# Kalos Health

# Member Handbook

*The **BEST** choice*

# KALOS HEALTH
# Managed Long Term Care

## Important Names and Phone Numbers

_____

(Member Name)

**KALOS HEALTH**
Main Number (toll free): (800) 894-2464
TTY line: (800) 662-1220 or 711

Your Care Manager is: _____

Your Member Services Advisor is: _____

Dear Member,

Congratulations on becoming a member of KALOS HEALTH. Your membership lets us know that living independently at home is your first choice for long term care. KALOS HEALTH is committed to helping our members continue to live independently in their homes and communities for as long as possible.

We achieve our goal by directly involving you in planning your care and by offering a wide range of flexible services and schedules to fit your everyday needs.

As a KALOS HEALTH member, you can get important information about the program in the language you understand best. For example, this Member Handbook and other health information are available in English, Spanish, and Russian. If you need a translated version of this Member Handbook, please call us at 1-800-894-2464 to ask for a copy in your language.

This Member Handbook, along with your signed Enrollment Application and Agreement, now become your contract with KALOS HEALTH, your managed long term care program. It describes the benefits of membership, eligibility for the program and our policies and procedures. It will help you understand what you need to do to obtain services and how best to work with your Care Manager and other KALOS HEALTH staff to ensure that your needs are being met. Please review this Handbook carefully. If you would like more information on anything covered in this handbook or if you have any questions, please call your Care Manager or your Member Services Advisor. You will find their telephone numbers on the inside cover of this handbook. They are here to help you.

We encourage you and your family to be involved in your long term care. We want you to have an ongoing relationship with your Care Manager and your doctor(s), who, working together, will help you receive the home, community, and facility-based long term care services you need.

The KALOS HEALTH program provides innovative long term care solutions that are beneficial for each member. Thank you for choosing KALOS HEALTH for your long term care. We look forward to serving you.

Sincerely,

*KALOS Health MLTCP*

# Table of Contents

# What is KALOS HEALTH?

KALOS HEALTH is a New York State licensed managed long term care program for adults who wish to, and are able to live safely at home but need assistance with day-to-day activities.

KALOS HEALTH is designed to provide you with the very best possible care so you can remain safely at home for as long as possible. We encourage our members to take an active part in their own health care, and we offer many choices in services and locations.

Once you choose to join KALOS HEALTH, you will work closely with a Care Manager whose job it is to understand all of your health needs and coordinate all the care you receive.

Your Care Manager will talk with you, offer professional advice and make sure you receive the right level of quality services you need. Your Care Manager will assess your needs and talk with your doctor about the assessment. Together, with your input, they will collaborate on the plan for your care. Your Care Manager will be there to help you whether you're at home, in the hospital, or if you require nursing home care.

As a KALOS HEALTH member, you will receive your covered long term care and health-related services through providers who are part of the KALOS HEALTH Provider Network. The current network Provider Directory is in your membership folder. Your KALOS HEALTH membership card, which also is in your membership folder, will let other providers know that you are enrolled in the program. For as long as you are a member, you will receive high quality long term care, even if your health care needs change.

Our goal is to help you live as independently as possible in your own home for as long as possible. We have the people and resources to provide you with a wide range of rehabilitation services and community-based services. We can even provide you with Durable Medical Equipment when necessary.

In addition, we will coordinate all KALOS HEALTH services with other services that are paid for by Medicaid and Medicare.

