6.1 Complaints

A complaint is any oral or written communication of dissatisfaction given by a member, family/caregiver, friend, provider on behalf of the member made to Senior Health Partners about the care and treatment a member receives from our staff or providers of covered services. Senior Health Partners will try its best to deal with member concerns or issues as quickly as possible.

Senior Health Partners cannot change the way a member receives services or the way they were treated by Senior Health Partner's staff or providers after tthe member filed a complaint. Interpreter services are also available to members who would like to file a complaint or appeal.

If a member asks you how to file a complaint direct them to: **1-800-633-9717** or to:

Senior Health Partners
Appeals and Complaints Department
PO Box 5166
New York, NY, 10274-5166
or
Fax: 1-646-313-4618

The member will need to provide their name, address, telephone number and the details of the problem.

Members may file a complaint with us orally or in writing. The person who receives their complaint will record it, and appropriate plan staff will oversee the review of the complaint. 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 a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to the member's health, we will address the complaint within 48 hours after receipt of all necessary information.
2. For all other types of complaints, we will notify the member of our decision within 45 days of receipt of all necessary information, but the process must be completed no later than 60 days of the receipt of the complaint. The review period can be increased up to 14 days if we need more information and the delay is in the member's interest.

If the member is not satisfied with the decision we make concerning their complaint, they may request a second review of their issue by filing a complaint appeal. Complaint appeals must be in writing and must be filed within 60 business days of receipt of our initial decision about their complaint. Once we receive the appeal, we will send a written acknowledgement. All complaint appeals will be conducted by appropriate staff who were not involved in the initial decision.

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

A report of all complaints is submitted to the Department of Health on a quarterly basis.

6.2 Appeals of Benefit/Service Determination

Below are all the details your patients need when appealing a decision by SHP regarding the benefits and services including timelines and requirements. You may contact your patient's Primary Care Management Team if you want to assist them in starting an appeal. You must sign and date a statement saying that the member has identified you to assist with filing a Plan Appeal.

Notice of Action – or a written decision about services by Senior Health Partners
A plan "action" includes when Senior Health Partners denies or limits services requested by the member or you (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, "actions". All actions are subject to appeal.

If Senior Health Partners decides to deny or limit services the member requested or decides 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 days** before we intend to change the service, except in cases of:

- Confirmed fraud (when the period is shortened to five (5) days)
- Death (when the notice is mailed by the change date)
- A signed written statement from the member requesting service termination or giving information requiring termination or reduction of services (when the notice is mailed by the change date)
- Admission to an institution making the member ineligible for further services (when the notice is mailed by the change date)
- The member's address is unknown and mail is returned with no forwarding address
- The member has been accepted for Medicaid services by another jurisdiction (when the notice is mailed by the change date).
- The member's doctor prescribes a change in the level of their medical care

Any notice we send to the member about an action will:

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

The notice will also inform the member about their right to a State Fair Hearing:

- It will explain the difference between a Plan Appeal and a Fair Hearing;
- It will say that for any denials on or after May 1, 2018, the member must file a Plan Appeal before asking for a Fair Hearing;
- It will explain how to request a Fair Hearing; and
- If we are restricting, reducing, suspending, or terminating an authorized service and the member wants their services to continue, the member must file a Plan Appeal within **10 days** of the date on the notice or the intended effective date of the proposed action, whichever is later.

Effective May 1, 2018, if we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell the member about the right to have services continue while we decide on the appeal; how to request that

services be continued; and the circumstances under which the member might have to pay for services if they are continued while we were reviewing the appeal.

How to file an appeal of a notice of action- information to help your patients
If the member does not agree with an action that we have taken, the member may appeal. When the member files an appeal, it means that we must look again at the reason for our action to decide if we were correct. The member can file an appeal of an action with the plan orally or in writing. An appeal must be requested within **60 calendar** days.

If a member needs assistance filing an appeal, direct them to Senior Health Partners at **1-800-633-9717** or have them write to

Senior Health Partners
Attn: Appeals and Complaints
PO Box 5166
New York, NY 10274-5166

The person who receives their appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling the member that we received their appeal, and how we will handle it. We will also include a copy of your case file which includes medical records and other documents used to make the original decision. The appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that the member is appealing.

Please note that the member can appeal any restriction, reduction, suspension, or termination of authorized Consumer Directed Personal Assistance Services (CDPAS) or denial of a request to change CDPAS. If Senior Health Partners denies their appeal, the member is entitled to a fair hearing.

