibited from displaying SWH of NY outreach materials.

Member Benefits

SWH of NY is a Medicaid Managed Long Term Care Plan that provides care and services, along with assistance with daily activities, to Medicaid-eligible adults 21 years or older wo are also eligible for long-term care. A full description of SWH of NY benefits is available the Member

Handbook at www.swhnymembers.com.

Additional Benefits

SWH of NY includes additional health and wellness benefits not covered by Medicaid. Providers may wish to encourage their patients to take advantage of these.

Preventative Health and Disease Management

SWH of NY offers several disease management programs to optimize patient care. To refer a patient, contact your nurse care manager. Programs Include: Congestive heart failure, diabetes management and chronic obstructive pulmonary disease.

Transitions of care

SWH of NY promotes continuity of care between care settings to assist member transitions of care and to reduce the potential for hospital/facility readmission during a period of high vulnerability. SWH of NY Nurse Care Managers actively engage in transition planning and follow up including facilitation of physician communication, and follow-up visits and medication management. Services are provided for all members; you do not need to make a request.

Non-emergency transportation

The SWH of NY medical transportation benefit is handled directly between SWH of NY and our members, with no paperwork required from the provider. Members may call 1-855-558-1638 to request transportation to/from medical appointments. Providers who believe a member may need transportation services to keep medical appointments may call SWH of NY.

Interpreter services

Language interpreter services must be provided during scheduled appointments and scheduled encounters by a third party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible.

Copays, Coinsurance, Deductibles

The SWH benefit offers members payment in full for all covered services with no copays (including for drugs unless required by regulation), no deductibles and no coinsurance.

Coverage Determinations

Providers who are uncertain whether a service is covered, or who recommend a course of treatment that is not covered, please call the SWH of NY Clinical Department at 1-877-635-3101 for a coverage determination. Providers will be asked to provide pertinent information via fax or telephone call. If we make an adverse determination, the member and provider making the request will be informed in writing in accordance with New York State and federal regulatory

guidelines.

Coverage determinations are also required for reductions, terminations or suspensions of services. Providers will be asked to provide pertinent information via fax or telephone call. If SWH of NY makes an adverse determination, the member will be informed in writing in accordance with New York State and federal regulatory guidelines.

Non-covered services
Prior to delivering any non-covered service, a provider must advise the member and the member must agree in writing that the service is not covered by SWH and that the Member is liable for payment in full.

Enrollment and Disenrollment

How to Enroll
If a perspective member would like to enroll in SWH of NY they, must go through an eligibility process that will include an assessment from the Conflict Free Evaluation and Enrollment Center (CFEEC). The CFEEC is administered by NY Medicaid Choice (Maximus). The purpose of the evaluation is to verify their eligibility for 120 days of continuous long-term care services. Once Maximus determines they qualify to enroll in an MLTC plan, they'll be given the opportunity to select an MLTC plan of their choice.

If they select SWH of NY, a nurse will visit them to complete an internal enrollment assessment. After we complete this assessment, they will be offered a Plan of Care based on their individual needs and goals. If accepted, they can enroll in SWH of NY.

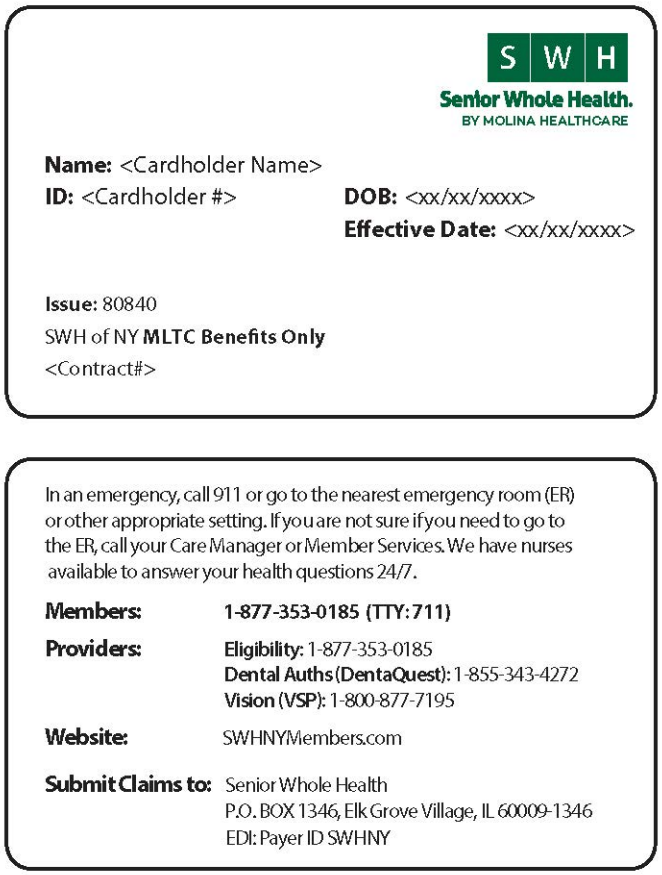
- Completed assessments are submitted daily to Maximus. If assessments and documentation are completed by the 20th day of a current month, they'll be enrolled effective the 1st day of the following month.

