IMPORTANT NAMES AND PHONE NUMBERS

When you become a member of GuildNet, please fill in the following important information:

Care Manager: ____________________________  ____________________________
                   Name                                      Phone Number

Member Service Representative: ____________________________  ____________________________
                                      Name                                      Phone Number

Names, addresses and phone numbers of your doctors:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

HOW TO CONTACT GUILDNE

New York City:  212-769-7855
Brooklyn:  718-495-2200
White Plains:  914-220-8600
Toll Free:  800-932-4703

(24 hours a day. 7 days a week. Including nights, weekends and holidays)

By mail, write to:

GuildNet Member Services
250 West 57th Street
10th floor
New York, NY  10107
Welcome to GuildNet

Welcome. Thank you for choosing GuildNet! As a valued member we will provide you with:

- A Care Manager who works with you
- An individual plan of care
- The care you need to stay in your own home

GuildNet is a Managed Long Term Care (MLTC) Plan approved by the New York State Department of Health. This handbook:

- Describes the services GuildNet provides
- Explains how you and your Care Manager will plan your care
- Tells you who to call when you need help

Please read the handbook with care. If you need more information, or have any questions, please call your Care Manager or your Member Services Representative. Once you become a member you can write their telephone numbers on the inside cover of the handbook. They are here to help you.

We encourage you and your caregivers to be part of the team in your long term care along with:

- Your Care Manager
- Your Member Services Representative
- Your doctors

Everyone working together will help you receive the services you need.

Thank you for choosing GuildNet for your care. We look forward to serving you.
We Speak Your Language

As a GuildNet Managed Long Term Care (MLTC) member, you can get important information about our plan in your language. For example, our GuildNet Member Services Handbook and other GuildNet information is available in English, Chinese, Creole, French, Korean, Russian and Spanish.

Our handbook is also available in Braille, or large print, or it can be read to you by one of our staff members.

We also provide:

- Qualified sign language interpreters
- Written information in other formats, for example: audio, accessible electronic formats

If you need these services, call us at 800-932-4703.

If you have a hearing impairment, for TTY/TYDD services, call 800-662-1220.

Write the names and phone numbers of your Care Manager and your Member Service Rep at the front of the handbook.
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What is GuildNet MLTC?

GuildNet Managed Long Term Care (MLTC) is a program of coordinated services for adults who are able to live safely at home and in their communities, but who need help with day-to-day activities.

The term "Managed Long Term Care" means that you have a team of people coordinating and providing your care. Leading the team is your Care Manager who will work closely with you and your family. Your Care Manager’s job is to understand your health needs and to coordinate care. You can expect to hear from someone on your Care Team at least once a month. Your Care Manager and Care Team are responsible for maintaining and coordinating your plan of care.

Your plan of care is tailored to your needs and is discussed and reviewed with you and your family. Your plan of care includes services covered by GuildNet, as well as services not covered by GuildNet, that you receive through Medicare, Medicaid fee-for service or other insurance.

As one of our members, you receive covered long term care and health-related services through a network of providers. The current GuildNet Provider Network Directory is in your Welcome Packet. Your doctor, Care Manager and other team members such as your Member Service Representative use the provider network to make sure that your care is as complete as possible.

We must approve most covered services before you receive them. You do not need approval from us for non-covered services.

Your GuildNet team will help you:

- coordinate all covered and non-covered services
- schedule your appointments
- arrange non-emergency transportation

Get your flu shot. Ask your Care Manager for help. The phone number is at the front of the handbook.
What Makes GuildNet Special?

GuildNet is a program of Lighthouse Guild. Lighthouse Guild addresses and treats vision loss through coordinated vision and healthcare services. With a track record of more than 100 years, we work every day to help individuals and families lead more independent and fulfilling lives. Our staff are experts in vision care. This means we care about vision problems that might affect your comfort and safety at home. An emphasis on vision and vision care makes GuildNet special when it comes to a health care plan.

Specialized vision care

We are trained to address the needs of a person who is blind or visually impaired. If you have vision problems, we will work with you to develop a plan of care that addresses your health, long term care and vision needs. Our experience means we understand the need for specialized devices, services and supports.

Our network of providers is carefully chosen to be sensitive to your visual loss. We can arrange all necessary vision and vision-related services. Services for blind and visually impaired persons include:

- Vision testing and ongoing care
- A network of optometrists (for eye exams)
- Living skills training, modifications in your home, adaptive devices
- Eyeglasses and/or specialized optical devices
- Assistance to complete any forms required for your GuildNet membership
- GuildNet materials in large print, Braille or on audiocassette
- Vision support groups
Member Satisfaction

We want feedback on your satisfaction with GuildNet, our staff, the services we provide and the staff of the providers that we use. You may receive written or telephonic surveys from us, asking about your satisfaction as a member of GuildNet’s Managed Long Term Care plan.

We want to hear from you! It is important that you complete these surveys. We value your feedback.
Eligibility and the Enrollment Process

GuildNet Managed Long Term Care (MLTC) is for individuals who need long term care services for more than 120 days, and would like to receive these services at home and in the community for as long as possible. Your membership in GuildNet is voluntary. You choose to enroll in the program and you may choose to leave the program for any reason.