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

We will send the member a notice about the decision we made about their appeal that will identify the decision we made and the date we reached that decision. If the member does not receive a response to the Plan Appeal or the decision is late, the member can ask for a Fair Hearing without waiting for the plan's decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while their appeal was pending, we will provide the member with the disputed services as quickly as their health condition requires. In some cases the member may request an "expedited" appeal.

Continuation of services while an appeal is reviewed
If the member is appealing a restriction, reduction, suspension or termination of services they are currently authorized to receive, the member must complete the internal appeal process prior to requesting a Fair Hearing. The member can request a Fair Hearing no later than **120 days** from the date on the determination notice.

How to ask for an expedited/fast review - information to help your patients
If you (the provider) or the member feels that taking the time for a standard appeal could result in a serious problem to their health or life, the member may ask for an expedited review of their appeal of the action. We will respond to the member with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than **3 business** days after we receive their appeal. (The review period can be increased up to 14 days if the member requests an extension or we

need more information and the delay is in their interest.).

Beginning May 1, 2018, we will respond to the member with our decision within 72 hours after we receive all necessary information. In no event will the time for issuing our decision be more than **72 hours** after we receive their appeal.

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

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

Note: Beginning May 1, 2018, the member must request a Fair Hearing within 120 calendar days after the date of the Final Adverse determination notice.
If we deny their appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

The member must exhaust internal appeal rights before requesting a Fair Hearing. The member must request a Fair Hearing within **120 calendar days** of the date we sent the member the notice about our original decision. The member must wait until the Plan decides their appeal and then ask for a Fair Hearing.

To make sure that their services continue pending the appeal, generally the member must request the Fair Hearing AND make it clear that the member wants their services to continue. Some forms may automatically do this for the member, but not all of them, so please read the form carefully. In all cases, the member must make their request within 10 days of the date on the notice, or by the intended effective date of our action (whichever is later).

Their benefits will continue until the member withdraws the appeal; the original authorization period for their services ends; or the State Fair Hearing Officer issues a hearing decision that is not in their favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that the member receives the disputed services promptly, and as soon as their health condition requires. Beginning May 1, 2018, we must make sure that the member receives the services no later than 72 hours from the date the plan receives the Fair Hearing decision. If the member received the disputed services while their appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

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

- Online Request Form: http://otda.ny.gov/oah/FHReq.asp
- Mail a Printable Request Form:

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings

Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

- Fax a Printable Request Form: (518) 473-6735

- Request by Telephone:

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

- Request in Person:

New York City	**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/

Senior Health Partners may not act in any manner that restricts a member's right to a fair hearing or influence their decision to pursue a fair hearing.

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

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

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

The member can get a faster decision if their doctor can say that a delay will cause serious harm to their health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or fewer. The reviewer will tell the member and us the decision right away by phone or fax. Later, a letter will be sent that tells the member the decision.

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

We can be reached by calling **1-800-633-9717** or by writing to:

Senior Health Partners
Attn: Appeals and Complaints
PO Box 5166
New York, NY 10274-5166

The person who receives their appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling the member that we received their appeal, and how we will handle it.

Their appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that the member is appealing.

Remember that if at any time the member is dissatisfied with how Senior Health Partners has treated the member, or how we have handled their complaint, the member can contact the New York State Department of Health by writing to:

New York State Department of Health
Bureau of Managed Long Term Care
One Commerce Plaza
Room 1620
Albany, New York 12210
1-866-712-7197

The member can also call the Participant Ombudsman called the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about their coverage, complaints, and appeal options. They can help the member manage the appeal process. They can also provide support before the member enrolls in a Managed Long Term Care (MLTC) plan like Senior Health Partners. This support includes unbiased health plan choice counseling and general program-related information. Contact ICAN to learn more about their services:

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

Senior Health Partners will cooperate with, and may not inhibit, the ICAN in the exercise of its duties.
Appeals are tracked by a formal mechanism.
A report of appeals is submitted to the Department of Health on a quarterly basis.

6.3 Complaints

- A complaint can be written or verbal.
- A complaint can be filed by the member, or by a family/caregiver, friend or provider on behalf of the member.
- A complaint can be made about a Senior Health Partners employee or provider.
- Provider complaints are included in the Provider Report Card Process.

6.4 Quality Review and Oversight

Records of complaints and appeals are stored, tracked ,and reviewed by the Vice President of Clinical Excellence or designee.
Providers may be asked to investigate individual or aggregate complaints and may be asked to define action improvement plans, as necessary.
Results of activities are reported to the Quality Utilization and Management (QUM) Committee to determine ongoing issues, trends, and opportunities for improvement.
Recommendations may also be made to limit a provider's participation in the network.
The results of the review and analysis are also reported to the Quality Management Committee.