What happens if enrollment is denied?

At any time before or during the enrollment process, they may change their mind and withdraw their application—even after they've completed the enrollment application process. They may withdraw an application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment. They may tell us they wish to withdraw either orally or in writing. After this point, they will still be able to leave SWH of NY by requesting disenrollment. For more information, please review the voluntary disenrollment section.

Member ID Card

Members will receive their SWH of NY identification (ID) card within 7-10 days of their effective enrollment date.



Voluntary Disenrollment

Members can ask to leave the SWH of NY at any time for any reason.

To request disenrollment, call 1-877-353-0185 (TTY 711) or they can write to us. The plan will provide members with written confirmation of their request. We will include a voluntary disenrollment form for them to sign and send back to us. It could take up to six weeks to process, depending on when the request is received.

Members may disenroll to regular Medicaid or join another health plan as long as they qualify. If members continue to require Community Based Long Term Care (CBLTC) services, like personal care, they must join another MLTC plan, Medicaid Managed Care plan or Home and Community Based Waiver program, in order to receive CBLTC services.

Involuntary Disenrollment

An involuntary disenrollment is a disenrollment initiated by SWH of NY. If members do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) business days from the date we know the member meets any of involuntary disenrollment reasons.

Members will have to leave SWH of NY if they:

- Are no longer are Medicaid eligible;
- Permanently move out of the SWH of NY service area;

- Are out of the plan's service area for more than 30 consecutive days;
- Need nursing home care, but are not eligible for institutional Medicaid;
- Are 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;
- Are assessed as no longer having a functional or clinical need for community-based long-term care (CBLTC) services on a monthly basis;
- Have Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool;
- Are receiving Social Day Care as their only service;
- No longer require, and receive, at least one CBLTC services in each calendar month;
- At point of any reassessment while living in the community, they are determined to no longer demonstrate a functional or clinical need for CBLTC services;
- Have been incarcerated; or
- Provide the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of their plan membership

We can ask members to leave SWH of NY if they:

- 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 of money, as determined by the Local Department of Social Services, owed to the plan as spenddown/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, SHW of NY NHC 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 community based long term care services, you will be required to choose another plan or you will be automatically assigned (auto-assigned) to another plan.

Transfers

Members can try us for 90 days. They may leave SWH of NY and join another health plan at any time during that time. If they do not leave in the first 90 days, they must stay in SWH of NY for nine more months, unless they have a good reason (good cause). Some examples of good cause include:

- Them member moves out of our service area.
- The member, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving (SWH of NY) is best for their interest.
- The members current home care provider does not work with our plan.
- We have not been able to provide services to the member as we are required to under our contract with the State.

If the member qualifies, they 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.

Member Rights and Responsibilities

SWH of NY is dedicated to providing quality health care services for our members and to treating each with dignity and respect. SWH of NY members have certain rights and expectations, along with certain responsibilities.

Member Rights Include the Right to:

- Receive medically necessary care.
- Receive timely access to care and services.
- Privacy about your medical record and when you get treatment.
- Access information on available treatment options and alternatives presented in a manner and language you understand.
- Receive Information in a language you understand; you can get oral translation services free of charge.
- Receive Information necessary to give informed consent before the start of treatment.
- Be treated with respect and dignity.
- Access to a copy of your medical records and ask that the records be amended or corrected.
- Take part in decisions about your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- 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.
- Complain to the New York State Department of Health or your Local Department of Social Services; and, the right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- Appoint someone to speak for you about your care and treatment.
- Seek assistance from the Participant Ombudsman program.