You are eligible to enroll in GuildNet if:

• You are at least 18 years old.
• You are a resident of Manhattan, Brooklyn, Bronx, Queens or Staten Island counties;
• You are eligible for MLTC, using an eligibility assessment tool designated by the Department of Health;
• You are eligible for Medicaid.
• You are capable of returning to or remaining in your home and community without jeopardy to your health and safety.
• You require at least one of the following Community Based Long Term Care services for more than 120 days from the start date of your enrollment. These services are:
  • Nursing services in your home
  • Therapies in your home
  • Home health aide services
  • Personal care services
  • Adult day health services
  • Private Duty Nursing
  • Consumer Directed Personal Assistance Services

Money Follows the Person (MFP)/Open Doors

Money Follows the Person (MFP)/Open Doors is a program that helps you move from a nursing home back into your home or residence in the community. You may qualify for MFP if you:

• Have lived in a nursing home for three months or longer
• Have health needs that can be met through services in your community
MFP/Open Doors has people who can meet with you in the nursing home and talk with you about moving back to the community. These people are called Transition Specialists and Peer Support. Transition Specialists and Peer Support are different from Care Managers and Discharge Planners. They can help you by:

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

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

**Conflict-free evaluation and enrollment**

If you want information about GuildNet or want to enroll, you will first be assessed by a Conflict-Free Evaluator who is a registered nurse (RN), or someone else designated by the New York State Department of Health. You will be evaluated to see if you need community based long term care services. If you do, the Conflict-Free Evaluator will connect you with GuildNet to be assessed by a GuildNet Intake Nurse. The Conflict Free Evaluation and Enrollment Center can be contacted at 855-222-8350.

You or your family/caregiver or other referral source may contact us directly to notify us of your interest in the Plan. The phone number is: 800-932-4703.

One of our staff members will contact you and arrange a meeting to explain the Plan. If you are interested, and are eligible for benefits under Medicaid, a meeting will be set up with an Intake Nurse. Our Intake Nurse will complete a New York State Assessment to determine if you qualify for nursing home level care. During this visit you will be asked to sign an enrollment agreement, a privacy notice form (HIPAA), a medical release form, and other enrollment forms. Your plan of care will be developed to fit your health care needs, including your vision care needs.
In most cases, if you are eligible, you will become a member of GuildNet on the first day of the month after you sign the enrollment application and agreement. If you are in the hospital, your enrollment will be effective on the first day of the month following your discharge.

During the enrollment process, you will receive an explanation on how to access services. You will receive a written notice of the proposed Person Centered Service Plan (PCSP) before enrollment. You will also receive a list of GuildNet providers. When the process is completed and you are a member, your Care Manager will make sure that you get all the services outlined in your initial plan of care.

Once you are a member, you will receive a personal GuildNet member identification card. You also need to keep your Medicaid and Medicare cards and any other insurance cards that you may have. These allow you to get services not covered by us but that are still covered by Medicare, Medicaid or other health insurers.

We want you to be satisfied with your care. Soon after you enroll, one of our staff members will contact you to answer any questions you may have about GuildNet. There is always room for improvement and we want to know how we can best serve you.

**Medicaid recertification**

You are required to renew your Medicaid coverage once a year. Your Local Department of Social Services sends out notices with required documentation. You must complete the form to renew your Medicaid coverage. We have staff who can assist you with the Medicaid renewal process. They will contact you to offer help. You can also contact your Local Department of Social Services (LDSS) if you need help filling out the form.

**Medicaid spend-down**

In New York State, you may be eligible for Medicaid even if your monthly income is over the Medicaid limit. To do this you have to pay what Medicaid calls a “spend-down”. This amount is determined by the Local Department of Social Services (LDSS).
LDSS will review your monthly income as part of your application for participation in GuildNet. They want to see if you meet the income eligibility requirement for Medicaid. LDSS may decide that you must “spend-down” a portion of your monthly income in order to meet the Medicaid income eligibility amount. If this happens, LDSS will inform you and us of the exact amount of your “spend-down”. The spend-down amount is owed to us each month when you are a member.

You will be expected to pay your spend-down amount to GuildNet by the 15th of each month. If you have a problem meeting this responsibility, please discuss the situation with your Care Manager.

We will send you a monthly bill for the amount you owe. If you fail to pay the amount owed you may be disenrolled from GuildNet.

A mandatory review of your eligibility is required by LDSS once a year. If your eligibility changes during your membership, LDSS will notify you of the change and we will adjust your payment.

<table>
<thead>
<tr>
<th>If you are eligible for:</th>
<th>You will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid without a spend-down</td>
<td>Nothing to GuildNet</td>
</tr>
<tr>
<td>Medicaid with a spend-down</td>
<td>A monthly spend-down to GuildNet as determined by the LDSS</td>
</tr>
</tbody>
</table>
What Are the Services Covered by GuildNet?

Health education services
We provide health education to all our members through newsletters, our website, and health education classes as well as over the phone. Nurses, Nutritionists, Diabetes Educators and others all play a part. Topics include chronic conditions such as Diabetes, Asthma, COPD (Chronic Obstructive Pulmonary Disease), Heart Failure and How to Stop Smoking.