# Who is eligible for KALOS HEALTH?

*KALOS HEALTH is for individuals who need long term care services and would like to receive these services at home and in the community for as long as possible. Your membership in KALOS HEALTH is voluntary. You choose to enroll in the program, and you may choose to disenroll for any reason.*

**To enroll in KALOS HEALTH, you must meet all of the following criteria:**

- ❑ Be at least 18 years old
- ❑ Live in the KALOS HEALTH service area of Erie, Niagara, Orleans, Genesee, Monroe, or Chautauqua Counties
- ❑ Be eligible for Medicaid
- ❑ Require community based long term care services for more than 120 days such as: Private Duty Nursing, Nursing Services in the Home, Therapies in the Home (Occupational, Physical, and Speech), Home Health Aide Services, Personal Care Services in the Home, Adult Day Health Care, and Consumer Directed Personal Assistance Services or reside in a Nursing Home.
- ❑ A member's health care needs can be safely met in their home
- ❑ Is determined eligible for MLTC by the Plan using an eligibility assessment tool designated by New York State

***Please note:***

Medicaid must verify your Medicaid eligibility prior to enrollment in KALOS HEALTH. In addition to the criteria listed above, your enrollment in KALOS HEALTH would be denied in the following circumstances:

- You are currently receiving care in a hospital or residential facility operated by the State Office of Mental Health, the Office of Alcoholism and Substance Abuse Services or the Office for People with Developmental Disabilities (OPWDD). An application to enroll in KALOS HEALTH may be accepted, but your enrollment may only begin upon discharge to your home in the community.
- You are already enrolled in another Medicaid managed care program, a home and community based services waiver program like the Long Term Home Health Care Program, a day treatment program sponsored by the Office for People with Developmental Disabilities, or a hospice program. If you terminate your participation in these programs, you can then be considered for enrollment in KALOS HEALTH.
- You were involuntarily disenrolled from KALOS HEALTH in the past and the situation that led to your disenrollment has not been resolved.

# How to Enroll

You or a member of your family can call KALOS HEALTH directly to request enrollment in the program. Sometimes, another health care provider (such as a nurse, social worker, or physician) may also refer an individual to KALOS HEALTH. Regardless of how we learn about your need for long term care services, the enrollment process is the same.

## Enrollment Process:

**1.** KALOS HEALTH staff member will contact you to talk about the program and to be sure that you are interested in the types of services offered by KALOS HEALTH. We also may check at this time to be sure that you are eligible for Medicaid.

**2.** If you are a new consumer to community based long term care services, our Member Service Department will transfer your call to the Conflict Free Evaluation Enrollment Center. The professionals at New York State Medicaid Choice (MAXIMUS), will coordinate an evaluation to be done at your home to establish your eligibility. If you are eligible for community based long term care, MAXIMUS will then assist you in picking a plan to meet your needs.

**3.** If you are transitioning from a Medicaid community-based long term care program, Kalos Health must now continue to provide services authorized under your pre-existing service plan for a minimum of 90 days. If Kalos Health moves to reduce, suspend, terminate or restrict any of your pre-existing services, we must provide you with a notice of action. The notice of action will explain to you, your right to a fair hearing and external appeal. You also will have the right to have your authorized services continue, when requesting a fair hearing.

**4.** If you need help applying for Medicaid, please let us know. A staff member from KALOS HEALTH can direct you to someone who will help you with this application. If you are applying for Medicaid at the same time that you enroll in KALOS HEALTH, the enrollment process will take at least one or two months longer than if you already have an active Medicaid number.

**5.** If you are interested in KALOS HEALTH, a Clinical Enrollment Specialist will come to your home, within 30 days of your first contact, at a time that is convenient for you, to complete an assessment of your needs. This assessment will determine if you are eligible for KALOS HEALTH. If you are eligible, the Care Manager will use the information to guide your plan of care.

**6.** The nurse will also ask you to sign a "Release of Medical and Health Information" form so that KALOS HEALTH can obtain any input from your doctor and other health providers. We want to know as much as possible about your health needs so that we can provide the services that are best for you. Please be assured that our staff will protect your confidential health information to the full extent of the law.

**7.** The assessment often takes more than one home visit to complete. During these visits, the nurse will discuss the program with you and your family to be sure that you understand how KALOS HEALTH works. She/he will give you a copy of your Member Handbook and discuss information about our policies and procedures that are provided in the Handbook.