Member responsibilities the responsibility to:

- Receive covered services through SWH of NY;
- Use SWH of NY network providers for covered services to the extent network providers are available;

- Obtain 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;
- Share complete and accurate health information with your health care providers;
- Inform SWH of NY staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions;
- Follow the plan of care recommended by the SWH of NY staff (with your input);
- Cooperate with and being respectful with the (SWH of NY) staff and not discriminating against SWH of NY staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status;
- Notify SWH of NY within two business days of receiving non-covered or non-pre-approved services;
- Notify your SWH of NY health care team in advance whenever you will not be home to receive services or care that has been arranged for you;
- Inform SWH of NY 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;
- Meet your financial obligations.

Member Complaints about Office Settings

SWH of NY will conduct a site visit if we receive after the first complaint about an office site (cleanliness or access, for example); if a practice-specific survey detects a deficiency; or if an unfavorable report is received as a result of a provider relations site visit.

What to expect during a site visit:

- SWH of NY Provider Relations will schedule an on-site office review within 60 calendar days of receipt of a member complaint or detection of a deficiency
- SWH of NY will provide a confidentiality statement to the practice prior to reviewing sample patient records as part of the standard on-site review (if patient record reviews are necessary). If requested by the practice, the SWH of NY representative will sign an appropriate confidentiality agreement provided by the practice
- Site reviews shall be conducted during normal business hours at a time acceptable to the practice and in a manner so as not to unreasonably interfere with practice operations
- A trained SWH of NY Provider Relations staff person will conduct the site review using the SWH Office Site Visit Checklist - Office Evaluation Survey Tool. A member of the office practice staff may accompany the SWH of NY reviewer during the entire site review
- Results of the office visit evaluation will be provided to the practitioner with any corrective action plan required
- If deficiencies are noted, the site must develop and submit a corrective action plan for improvement within 30 days of notification of the office visit results
- Once an action plan has been submitted and approved by SWH of NY, an SWH of NY site

representative will evaluate the site at least every six (6) months and will reassess each area where a deficiency is noted until the performance standard for that area has been met.

Member Non-Liability

SWH of NY members, as New York State Medicaid beneficiaries, cannot be held liable for payments. Providers may not bill or collect payment for a covered service from members for any reason. Please contact Provider Relations if you have questions. A SWH of NY member has at least 120 calendar days to submit a claim for billed out-of-network services in accordance with INS §§ 4305(1) and 4306(n).

Section 7 – Service Authorizations, Complaints & Appeals

Service Authorizations

To submit a service authorization request, members or their provider may call Member Services at 1-877-353-0185 or send a request in writing to:

SWH of NY
15 MetroTech Center, 11th Floor
Brooklyn, New York 11201

Prior Authorizations

Some covered services require prior authorization (approval in advance) from the SWH of NY Utilization Management (UM) team before they receive them or in order to be able to continue receiving them. Members or someone they trust can ask for this. To obtain prior authorization, please call Member Services at 1-877-353-0185 (TTY 711) Monday through Friday, 8 a.m. to 8 p.m.

Timeframes for prior authorization requests

- Standard review: We will make a decision about a request within 3 workdays of when we have all the information we need, but members will hear from us no later than 14 days after we receive their request. We will tell them by the 14th day if we need more information.
- Fast track review: We will make a decision and members will hear from us within 72 hours. We will tell them 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 they will hear from us no later than 14 days after we received their request.
- Fast track review: We will make a decision within 1 workday of when we have all the information we need. Members will hear from us within 72 hours after we receive their request. We will tell them within 1 workday if we need more information.

If we need more information to make either a standard or fast track decision about the members service request, the timeframes can be extended up to 14 days.

Actions

When SWH of NY denies or limits services requested by members or their 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.

Timing of notice of action
If we decide to deny or limit services a member requested or decide not to pay for all or part of a covered service, we will send the member 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 (ten) days before we intend to change the service.

Filing an Appeal or Complaint on Behalf of Member

A physician may, when acting on behalf of a member and with the member's written consent, file an appeal or a grievance. In accordance with PHL §§ 4906 (2), 4914, and 4917, if a provider is appealing on his/her own behalf and not as a designee of the member, the cost of the external appeal shall be paid by the party who lost the appeal. If a partial determination is made, then SWH of NY and the provider share the cost evenly. SWH of NY and an Article 28 facility can agree to an alternative dispute resolution mechanism to resolve adverse medical necessity determinations. A provider requesting an external appeal, either on a member's behalf or on the provider's behalf, is prohibited from seeking payment from the member for services determined to not be medically necessary.