Veterans’ services
If you are a veteran, the spouse of a veteran, or a Gold Star parent, you can receive long term placement services in Veterans’ Home. Contact your GuildNet Care Manager to discuss Veterans’ Homes in your area that are in the GuildNet network.

The GuildNet Provider Network
We have a network of providers for our covered services. These health care providers must meet our strict credentialing criteria and operating standards before they can become part of our service network. As a GuildNet member, you must get your covered services from one of our network providers. You will receive an updated provider directory every year and/or upon request.

A list of GuildNet network providers will be given to you during the intake process to aid you in making your decision to join GuildNet. You may choose any provider within our GuildNet network.

If your provider leaves the Network
We will tell you if your provider leaves the network and help you to choose another provider from our network. A provider who leaves the network is required to continue providing services to you for at least 30 days until your transition to a new provider is in place.

If you require specialized health care needs, we will work with you to obtain the services.
We will ask your opinion about the services you receive from our network providers. The information you give us will remain confidential. We will provide regular, confidential feedback to your service providers so that our services can continue to improve. Remember that you can make a change if you are not happy with a provider in our network.

If you want to change a provider, call us. Your Care Manager will help you identify another provider in our network. Your satisfaction with the services you receive is important to us and to you.

**We speak your language**

As a GuildNet member, you can get important information in your language. For example, our Member Handbook and other health information is available in English, Chinese, Creole, French, Korean, Russian and Spanish. We have staff, providers and translators who speak many languages.

**Hearing impaired**

If you are deaf or hearing impaired, you can contact us by calling the Telecommunications Relay Services (TRS). You can reach them at 711.

**Visually impaired**

If you are visually impaired, we will help you by talking over all of the information about GuildNet with you. We can also provide written information that will help your caregivers assist you.

**Questions about covered services?**

Just pick up the phone and call your Care Manager or Member Services Representative. They are here to help you 24 hours a day, 7 days a week.

Your Care Manager, Member Services Representative, and other GuildNet staff can be reached at 800-932-4703. Our hours are 8:00 am to 5:30 pm Monday to Friday. If you need help after this time or on the weekend, please call 800-932-4703.
# What Services Are Covered by GuildNet?

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Is your GuildNet Care Manager’s prior approval required?</th>
<th>Is a Physician’s Order needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health Care</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Adult Social Day Care</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Audiology - Hearing Exams</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Audiology - Hearing Aids</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Certified Home Health Care Services</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Consumer Directed Personal Assistance Services</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Dentistry (see page 16)</td>
<td>YES - HEALTHPLEX</td>
<td>NO</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Medical and Surgical Supplies</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Licensed Home Care</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Meals (Home/Congregate)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Non-Emergency Transportation (see page 16)</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Optometry</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Outpatient and in-home physical, occupational, speech therapy</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Podiatry</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Personal Emergency Response System (PERS)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Prosthetics/Orthotics</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Social and Environmental Supports</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Social Work Services</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Telehealth</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

For your transportation needs call 800-934-7704.
What Services Are Not Covered by GuildNet?

The following services are not covered by GuildNet Managed Long Term Care Plan, however your Care Manager can help coordinate both covered and non-covered services.

- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services, including services provided in an office setting, a clinic, a facility or in the home
- Laboratory Services
- Radiology and Radioisotope X-Rays services
- Hospital Emergency Room Care
- Rural Health Clinic Services
- Emergency Transportation
- Chronic Renal Dialysis
- All Prescription and Over the Counter Medications
- Mental Health Services
- Office for Persons with Developmental Disabilities (OPWDD) Services
- Alcohol and Substance Abuse Services
- Family Planning Services

And any other services covered by Fee-For-Service Medicaid.
Transportation and Dental Services

How do I get transportation?
As a GuildNet member, you can call National Med Transportation for your medical transportation needs. Their phone number is 800-934-7704. Your GuildNet Care Manager will help you coordinate non-emergency transportation. We are here to help you.

How do I get dental care?
We work with HealthPlex to provide all your dental needs. When you enroll in GuildNet, you will receive a HealthPlex ID card and a HealthPlex Directory that lists the dental offices you can visit. You will need to bring your HealthPlex ID card to your dental appointments. HealthPlex can be reached by calling 800-468-9868 Monday to Friday from 8:00 am to 6:00 pm.

What if I have problems?
If you have difficulty getting access to these services, you may call and report your difficulties to one of our staff members and your Care Manager will help you. If you are unhappy with the provider’s service delivery or access to the service, you may use our Internal Grievance Process (see page 26).
Your Care Plan

How is my Care Plan developed?

A GuildNet Intake Nurse will develop a Care Plan with you during the initial assessment visit. Your Care Plan, also referred to as a Person Centered Service Plan (PCSP), is based on your health needs and includes all of the services that you need. It includes the goals that you, your family, your physician and Care Manager have discussed. Your PCSP may change over time as your needs change.

As a GuildNet member, you will have your own Care Manager and Member Services Representative. They are a part of your Care Team. They will work with you and will update your Person Centered Service Plan as your needs change.