**8.** The nurse will also work with you and your physician to develop an initial plan of care for you. This plan of care includes the services you will receive once you are a member of KALOS HEALTH. If your condition changes, your nurse will modify the plan of care so that we can continue to meet your long term care needs.

**9.** Enrollment in KALOS HEALTH is voluntary. If you are interested in the program, the nurse will ask you to sign an enrollment application and agreement. If you choose not to enroll in the program, you can withdraw your application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment, verbally or in writing. If KALOS HEALTH finds you are not eligible you will be asked to withdraw your application. Should you still wish to pursue enrollment in KALOS HEALTH, your application will be transmitted to the designated New York entity for review and final determination.

**10.** KALOS HEALTH will send your enrollment information to New York State Medicaid Choice (MAXIMUS). In most cases, you will become a member of KALOS HEALTH on the first day of the month after you sign the enrollment application and agreement. We will confirm your actual enrollment date by telephone as soon as possible-usually a few days before your membership begins. Once you are a member, your Care Manager will ensure that you get all the services that are outlined in your initial plan of care.

# How does my health care change when I become a member?

The decision to join KALOS HEALTH is important because it affects how you receive many of the health care services you need on a regular basis. When you become a member of KALOS HEALTH, your Care Manager will meet with you to be sure you understand how your health care has changed and how to use your Medicaid benefits. Your Care Manager is a nurse or social worker with experience caring for people with long term care needs.

You may receive a wide range of covered services from KALOS HEALTH. These services are listed on pages 8-9. They are provided to you in your home, at community sites in your neighborhood, and in local nursing homes. As a KALOS HEALTH member, one call can connect you to all the services you need.

KALOS HEALTH uses a network of high quality credentialed community providers to deliver many of the services you need. You must receive all services covered by KALOS HEALTH from the providers in our Provider Network. (Please see the Provider Network section for information on the circumstances when we will make an exception to this rule.)

***The Network includes:***
**Programs**
**Agencies**
**Professionals**

This network provides each of the services covered by KALOS HEALTH. For many health services, the KALOS HEALTH network is quite extensive so that you have many providers to choose from. Please check your Provider Directory to see if your local provider is in our network.

# Your Care Manager

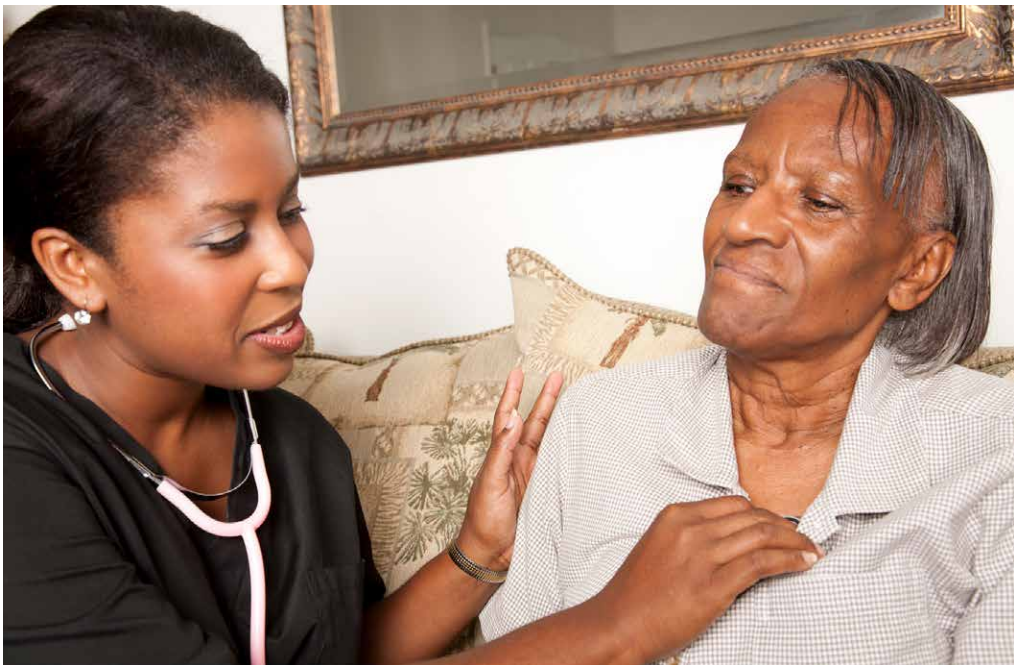
Your Care Manager is a nurse or social worker with experience caring for people with long term care needs. Your Care Manager will visit you periodically and stay in touch by telephone, depending on your medical needs. She/he will make sure that all of your health care and long term care services are closely coordinated. Your Care Manager will talk with your doctor about your medical needs, and she/he will make sure the doctor knows how you are doing at home. If you need a service that is not covered by KALOS HEALTH but is paid for by Medicare, Medicaid, other insurance, your Care Manager also will help you arrange for these services if you wish. Your Care Manager is available to you by phone at the number listed in the front of this Handbook.