To be appointed as a member's representative, both the member making the appointment and the representative accepting the appointment must sign, date and complete an Appointment of Representation Form. A non-clinical representative may also complete and sign the form with the member's consent. To obtain a form, call Senior Whole Health at 1-877-353-0185 and ask for the Quality Department. You may also download the form at www.swhnyproviders.com.

A signed Appointment of Representation form is valid for one year from the date of signature. To file an appeal or grievance on behalf of a member, call or write the SWH of NY Quality Department at:

SWH of NY
Attn: Quality Department
15 MetroTech, 11th Floor
Brooklyn, NY 11201

Appeals

Any member has the right to appeal a service decision made by SWH of NY that terminates, suspends, or reduces a previously authorized service, denies a requested service or delays providing or arranging for a service.

Members can file an appeal of an action with the plan orally or in writing within 60 days of the date on the notice by calling 1-877-353-0185 or writing to:

SWH of NY
15 MetroTech Center, 11th Floor
Brooklyn, New York 11201

If we are reducing, suspending or terminating and authorized service and they want their services to continue while their appeal is decided, they must ask for an appeal within 10 (ten) days of the date on the notice or the intended effective date of the proposed action, whichever is later.

Appeals Process
Unless expedited, appeals will be answered in writing within 30 calendar days of the date of receipt. If a delay is in the interest of the member, a 14 calendar-day extension may be requested. If information from the physician or other sources indicates that waiting the 30 calendar days could jeopardize the member's life, health or ability to regain maximum function, the appeal will be expedited.

Expedited appeals will be answered no more than 72 hours after we receive the appeal. If a delay is in the interest of the member, a 14 calendar-day extension may be requested.

State Fair Hearings
If we deny a plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under the required timeframes, members may request a Fair Hearing from New York State.

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

- Online request form: https://errswebnet.otda.ny.gov/errswebnet/erequestform.aspx Member Services: 1-877-353-0185 Fax: 1-855-818-4870 www.seniorwholehealthny.com -20-
- Mail a printable request form: NYS Office of Temporary and Disability Assistance Office of Administrative Hearings Managed Care Hearing Unit P.O. Box 22023 Albany, New York 12201-2023
- Fax a printable request form: 1-518-473-6735
- Request by telephone: Standard Fair Hearing line – 1-800-342-3334 Emergency Fair Hearing line – 1-800-205-0110 TTY line – 711 (request that the operator call 1-877-502-6155
- Request in Person: New York City Albany 14 Boerum Place, 1st Floor 40 North Pearl Street, 15th Floor Brooklyn, New York 11201 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
Members may ask for an external appeal from New York State if we deny their appeal because we determined the service was not medically necessary or was experimental or investigational.

State external appeals must be field with the New York State Department of Financial Services within four months of the date we denied the members appeal. Members may ask for both a Fair Hearing and an external appeal. If they ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

Complaints

SWH of NY will try our best to deal with member concerns or issues as quickly as possible and

to their satisfaction. They may either use our complaint process or our appeal process, depending on what kind of problem they have.

A provider, when assigned by a member, may file a complaint on behalf of the member.

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

SWH of NY
15 MetroTech Center, 11th Floor
Brooklyn, New York 11201

We will send the member a letter telling them that we received their complaint and a description of our review process. We will review their complaint and give you a written answer within one of two timeframes.

- If a delay would significantly increase the risk to the members 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.
- For all other types of complaints, we will notify the member 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 the member requests it or if we need more information and the delay is in their interest.

Section 8 – Primary Care Providers

The interdisciplinary care team (IDT) and responsibilities

SWH forms an Interdisciplinary Care Team (IDT) for each member. The IDT is designed to work with providers in the management of member care by offering SWH resources to coordinate medical and non-medical resources, such as transportation, personal care, and homemaking. The PCP or their designee provides clinical direction and oversight.

IDT meetings may range from brief telephonic discussions to face-to-face meetings and may include professionals and persons critical to meeting the care needs of the member. The member or designated representative is an active participant in care plan decisions.