Your Care Team members will:

- Help you to schedule your medical appointments.
- Assist you in coordinating non-emergency transportation to appointments and services.
- Assess your needs and modify your Person Centered Service Plan.
- Coordinate your care with your physician.
- Arrange for medically necessary equipment covered by GuildNet.
- Arrange for modifications in your home that are clinically necessary.
- Identify GuildNet network service providers in your community.
- Answer questions or discuss any aspect of your care.
- Help you by coordinating all covered and non-covered services.
- Help you learn about injury prevention, how to stop smoking, immunizations, nutrition and other areas of preventative health.
- Call you, your family or others who may be assisting you, on a regular basis.
- An assessment nurse will visit you every 6 months to make sure you are receiving the care you need.
Are there formal authorization procedures?
Most services covered by GuildNet require prior authorization. This means that if you need certain services you must get approval in advance, before receiving care. We try to keep our authorization process simple so that you can get the care you need.

Service authorization process

- **Prior authorization review**

  If you or your physicians ask for new services, you will be informed of our decision within 14 days of your request. If we need more information to make our decision about your authorization, we may extend the time it takes to review your request by 14 days to make our decision.

  If you or your physician ask for an expedited (fast) prior authorization because you or your physician or provider believe that a delay would jeopardize your health, and the plan agrees to the expedited review, we will make our decision within 72 hours from the date of your request.

- **Concurrent authorization review**

  If you or your physician ask for additional services that are currently authorized in your plan of care, this is called a concurrent review and you will be informed of our decision within 14 days of your request.

- **Expedited (fast) review**

  If you and our doctor think a quick determination is needed, because you believe the regular time frame will jeopardize your health, you can ask for an “expedited (fast) review”. An expedited review will be reviewed by our staff within 1 working day, if all information is received to make the decision. If we do not receive all the information a decision will be made within the standard time frame.
● **Extension of authorization decision time frames**

If your doctor does not give us enough information to make a decision, we will send you an extension letter. This will give us an additional 14 days in order to get the information and make our decision. You as the member, or a provider on your behalf, may also request an extension in writing or verbally.

● **What are the general criteria used to make decisions?**

We will provide services that are covered by Managed Long Term Care and that are medically necessary. All services that we provide must meet the following criteria:

- The service does not duplicate other services being provided.
- The requested service is expected to achieve the purpose for which the service is requested/furnished according to a physician or other appropriate healthcare professional (applies to all services).
- Can be provided safely.
- Services that are medically necessary.
- Is the most appropriate level of service or item that can be safely and effectively provided to you and is acceptable to you/your Caregiver/your Family.
- The needed services are the result of assessment and are clinically appropriate.
- Network providers must be utilized, unless an exception is approved by us.
What Are My Responsibilities as a GuildNet Member?

As a member of GuildNet, you have certain rights and responsibilities when you join GuildNet Managed Long Term Care (MLTC). Your rights are discussed in the next section.

As a member of GuildNet, you must:

- Receive all of your covered benefits through our provider network.
- Get approval from your physician, Care Manager or care management team before receiving a covered service that requires such approval.
- Talk with your Care Manager about your care needs and concerns and work with your Care Manager in addressing them.
- Let your Care Manager know if you plan to go out of town.
- Make all required spend down/surplus payments to GuildNet.
- Cooperate with requests for documentation related to maintaining your Medicaid eligibility.
- Allow our nurses to come to your home every 6 months and perform a reassessment.
- Provide us with information about any other insurance coverage you may have.
- Call us whenever you have a question regarding your membership or need assistance.

We want to make GuildNet the very best long term care program. To do that, we need your help and ideas. Every so often we or our representatives may send you a short survey or call you on the phone to ask how you feel about us. Our staff considers each comment and suggestion from members and families to see how we can improve the program for everyone. It is an important way for you to take part in improving our policies, providers and services.

Get your flu shot. Ask your Care Manager for help. The phone number is at the front of the handbook.
What Are My Rights as a GuildNet Member?

Your health, safety and well-being are our concern. As a member, you have certain rights that are important for you to understand. If you have any questions, please ask your Care Manager or Member Services Representative to explain them to you. As a member of GuildNet:

- You have the right to receive medically necessary care.
- You have the right to privacy about your medical record and when you get treatment.
- You have the right to timely access to care and services.
- You have the right to get information on available treatment options and alternatives presented in a manner and language that you understand.
- You have the right to get information in a language you understand and the right to get oral translation services free of charge; TTY phone service is available at 800-662-1220.
- You have the right to get information necessary to give informed consent before the start of treatment.
- You have the right to be treated with respect and dignity.
- You have the right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the right to take part in decisions about your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the right to be told where, when and how to get the services you need from us, including how you can get covered benefits from out-of-network providers if they are not available in the plan network. You must receive authorization from us before seeing an out of network provider.
- You have the right to complain to the New York State Department of Health, your Local Department of Social Services, the right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
The New York State DOH’s toll free complaint line is 866-712-7197. Or you may write to The New York State DOH MLTC Technical Assistance Center, 16 floor, One Commerce Plaza, Albany, NY 12210
Don’t forget to schedule an annual physical exam. Ask your Care Manager for help.
• You have the right to appoint someone to speak for you about your care and treatment.
• You have the right to make advance directives and plans about your care.
• You have the right to seek assistance from the Participant Ombudsman program (ICAN Representative).

In addition, as one of our members, you may be receiving care from a home care agency, a hospital, or an adult day program. You have important rights that the health provider must respect. Please be sure that you understand all of your rights as you continue to receive services from us and our provider network.