Your Care Manager will be sure you get all the services that are outlined in your plan of care. The services you get from KALOS HEALTH are based on a plan of care. This plan is updated periodically, based on your nurse's and doctor's assessment of your health needs. And you have an important part in this process. If you feel you need a service that is covered by KALOS HEALTH, please talk with your Care Manager.

# Can I keep my Doctor?

You do NOT have to change doctors, but you may change doctors at any time. Your Care Manager will talk to your doctor about your health assessment and obtain medical orders for the services that require them in your plan of care.

As a KALOS HEALTH member, you are still eligible for all the services you normally get from Medicaid and Medicare that are not covered by KALOS HEALTH. Some examples of these services are the physician, the hospital, the emergency room, prescriptions and over-the-counter drugs, a mental health program, or substance abuse service. A list of the services that are still covered by Medicare and/or Medicaid appears in the Benefits and Services section of this handbook. If Medicaid determines that you have a Medicaid surplus (or "spend down") you will be responsible for paying this amount to KALOS HEALTH. You will get a bill from KALOS HEALTH each month for the amount you owe.



***Please read this Member Handbook carefully for more information on these topics.***

**This Member Handbook includes:**

*Information on the key policies and procedures of KALOS HEALTH is an important part of your agreement to enroll in this program. You should keep this Member Handbook in a handy location so that you can refer to it whenever you have questions about KALOS HEALTH. Please do not hesitate to call a KALOS HEALTH representative; phone numbers are listed at the front of this handbook.*

**Please share this Member Handbook with your family and or other caregiver.**

# Covered Benefits & Services of KALOS HEALTH

KALOS HEALTH offers a wide range of home, community and facility-based long term care and health-related services. One call connects you to all the services of the program. We will provide or arrange for services that are medically necessary. Medically necessary means necessary to prevent, diagnose, correct or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with a member's capacity for normal activity, or threaten some significant handicap. This means any health service that is needed to prevent, diagnose, correct, or cure (when possible) your health problems. Health problems may cause pain, illness, injury, or handicap. They can interfere with normal activities, and in some cases, could endanger one's life.

## At KALOS HEALTH, we want to understand your health needs so that we can provide specific services to help you.

**Your Care Manager will work with you to develop a plan of care that uses the following services as medically necessary to meet your needs. Some service(s) may need prior authorization.:**

- Comprehensive care management and coordination of your health care services
- Nurse availability by telephone - **24 hours a day, 7 days a week**
- Home health care
  - * Nursing care
  - * Home health aide services
  - * Physical therapy (PT)
  - * Occupational therapy (OT)
  - * Speech therapy (ST)
  - * Medical social services
  - * Private duty nursing
- Preventive and health education services
- Rehabilitation therapies (PT, OT, ST) provided in settings other than the home
- Personal care
- Chore service and housekeeping
- Personal emergency response system (PERS)
- Consumer Directed Personal Assistance Services
- Scheduled transportation to medical appointments
- Home-delivered meals
- Nutritional counseling
- Social adult day care
- Adult day health care
- Durable medical equipment and supplies
- Medical and surgical supplies
- Respiratory therapy and oxygen
- Environmental supports, such as home safety modifications or improvements that are needed to safeguard your health
- Prosthetics, orthotics, and orthopedic footwear
- Dental care
- Eye exams and glasses
- Podiatry (foot care)
- Hearing exams and hearing aids (including hearing aid batteries)
- Nursing home care
- Hospice
- Telehealth Services