SWH Nurse Care Managers, the Member Services representative and the certified and licensed agencies may be part of the IDT and are essential in care planning and identifying supportive services. The SWH Nurse Care Manager communicates with the member and implements and manages the care plan established by the IDT.

Member initial assessments

Initial assessments are critical in that they allow the SWH Nurse Care Manager to understand key issues facing the member. We combine the information for the PCP Assessment Form with the information gathered from the home-based assessment to identify a new member's health and functional status more easily and quickly.

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- We will mail an Assessment Form to providers The forms may also be downloaded from our website. The PCP must complete an initial assessment when a new member joins SWH. The initial assessment must be completed within 30 days of the member effective date and is critical to implementing timely treatment or other interventions.
- Providers with an EMR, electronic medical record, may pull the required data from the EMR and send it to us in lieu of using our form. EMRs must include:

Chart summaries from the EMR
The PCP's clinical and non-clinical assessment of the member
Current diagnoses
Medications
Allergies
Advanced directives
Health care proxy
Other pertinent information

- Visit notes pertaining to a specific visit or notes limited to an Rx change are not adequate.
- Assessments must be signed by the PCP but may have an electronic signature.
- Whenever there is a significant health status change, an updated assessment is needed within 30 days of the request. Significant health status changes include:

Member entering a nursing facility

Member acquiring a new diagnosis
Change in members' ability to complete an ADL

- If no significant health status changes occur, we require an annual assess completed on the anniversary of the member effective date.

Opening and Closing a Member Panel

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All changes to panel status require written notice.

Panel change from **Existing** to **New:** providers may change a panel status from existing to new with five-days written notice.

Panel changes from **New to Existing:** If a Provider closes their panel to all new patients, an SWH member who is not currently the Provider patient may be excluded. However, a new SWH member who is the Provider existing patient at the time of enrollment in SWH, must be included. The PCP must notify SWH in writing at least 60 calendar days prior to closing the panel to new members.

All panel status changes must be sent in writing to:
Senior Whole Health
Attn: Provider Relations
15 MetroTech, 11th Floor
Brooklyn, NY 11201
Fax: 1-855-818-4873

Removing SWH members from provider practices

We view decisions to terminate physician-patient relationships very seriously. We are available to assist providers with difficult patient situations. Providers seeing assistance should call Member Services at 1-877-353-0185.

When removing a member, the provider must continue to provide care to the member for at least 30 calendar days beyond the termination date. We will assist the member in selecting another provider and notify the provider if this transition occurs in less than 30 days.
The provider must send the member written notification that clearly states the effective date of the termination, the reason(s) for termination, and a reference to the provider's internal policy. Notification must be sent by certified mail, return-receipt. The same correspondence must be forwarded to SWH at:

Senior Whole Health
Attn: Client Services Director
15 Metro Tech, 11th Floor
Brooklyn, NY 11201

Visit and access requirements

All urgent care and symptomatic office visits must be available to members with 24 and 48 hours, respectively. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention.

All non-symptomatic office visits must be available to members within 30 calendar days of member's request. Examples of non-symptomatic office visits include but are not limited to well and preventive-care visits for covered services, such as annual physical exams or immunizations.

Section 9 – Specialty Care Providers

Referrals

Specialists who are participating SWH of NY providers do not need to obtain an authorization for most professional services rendered in an office or outpatient setting. Refer to the Authorization Grid in the Appendix to determine if a service requires an authorization. Referrals to non-participating specialists must come from the member's PCP and be authorized by SWH of NY.

If a specialist feels that additional treatment is needed and they cannot provide this treatment, the specialist is responsible for contacting the member's PCP and suggesting the PCP provide the member with an additional referral.

Removing members from provider practices

We view decisions to terminate physician-patient relationships very seriously. We are available to assist providers with difficult patient situations. Providers seeing assistance should call Member Services at 1-877-353-0185.

When removing a member, the provider must continue to provide care to the member for at least 30 calendar days beyond the termination date. We will assist the member in selecting another provider and notify the provider if this transition occurs in less than 30 days.

The provider must send the member written notification that clearly states the effective date of the termination, the reason(s) for termination, and a reference to the provider's internal policy. Notification must be sent by certified mail, return-receipt. The same correspondence must be forwarded to SWH at:
SWH of NY
Attn: Client Services Director
15 MetroTech, 11th Floor
Brooklyn, NY 11201

Visit and Access Requirements

All urgent care and symptomatic visits must be available to members with 24 and 48 hours, respectively. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention.