**Participant Ombudsman**

The Participant Ombudsman, also known as the Independent Consumer Advocacy Network (ICAN) is a free resource available to you. ICAN is the New York State Ombudsman program for people with Medicaid who need long term care services. It can provide advice to you about your coverage, complaints and appeal options. It can also tell you about community-based resources and support services.

These services include, but are not limited to:

• Providing you with pre-enrollment support. This can include unbiased health plan choice counseling and general program-related information.
• Compiling your complaints and concerns about enrollment access to services.
• Helping you to understand the fair hearing, grievance and appeal rights and processes within the health plan as well as at the State level. It can assist you through the process if needed, including making requests of plans and providers for records.
• Informing plans and providers about community-based resources and supports that can be linked with covered plan benefits.

You can reach ICAN by calling **844-614-8800** (TTY Relay Service: 711). You can visit their website www.icannys.org or email ICAN at ican@cssny.org.
What Should I Do in An Emergency?

If it’s an emergency—Call 911
If you think your problem is an emergency, call 911 to get help right away. Go to the closest hospital, emergency room, clinic or doctor’s office. They will evaluate your health. They will make sure you get the care you need in order to stabilize your condition. If you have an emergency medical condition, you do not need to contact us before getting care. Do not worry about whether the emergency service is authorized or if the provider is part of the GuildNet Provider Network.

What is an emergency medical condition? An emergency medical condition is a health problem that happens suddenly or very rapidly. The problem includes pain or other symptoms that are so severe that an average person, who has no special knowledge of health or medicine, believes that there will be serious harm done if immediate help is not obtained.

You may receive emergency care anywhere in the United States. Wherever you are, it is important that you call your GuildNet Care Manager as soon as you, a family member or a friend is able. Your membership card lists the local and the toll-free number that you can call. Your Care Manager can rearrange any scheduled services that you might miss at this time, and begin to make any necessary changes to your plan of care. He/she will help you avoid any unnecessary gaps in the services you need.

What if I need urgent care?—Call your physician or GuildNet
When you need urgent care for symptoms that require attention sooner than a regular medical visit can be scheduled, you should call your physician. He/she will respond to your need immediately by recommending treatment, scheduling an office visit for you, or sending you to a hospital emergency room. If you prefer, you may call us and we will assist you.

How do I get help during non-working hours?
It is always best for you to discuss your questions directly with your Care Manager who knows you best. However, you might have an urgent need for assistance, or questions that cannot wait until business hours. If you need help after hours, on a weekend, or on a holiday, contact us at the 24-hour toll-free number 800-932-4703 and an on-call nurse will help you.

TTY users may access the New York State Relay Line: 800-662-1220.
What if I leave the GuildNet service area?

Wherever you are, if you have an emergency or urgent situation, seek the care first, and then contact your Care Manager as soon as you are able so we can make arrangements for your continuing medical care.

Continuity of your care is important to us. Please let us know if you are planning to spend time temporarily outside of our service area. We want to make sure your health care needs are properly addressed at all times. If you leave our service area for more than 30 consecutive days, you will be involuntarily disenrolled from GuildNet unless you have requested to disenroll.

Get your flu shot. Ask your Care Manager for help. The phone number is at the front of the handbook.
Complaints and Appeals

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

There will be no change in your services or the way you are treated by GuildNet staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint or to appeal a plan action, please call: 800-932-4703 or write to:

GuildNet
Attention: Quality Assurance & Performance Improvement
250 West 57th Street
10th Floor
New York, NY 10107

If you are hearing impaired, you can contact us by calling Telecommunications Relay Services (TRS). You can reach them at 711. They will help you file a complaint and will call us at 800-932-4703.

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

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us.
The Complaint Process
You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

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

2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

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

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

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

When GuildNet denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn’t provide timely services; or doesn’t make complaint or appeal determinations within the required timeframes, those are considered plan “actions”. An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

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

Contents of the Notice of Action

Any notice we send to you about an action will:

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

If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.
How do I File an Appeal of an Action?
If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?
We can be reached by calling 800-932-4703 or writing to

GuildNet
250 West 57th Street
10th Floor
New York, NY 10107

If you are hearing impaired, you can contact us by calling the Telecommunications Relay Service (TRS). You can reach them at 711 or 800-662-1220. They will help you file an appeal and will call us at 800-932-4703.

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

For Some Actions You May Request to Continue Service During the Appeal Process
If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while your appeal is being decided. We must continue your service if you make your request no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later.
Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

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

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

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

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

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

**Expedited Appeal Process**

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 72 hours. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)
If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

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

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

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

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

**State Fair Hearings**

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

Your benefits will continue until you withdraw the Fair Hearing; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.
If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

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

- Online Request Form: [http://otda.ny.gov/oah/FHReq.asp](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 – **800-342-3334**
  - Emergency Fair Hearing line – **800-205-0110**
  - TTY line – 711 (request that the operator call **877-502-6155**)

- Request in Person:

  **New York City**
  **14 Boerum Place, 1st Floor**
  **Brooklyn, New York 11201**

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

[http://otda.ny.gov/hearings/ request/](http://otda.ny.gov/hearings/ request/)
State External Appeals

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

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal.