All of the services are provided by KALOS HEALTH and the KALOS HEALTH Provider Network. To find the network providers in your neighborhood, check the current Provider Directory in your membership folder. Your Member Services Advisor can help you find the most convenient locations and can tell you which providers are taking new patients. Just call your Member Services Advisor at the number listed at the front of this Handbook or speak with your Care Manager.

# Services

## Comprehensive Care Management

KALOS HEALTH coordinates all of your home and community-based services as well as all of your medical care. Your Care Manager will provide or arrange for these services, and she/he will be sure that all the care you receive is carefully coordinated. You'll help develop your plan of care and, of course, agree to it. As your needs change, you and your Care Manager, along with your doctor, may decide to change your plan of care. In addition to home and community based services, your Care Manager will oversee all of your services and work with the providers to make sure your overall plan of care meets your health care needs. If you need to receive care in a hospital or nursing home, your Care Manager, will coordinate with their staff assuring that you have the services you need for your return home.

## Home Care

KALOS HEALTH coordinates the provision of home care services including care from nurses, social workers, physical therapists, occupational therapists and speech therapists. These services are provided to help prevent, rehabilitate, guide and/or support your health. The staff provide these services based on a plan of care that your physician approves, and all services are provided in your home.

## Personal Care

KALOS HEALTH will coordinate the provision of personal care and help you with such activities as personal hygiene, dressing and eating, and home-environment support. Personal care must be medically necessary, and are based on a plan of care that is approved by your physician.

## Private Duty Nursing

Services for continuous and skilled nursing care provided in your home by properly licensed registered professional or licensed practical nurses.

## Nutritional Counseling

KALOS HEALTH may connect you with a nutritionist who will assess your dietary needs if medically necessary.

## Home Delivered/Congregate Meals

KALOS HEALTH can provide you with home-delivered or congregate meals provided in accordance with your plan of care. Typically, one or two meals are provided per day for individuals who are unable to prepare meals and who do not have personal care services to assist with meal preparation.

## Rehabilitation Therapy

KALOS HEALTH Rehabilitation services may be provided at outpatient locations, based on your needs. These services include: Physical Therapy, Occupational Therapy, and Speech-Language Pathology which are rehabilitation services provided by licensed registered physical therapists, occupational therapists, or speech- language pathologists for the purpose of maximum reduction of physical or mental disability and restoration to your best functional level. Physical, occupational and speech therapy are limited to twenty (20) visits per therapy per year for each discipline. If you receive benefits from both Medicare and Medicaid through KALOS HEALTH MLTC, PT, OT or ST visits that are paid for as part of your Medicare benefit do not count as part of the 20 rehabilitation visit limit.

These Medicaid limits apply to rehabilitation therapy visits received in a private practitioner's office as well as visits received in a certified hospital outpatient department or a diagnostic and treatment center (free-standing clinic). These service limits do not apply to visits that take place in a hospital inpatient setting, a skilled nursing facility or through a certified home health agency (CHHA) or licensed home care services agency (LHCSA). Additional service may be authorized on a case by case basis, based on medical necessity.

# KALOS HEALTH Services

## Non-Emergency Transportation

KALOS HEALTH will arrange and pay for your transportation to and from your doctor, as well as other providers for non-emergency health-related services. Services will be provided by taxi, van, or ambulette service depending on your individual need. If you need transportation, please call us at least 2 business days in advance, if possible, so that it can be scheduled with a participating transportation company.