All non-symptomatic office visits must be available to members within 30 calendar days of member's request. Examples of non-symptomatic office visits include but are not limited to well and preventive-care visits for covered services, such as annual physical exams or immunizations.

Section 10 – Quality Improvement Program

Quality Improvement

The Molina Healthcare Quality Improvement (QI) Program provides the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement of care and service, and improvement of members' health. The QI Program assists the organization to achieve these goals. It is an evolving program that is responsive to the changing needs of the health plan's customers and the standards established by the medical community, regulatory and accrediting bodies.

The key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health statuses.
- Collaboration with our contracted provider network to identify relevant care processes, develop tools, and design meaningful measurement methodologies for the provided care and service.
- Evaluation of the effectiveness of programs, interventions and process improvements and determine further actions.
- Designing effective and value-added interventions.
- Continuously monitoring performance parameters and comparing to SWH of NY standards, national and regional benchmarks, as well as regulatory requirements.
- Analysis of information and data to identify trends and opportunities, and the appropriateness of care and services.
- Oversight and improvement of delegated functions: Claims, UM and Credentialing.
- Ensuring a high-quality, adequate provider and Health Delivery Organization network through appropriate contracting, studies, and credentialing processes.
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral and case management.

The QI Program promotes and fosters accountability of employees and network and affiliated health personnel for the quality and safety of care and services provided to SWH of NY Members.

If you would like more information about our QI Program, initiatives, and/or the progress toward meeting our quality goals, please contact SWH of NY Provider Relations.

Section 11 – Provider Credentialing and Changes

Credentialing a new physician provider

Credentialing a new Provider is a simple process. Providers may only become credentialed if they are directly contracted with, or part of, a larger entity contracted with SWH of NY.

SWH of NY requires that new providers submit:

- A completed SWH of NY Provider Data Form
- W-9
- Sample claim (with PHI removed)
- Joinder (if contract requires a joinder, you will be notified by SWH of NY)

Providers must enroll in CAQH and enable SWH of NY to access record through CAQH.
The Provider Data Form is available on our website at www.swhnyproviders.com or may be requested by contacting Provider Relations at 1-877-353-9819.

SWH of NY may follow-up with providers to gather more complete or up-to-date information than what is available from CAQH. This includes office hours, languages spoken or other information required for Medicare.

Providers undergoing full credentialing will be effective the first day of the month following the month in which they are approved at SWH of NY's Credentialing Committee. SWH of NY will notify providers in writing once they have been approved by the committee.

For large group providers, SWH of NY also offers a convenient group submittal form upon request.

A health care professional that is newly licensed or new to the state will be deemed credentialed and treated as a participating provider if they join a participating group practice, and SWH of NY does not make a credentialing determination within 90 days of receipt of the provider's completed application.

Credentialing a new non-MD provider

In addition to physicians, SWH of NY also credentials licensed health professionals such as NPs, physical, occupational and speech therapists, dieticians, podiatrists and chiropractors.

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Contact Provider Relations at 1-877-353-9819 with any questions about credentialing.

Reporting

SWH of NY monitors Medicare and Medicaid sanctions and limitations on licensure on an ongoing basis. SWH of NY also reviews complaints and adverse events involving providers. If we receive information about a sanction, limitation or specific reportable incident that involves an

SWH of NY provider, we will report to the appropriate authority when required, including the National Practitioner Database, Medicare or NYS Department of Health. If SWH of NY suspends or terminates a provider for quality reasons, SWH of NY will also report to the appropriate authority.

If SWH of NY suspends or terminates a practitioner from the network, the practitioner may appeal the suspension or termination. SWH of NY will provide written notification to any practitioner that is suspended or terminated with an explanation of the action taken by the SWH of NY and will include information on appeal rights and the appeal process.

Recredentialing Providers

SWH of NY recredentials providers in accordance with New York regulations. SWH of NY makes best efforts to begin the process two months in advance of the recredentialing due date and notifies providers at least two times in writing if information is missing or requires updating. Timely provider assistance with this process is appreciated and avoids potential patient care disruptions.