If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

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

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

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

Definitions

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee’s behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such service is provided to the Enrollee.

Concurrent Review: review of a request by an Enrollee, or provider on Enrollee’s behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Expedited Review: An Enrollee must receive an expedited review of his or her Service Authorization Request when the plan determines or a provider indicates that a delay would seriously jeopardize the Enrollee’s life, health, or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.

General Provisions

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered health care professional when such determination is based on an assessment of the Enrollee’s health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit when coverage is dependent on an assessment of the Enrollee’s health status, and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals, and out-of-network services.
The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance.

The Contractor shall utilize the Department’s model MLTC Initial Adverse Determination and 4687 MLTC Action Taken notices.

**Timeframes for Service Authorization Determination and Notification**

1. For Prior Authorization requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee’s condition requires and no more than:

   a. Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request
   b. Standard: Fourteen (14) days after receipt of request for Service Authorization Request.

2. For Concurrent Review Requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee’s condition requires and no more than:

   a. Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request
   b. Standard: Fourteen (14) days of receipt of the Service Authorization Request
   c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.
3. **Up to 14 calendar day extension.** Extension may be requested by Enrollee or provider on Enrollee’s behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee’s interest. In all cases, the extension reason must be well documented.

   a. The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination, and help the enrollee by listing potential sources of the requested information.

4. **Enrollee or provider may appeal decision –** see Appeal Procedures.

5. **If the plan denied the Enrollee’s request for an expedited review, the plan will handle as standard review.**

   a. The Contractor must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee’s service request will be reviewed in the standard timeframe.

### Other Timeframes for Action Notices

1. **When the Contractor intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period,** whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:

   a. the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or
   b. the Contractor may mail notice not later than date of the Action for the following:

   i. the death of the Enrollee;
   ii. a signed written statement from the Enrollee requesting service termination or giving
information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);

iii. the Enrollee’s admission to an institution where the Enrollee is ineligible for further services;

iv. the Enrollee’s address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;

v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or

vi. the Enrollee’s physician prescribes a change in the level of medical care.

c. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)-(b).

i. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a non-business day, unless the Contractor provides “live” telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals.

d. The Contractor must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,

e. When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

Write important names and phone numbers at the front of the handbook.
Contents of Action Notices

1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.

2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:
   a. the date the restriction will begin;
   b. the effect and scope of the restriction;
   c. the reason for the restriction;
   d. the recipient’s right to an appeal;
   e. instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
   f. the right of Contractor to designate a primary provider for recipient;
   g. the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;
   h. the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
   i. the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;
   j. the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
   k. the name and telephone number of the person to contact to arrange a conference;
   l. the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
   m. the fact that the conference does not take the place of or abridge the recipient’s right to a fair hearing;
   n. the right of the recipient to examine his/her case record; and
   o. the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This information is generally referred to as “claim detail” or “recipient profile” information.
What If I Decide to End My Membership in GuildNet?

If you are not satisfied with GuildNet for any reason, or you move out of our service area, you may end your membership. In other words, you may disenroll.

If you want to disenroll, call your Care Manager. He/she will assist you in the disenrollment process. Or you can directly call New York Medicaid Choice (MAXIMUS) and request disenrollment from GuildNet.

You will receive written notification of the date when your disenrollment comes into effect. Until that date, you are still a member of GuildNet. That means you must continue to follow your agreed-upon plan of care. You must obtain authorization when necessary for covered services, and receive covered services from our network providers. We will continue to provide or arrange for your long term care services until your disenrollment is effective.

In order to ensure your safe transition, GuildNet will make all necessary referrals to the HRA/LDSS, another MLTC or alternative services.

If I go to a nursing home, will I still be enrolled?

Our goal is to keep you independent at home. However, there may be times when, in consultation with you, your family and your physician, placement in a nursing facility for a short time or even permanently is necessary. If this is the case, your Care Manager will help arrange and coordinate your placement in a nursing home in our Network.

It is important to note that there are two types of Medicaid coverage:

- “institutional”, which covers nursing home care and
- “community”, which does not.

Your Local Department of Social Services (LDSS) determines which type of Medicaid you have. If you have community Medicaid and are not eligible for nursing home coverage, we cannot cover that care and you must be involuntarily disenrolled from GuildNet. We will assist you with this transition, including making referrals to alternative services.
Can GuildNet disenroll me?

We cannot disenroll you based solely on deterioration in your health status or your health care needs.

We value your membership, but, in certain situations listed below, you must be disenrolled from the Plan:

- You move out of our service area and refuse to voluntarily disenroll;
- You leave our service area for any reason for more than 30 consecutive days;
- You are hospitalized or enter a New York State Office of Mental Health, Office of Mental Retardation or Office of Alcohol and Substance Abuse Services residential program for longer than 45 days;
- Your Medicaid is terminated;
- You clinically require nursing home care but are not eligible for such care under the Medicaid program’s institutional eligibility rules;
- Your annual reassessment indicates that you no longer have a functional or clinical need for community-based long term care services;
- You no longer meet the nursing home level of care as determined by the Department of Health’s assessment tool if your primary service is Social Day Care;
- You are incarcerated.