## Dental Services

All dental services are provided through our network, and you can select any dentist listed in your Provider Directory for your care. Your Care Manager or Member Services Advisor can help you with selecting a dentist or making an appointment, if you wish. As part of your dental benefit, you are entitled to twice yearly check-ups including cleanings, x-rays, and basic restorative services such as fillings, extractions, and dentures.

## Personal Emergency Response System

PERS is an electronic device that enables members to secure help in the event of an emergency (including a physical, emotional or environmental emergency). Such systems are usually connected to a member's phone and signal a response center once a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted on by our contracted response center.

## Podiatry (Foot Care)

Services provided by a podiatrist which may include routine foot care when they are performed as a necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections.

## Eye Exams and Glasses

Fully credentialed optometrists provide eye exams and glasses. You can get a routine eye exam once a year and eyeglasses every 2 years or more frequently if medically necessary. Please remember to get your care at one of the eye care centers listed in your KALOS HEALTH Provider Directory. Your Care Manager or Member Services Advisor can help you with selecting an optometrist or making an appointment, if you wish.

## Hearing Exams and Hearing Aids

Hearing exams, hearing aids, and their batteries are provided by a network of local, independent audiologists. Every exam is performed by a fully licensed audiologist. Several offices are located in the KALOS HEALTH service area. If you think you need a hearing exam, we may ask you to see your doctor first to be sure that another health problem is not affecting your ability to hear.

## Social and Environmental Supports

In the event you require it, KALOS HEALTH can provide you with social and environmental support services and items that support your medical needs and are included in your plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, pest control, housing modifications to improve your safety, and respite care.

## Medical Supplies

KALOS HEALTH will arrange for all required medical supplies. Which are items for medical use other than drugs, which treat a specific medical condition such as diabetes. This may include wound dressings, and other prescribed supplies. Your Care Manager will consult with your doctor and arrange for delivery.

## Durable Medical Equipment

KALOS HEALTH will arrange for all required Durable Medical Equipment such as adaptive devices and equipment prescribed by a medical provider. Such as a cane, walker, wheelchair, hospital bed, etc. Your Care Manager will consult with your doctor and arrange for delivery and installation if necessary.

If you need medical equipment or devices in your home, your doctor or treating practitioner (like a nurse practitioner, physician assistant, or clinical nurse specialist) henceforth known as provider, must order the type of product or equipment you need. This prescription must include the frequency, amount and diagnosis that can support the medical need. For some equipment, your provider may need to provide additional information. Kalos Health will work with your provider and the supplier to ensure this happens. If your needs and/or condition changes, your provider must complete and submit a new, updated order. Kalos Health will work with your care team to ensure your needs are met. Your provider may be the one to recommend products or equipment to you. Kalos Health can only pay for your supplies and equipment needs if your provider signs an order, prescription or certificate that states that you need these things to help a medical condition or injury. This means you need to maintain your relationship with your provider to ensure Kalos Health can continue to provide the services and products you require to keep you healthy and safe at home.

## Respiratory Therapy & Oxygen

KALOS HEALTH will arrange for oxygen, respiratory therapy, and other inhalation therapies as prescribed by your doctor.

## Prosthetics, Orthotics, and Prescription Footwear

KALOS HEALTH will coordinate the provision of prosthetic appliances and devices. Prosthetic appliances and devices are devices that replace any missing part of the body. Orthotic appliances and devices are devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.

- Prescription footwear are shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.

## Adult Day Health Care

KALOS HEALTH can arrange for you to receive adult day health care in a residential health care facility or State-approved site supervised by a physician. The services provided at an adult day health care include: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities, dental, pharmaceutical, and other services. You must not be homebound and require certain preventive or therapeutic services to attend an adult day health care center.

## Social Day Care

Social day care is a structured program that provides you with socialization, personal care and nutrition in a protective setting. You may also receive services such as enhancement of daily living skills, transportation, and caregiver assistance. If interested, your Care Manager can arrange for you to attend a social day care facility.