This shall include, but not be limited to, requesting and reviewing any certifications required by contract or completed by the participating provider since the last time the contractor credentialed the participating provider.

Provider Rights and Responsibilities

Provider rights

- SWH of NY does not make credentialing or recredentialing decisions based on practitioner's race, ethnic, national identity, gender, age, sexual orientation, or the types of procedures or patients a practitioner specializes in treating.

Provider responsibilities

- Provider must comply with all contractual, administrative, medical management, quality management, and reimbursement policies as outlined in the SWH of NY provider contract, provider handbook and updates.
- Provider shall perform all services in compliance with applicable Federal and State requirements, laws, rules, regulations, and in compliance with all agency bylaws, rules, regulations, policies and procedures with respect to service delivery, participant rights, quality assessment and performance improvement activities. These include but are not limited to:
    - Compliance with NYSDOH guidelines, regulations and CMS instructions
    - Agree to audits and inspections by CMS and/or its designees, cooperate, assist and provide information as requested
    - Maintain records for a minimum of ten (10) years
    - Compliance with all applicable federal and state laws regarding confidentiality of patient records.

    - Meet applicable State minimum training requirements, including minimum hours and topics of training
- Provider must commit to providing high quality services in an ethical and responsible manner.
- Provider agrees to provide services within the scope of the provider's license and/or specialty.
- Provider agrees to adhere to established standards of medical practice and the customary rules of ethics and conduct of the American Medical Association and all other medical and specialty governing bodies.
- Provider agrees to report to SWH of NY any reports or sanctions against them for failure to provide quality care, negligence determinations or licensing terminations imposed upon them.
- The Provider shall participate in and comply with quality assurance and utilization review programs, including grievance and appeal procedures, and the monitoring and evaluation of the plan program, and continuing education and other similar programs established by SWH of NY.
- The Provider will protect all confidential information received consistent with applicable legal and ethical standards. Provide all services ethically, legally and in a culturally competent manner meeting the unique needs of the full member population.
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation must be clearly defined and communicated to members.
- Manage the medical and health care needs of members, including monitoring and following up on care provided by other health care providers, providing coordination necessary for services provided by a specialists and ancillary providers (both in and out of network).
- Make provisions to communicate in the primary language or fashion used by their members. Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Agree NOT to balance bill members for balance that are not their responsibility or that are the responsibility of another carrier
- Establish an appropriate mechanism to fulfill obligations under the American with Disabilities Act of 1990 (ADA) including reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities.
- Support, cooperate and comply with SWH of NY Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost effective and reasonable manner.
- Notify SWH of NY if a member objects to the provisions of any counseling, treatments or referral services for religious reasons.
- Manage a member's transition of care when the provider is the transferring provider:
    - Notify the member's usual practitioner of the transition within three (3) business days after the notification of the transition.
    - Provide a treatment plan and discharge instructions to the member prior to

being discharged.
    - Nothing herein prohibits or restricts you from disclosing to any Member, prospective Member, or designated representative any information that you deem appropriate regarding:
    - A condition or course of treatment including the availability of other therapies, consultations, or tests; or
    - The provisions, terms, or requirements SWH of NY products.
- Will arrange for specialty care outside of SWH of NY's provider network when network providers are unavailable or inadequate to meet a member's medical needs
- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. SWH of NY utilizes the provision of translator services and interpreter services
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies, and utilization management that allow for individual medical necessity determinations
- Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services
- Have in effect procedures that:
    - Establish and implement a treatment plan that is appropriate;
    - Include an adequate number of direct access visits to specialists;
    - Are time-specific and updated periodically;
    - Facilitate coordination among providers; and
    - Considers the member's input.
- Throughout your participation, you must allow members to:
    - Obtain complete current information concerning a diagnosis, treatment, prognosis in terms the member can understand. When it is not advisable to give such information the member, the information must be made available to an appropriate person acting on the member's behalf;
    - Receive information as necessary to give informed consent prior to the start of any procedure or treatment; and
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

  Members have certain rights by virtue of their enrollment in SWH of NY. These include, but are not limited to, the rights to:
    - Receive medically necessary care
    - Continuity of care
    - Timely access to care and services
    - Privacy about their medical record and when they get treatment
    - Get information on available treatment options and alternatives presented in a manner and language they understand
    - Be treated with respect and dignity

- Obtain a copy of their medical records and ask that the records be amended or corrected
- Take part in decisions about their health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion
- Not be balanced billed for covered services
- Have choice of providers
- Be told where, when and how to get the services needed, including how you can get covered benefits from out-of-network providers if they are not available in the plan network
- Complain or express grievances, use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate
- Appoint someone to speak about care and treatment
- Know what rules and regulations apply to your conduct

As a participating provider you are expected to not only respect these rights but assist members in leveraging these rights.