GuildNet May Initiate Involuntary Disenrollment If:

- You or any of your family members or other caregivers are abusive, disruptive or uncooperative to such a degree as to jeopardize our ability to provide care to you or to other members. This decision is reached only after we have made and documented a serious effort to resolve identified problems, and we have determined that your behavior is not related to your use of medical services or to diminished mental capacity; or uncooperative or disruptive behavior resulting from any special needs;
- You, or any of your family members or other caregivers knowingly provide us with false information or engage in fraudulent conduct with respect to any significant aspect of your membership in GuildNet;
- You knowingly fail to complete and submit any necessary consent or release;

Write important names and phone numbers at the front of the handbook.
• You fail to pay the amount, as determined by your Local Department of Social Services (LDSS), owed to us as spend-down/surplus within 30 days after the amount first becomes due. We will notify you in writing that you can be disenrolled for non-payment after we have made reasonable efforts to collect the amount within the 30 days.

We will notify you in writing if you are at risk of being disenrolled and we will make every attempt to work with you to resolve the matters that are putting you at risk for disenrollment. In all instances, we must obtain the approval of your disenrollment from New York Medicaid Choice (Maximus) before you can be involuntarily disenrolled.

We will continue to provide or arrange for your long term care services until your disenrollment is effective. We will also assist you in finding and referring you to alternative service providers.

Involuntary disenrollments can only become effective on the first day of a calendar month, and are according to the same time frames as voluntary disenrollments.
**Glossary of Terms Used in This Handbook**

**Adaptive Devices:** If you have a vision impairment, adaptive devices are equipment that helps you make the most of your functional ability and communication skills. For example: large-number clocks and watches, signature guides, big-button telephones, large-print books.

**Adult Day Health Care (ADHC):** These are services provided in a residential health care facility or approved site under the direction of a medical doctor. Services are provided to you if you are not homebound but who do require preventative, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult Day Health Care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation services, leisure time activities, dental, pharmaceutical and other ancillary services.

**Authorization of Services:** Includes the determination that a requested or identified service need meets the criteria established for that service according to our policies. Once the determination is made, an authorization is sent to the selected provider informing the provider that

a) they have the authority from GuildNet to provide the service and

b) that they can bill GuildNet for the service provided

If you obtain a covered service requiring authorization without our authorization, neither GuildNet nor Medicaid may be responsible for payment. In these circumstances, the provider cannot bill you for payment.

**Blind:** Legal blindness is defined as visual acuity that cannot be corrected to better than 20/200 and/or restricted field vision less than 20 degrees.

**Care Management:** A process that assists you with getting access to necessary covered and non-covered services that are identified in your Person Centered Service Plan (PCSP). This can include referrals and assistance needed to obtain medical, social, educational and other services that support your PCSP.

**Care Manager:** As a GuildNet member you are assigned a Care Manager. Your Care Manager works closely with you and/or your designated representative and your physician, to develop and carry out a plan of care designed for you. Your Care Manager also provides referrals and coordination of other services.
**Community Based Long Term Care Services (CBLTCS):** CBLTCS are health care and supportive services provided to you if you have functional limitations or chronic illnesses and need help with routine daily activities. This might include help with bathing, dressing, preparing meals and the administering of medications. CBLTCS are made up of different services, such as Home Health Services, Private Duty Nursing, Consumer Directed Assistance Services (CDPAS), Adult Day Health Care and Personal Care Services.

**Consumer Directed Personal Assistance Services (CDPAS):** When you are able to direct your own care, you or someone you designate (designated representative) can choose your own home attendant employed through our provider network. This allows you to hire, supervise, train or fire your home attendant, if necessary. The home attendant will perform personal care tasks as well as additional services. This is a voluntary program you can enter or leave at any time.

**Covered Services:** These are the health, long term care and vision services provided to you by GuildNet’s Provider Network for which we receive a capitated payment from Medicaid. For example, covered services include dentistry, licensed home care and optometry.

**Disenroll:** This refers to your ability to leave GuildNet.

**Durable Medical Equipment (DME)/Medical and Surgical Supplies:** This refers to medical and/or surgical supplies, prosthetics and orthotics, orthopedic footwear, enteral and parenteral formula and hearing aid batteries. Devices and equipment other than prosthetic or orthotic devices, which have been ordered by a practitioner, must:
- withstand repeated use for a long period of time,
- be used for medical purposes and
- are not useful in the absence of an illness or injury.
You must meet criteria for the above.

**Emergency Medical Condition:** This is a medical condition in which you have symptoms of such severity (including severe pain) that a person who is not a doctor, and who has an average knowledge of health and medicine, might expect the lack of immediate medical attention to result in serious risk to your health or,
- in the case of a pregnant woman, to the health of the woman or her unborn child;
- serious impairment to bodily functions;
- in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- serious dysfunction of any bodily organ or part;
- serious disfigurement of such person.
**Environmental Adaptations:** This means the assessment and modification of your physical environment, such as your home, to make it safe and accessible. For example, improving the lighting, using bright colors, using strong contrast, and making things larger, are practical and cost-effective adaptations.

**Fee-for-Service (FFS) Medicaid:** This is the name for the traditional Medicaid reimbursement of the provider of services. The provider is paid according to each service performed.