Access and Availability Standards

SWH of NY is required to adhere to patient care access and availability standards as required by the NYDOH and CMS. SWH of NY will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the need of the population served. These standards ensure that SWH of NY members can get an appointment for care on a timely basis, can reach the provider over the phone and do not experience excessive wait times during their scheduled appointments.

Participating providers must:

- Provide coverage for members 24 hours a day, 7 days a week
- Ensure another on-call provider is available to administer care when the PCP is not available
- Not substitute hospital emergency room or urgent care centers for covering providers
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to an urgent phone call with one (1) hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency room
- Ensure that services are provided in a culturally competent manner to all enrolled including those with limited English proficiency or reading skills
- Contracted providers are expected to comply with the following appointment, telephone access and practitioner availability service standards. SWH of NY conducts

audits of provider appointment availability, office waiting times and 24HR access and coverage. All participating providers are held to these standards in providing care for SWH of NY members. SWH of NY will develop a corrective action plan for providers and health networks that do not meet these standards.

Appointment Types	Standard
Routine, asymptomatic	Within 28 calendar days
Routine, symptomatic	Within 2-3 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (High Volume)	Within 28 – 42 calendar days
Specialty Care (High Impact)	Within 28 - 42 calendar days
Urgent Specialty Care	Within 24 hours

Practitioner rights in the credentialing and Recredentialing process includes:

- The right to correct erroneous information
- The right to review information submitted to support the credentialing application (except National Practitioner Data Bank (NPDB) reports, as required by law)
- The right to be informed of the status of their credentialing or recredentialing application upon request
- The right to confidentiality

Provider Demographic Changes

Change	Action	Notice Period
New provider to a practice	Submit Provider Data Form and federally required Disclosure Form	60 day prior to joining group
Providers leaving a practice	Written notice	30 days in advance of last day
Change of address, phone panel status, etc.	Written notice	30 days prior to effective date
New Tax ID number	New W-9	30 days prior to effective date

Send written notification to:
SWH of NY
15 Metro Tech, 11th Floor
Brooklyn, NY 11201
Fax: 1-855-818-4873
Email: providerrelationsny@seniorwholehealth.com

Questions should be directed to Provider Relations at 1-877-353-9819.

Notice Requirements for Practitioner's Termination from Groups

Provider groups shall provide SWH of NY written notice of a credentialed SCP's termination of group affiliation at least 60 calendar days prior to such termination. In the event the SCP's termination is effective in a time period less than 60 calendar days, the group shall provide SWH written notice immediately. When we receive notice of a termination less than 45 calendar days prior to such termination, we will enter a provider termination date into its system 45 calendar days in advance of the termination date. This will allow us at least 30 calendar days to notify members of the termination.

Delegated Credentialing

SWH of NY may delegate credentialing to practitioner groups, ancillary facilities (e.g., hospitals, NCQA certified credentialing vendors Delegates must follow individual state laws for recredentialing timeframes.

Facility Credentialing

SWH of NY initially credentials and recredentials ancillary facilities. An ancillary facility is an institution or organization that provides services: hospital, residential treatment center, home health agency or rehabilitation facility.

Medical ancillary facilities include:

- Home health agencies
- Skilled nursing facilities
- Free-standing surgical facilities

The Centers for Medicare and Medicaid (CMS) requires that specific ancillary facilities are accredited and in good standing.

Section 12 – Provider Directory

SWH of NY Provider Directory

SWH of NY publishes a Provider Directory for members and providers online and by request. SWH of NY includes contracted providers in such directories on the same basis as other similar participating providers.

Find a Doctor Search Tool

SWH of NY maintains an online Provider Directory search tool that can be accessed for each county via the web at www.swhnymembers.com.

Directory Corrections and Updates

If any information regarding a provider listing is incorrect or needs to be modified, please contact the Provider Relations. Refer to the Notice Provisions in the *Provider credentialing and provider changes* section of this manual.