**GuildNet:** GuildNet is a Managed Long Term Care Plan authorized by the New York State Department of Health to operate in New York State. GuildNet has a special focus on serving persons who are blind or visually impaired.

**GuildNet Network Providers:** A network provider is the provider of services. We have carefully selected these providers and made a contract with them to provide services to you. These are called covered services.

**Home Care:** Home Care includes the following services which are of a preventive, therapeutic, rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.

**Home Delivered or Congregate Meals:** This refers to meals delivered to your place of residence or provided in a group setting, such as day care.

**Human Resources Administration (HRA):** HRA refers to the New York City Human Resources Administration. This is the local department of social services for our service area.

**Involuntary Disenrollment:** In certain specific circumstances, your membership in GuildNet may be canceled, even if you have not chosen to leave the program. This is called involuntary disenrollment.

**Institutional Long Term Services and Supports (ITLSS):** ITLSS refers to residential health care facility (Nursing Home) services provided to you when they are medically necessary.

**Living Skills Training:** This training refers to the skills needed to make you as independent as possible. Living Skills means the normal activities of daily living such as self-grooming, self-feeding, and cooking.
**Local Department of Social Services (LDSS):** The LDSS is the local agency that must determines your Medicaid eligibility.

**Long Term Placement (Permanent Placement) Status:** This refers to you if you are in a Residential Health Care Facility (RHCF), and are not expected to return home, because of your medical condition.

**Managed Long Term Care (MLTC):** MLTC Plans are designed for you if you are chronically ill or disabled and need medical services at nursing home level of care, but want to live at home. All plans must be approved by the New York State DOH. Plans receive a pre-determined rate of payment from Medicaid to provide all medically necessary covered services to you.

**New York State Medicaid Choice (MAXIMUS):** MAXIMUS is the enrollment broker for New York State. It is designed to assist New Yorkers with learning about New York State health plans as well as enrolling in New York State health plans.

**Medically Necessary:** A service is considered medically necessary if it is needed to prevent, diagnose, correct or cure a condition that is:

- causing acute suffering,
- endangering life,
- resulting in illness or infirmity
- interfering with your capacity for normal activity, or
- threatening a significant handicap.

**Medical Social Services:** This refers to assessing the need for, arranging for and providing help for social problems related to your support in your own home. Services are provided for by a Social Worker, within the scope of your Person Centered Service Plan or PCSP.

**NAMI:** This acronym means Net Available Monthly Income. If you are a nursing home resident, this is the amount of your income that you are expected to contribute toward the cost of your care as determined by the LDSS. This must be done in order for you to qualify for Medicaid benefits and to be eligible for GuildNet MLTC.
**Physician Order:** This is a written or verbal order from your doctor asking for a particular service. Some providers require a physician’s order before they will arrange or provide services.

**Plan of Care/Person Centered Service Plan (PCSP):** These terms are used interchangeably. They refer to a written description of all the services based on an assessment of the member’s healthcare needs, that have been determined to be

- medically necessary,
- necessary through care management, as well as
- non-covered services you may be receiving

**Private Duty Nursing Services:** These are medically necessary services. They are provided to you where you live, either by a licensed practical nurse (LPN) or by a registered nurse (RN), in accordance with a physician order from your doctor. These services can be continuous and go beyond the scope of care from certified home health care agencies (CHHAs).

**Social Day Care (SDC):** Social Day Care provides you with socialization, supervision, monitoring, and nutrition in a protective setting. Some of the services that may be included but are not limited to are:

- personal care maintenance and enhancement of daily living skills,
- transportation,
- caregiver assistance and
- case coordination.

**Social and Environmental Supports:** These are services and items that support your medical needs and are included in your plan of care. These services and items include but are not limited to:

- home maintenance tasks,
- homemaker/chore services,
- housing improvement, and
- respite care.
**Specialized Vision Care:** We offer specialized vision services, adaptive skills training, adaptive devices and materials. Our services also include optometry and eyeglasses, which are integrated into your plan of care as needed.

**Spend-down:** If you are requested to make a spend-down, it means that your monthly income is too high for you to qualify for Medicaid and to be eligible for GuildNet. A spend-down is the amount determined by the HRA/LDSS that you must contribute toward the cost of your care and allows you to qualify for Medicaid and to be eligible for GuildNet.

**Telehealth:** Telehealth refers to electronic and communication technologies you and your medical provider can use. Your medical provider can use the technology to provide you with clinical support, education and other services at a distance.

**Therapy:** Includes Occupational Therapy, Physical Therapy and Speech Therapy.

**Visually Impaired:** This refers to legal blindness or a vision impairment that presents you with significant difficulties in the performance of everyday activities.

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Don’t forget to schedule an annual eye exam. Ask your Care Manager for help.
Non-discriminatory Practices

We comply with all Federal civil rights laws. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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

- Mail: GuildNet Quality Assurance and Performance Improvement
  250 West 57th Street, 10th Floor
  New York, NY 10107
- Phone: 800-932-4703 for TTY/TDD services, call 800-421-1220
- Fax: 646-619-6093
- In person: 250 West 57th Street, 10th Floor, New York, NY 10107

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

- Web: Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail:
  US Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH
  Building Washington, DC 20201

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

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