## Consumer Directed Personal Assistance Services

Provides members with the responsibility for coordination and management of their own home care services including hiring, training, supervising, and scheduling their own staff as an alternative to traditional home care services.

## Nursing Home Care

Although we do our best to meet your needs at home, there may be times when it is more appropriate for you to receive care in a nursing home. Admission to one of our participating nursing homes is made on an individual basis. The decision to receive care in a nursing home must be made by you, your doctor, your family, and your Care Manager. There are two types of nursing home stays. They are short term or rehabilitation stays following hospitalization, and long term stays for ongoing care.

If it is determined that you need to be permanently placed in a nursing home, the local Department of Social Services, along with the nursing home, will assist in the long term Medicaid application process.

Nursing Home Care for Veterans

If you are a Veteran, spouse of a Veteran or Gold Star Parent, we appreciate your service. You have the right to receive your Long Term Nursing Home Care in a Veterans Home. Kalos Health will contract with a regionally based Veterans Home. If Kalos Health does not have a contract, we are obligated to pay your stay "Out of Network", until you are transferred to a plan the Veterans Home participates with.

## Hospice

Hospice provides care to individuals with terminal or chronic conditions that have a life expectancy of approximately six months or less. Current enrollees who require hospice care may access hospice services without disenrolling from Kalos Health. Kalos Health will work with providers for any care provided in the home that is unrelated to the enrollee's terminal illness. This includes hospice services provided in the enrollee's home to include a hospice residence, nursing home or hospital setting. Kalos Health will coordinate with hospices to provide care, services and support to meet all the enrollee's needs.

## Telehealth Services

Effective January 1, 2016, health care services delivered by telehealth are covered by Kalos Health. Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee. Telehealth provider means: physician, physician assistant, dentist, nurse practitioner, registered professional nurse (only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring), podiatrist, optometrist, psychologist, social worker, speech language pathologist, audiologist, midwife, certified diabetes educator, certified asthma educator, certified genetic counselor, hospital, home care agency, hospice, or any other provider determined by the Commissioner of Health pursuant to regulation. The Contractor is responsible for covering services in the benefit package that are delivered by telehealth in accordance with Section 2999-cc of the Public Health Law.

## Money Follows the Person (MFP)/Open Doors

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

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

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

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

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

## Continuing Education

Kalos Health is dedicated to assuring you stay healthy. We will provide you with health education resources in person and on our web page.

### *We speak your language*

As a KALOS HEALTH member, you can get important information in the language you understand best. For example, this Member Handbook and other health information are available in English, Spanish, and Russian. We have staff, providers, and translators who speak many languages.

### *Hearing Impaired*

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

### *Visually Impaired*

If you are visually impaired, we will assist you by discussing all of the information about KALOS HEALTH with you. We will also provide written information so that your caregivers can assist you.

# How do I obtain services?

**It's really quite easy.** When you enroll in KALOS HEALTH, your Care Manager will work together with you, your family, and your doctor to develop a plan of care that meets your needs. Your plan of care is a list of all the services you need based on both your Care Manager's assessment and your doctor's orders.

To develop your plan of care, your Care Manager also talks with you and your family about your needs and personal preferences. Your plan of care will be in writing and your Care Manager will formally authorize services that are listed in your plan of care. (Please see page 12 for more information on KALOS HEALTH's authorization procedures.) You will receive a form that outlines the services that have been authorized to meet your needs. This form will include information about how frequently the services will be provided and how long you can expect them to continue.

**You are an important member of your health care team,** and it is important that you let us know what you need and whether you are satisfied with the care you are receiving from KALOS HEALTH.

## Can I get additional services or change my plan of care?

From time to time, your needs may change. You may require different types of services or you may need the same services more or less frequently. Because of this, your Care Manager will review and update your plan of care at least once every six months. When she/he updates your plan of care, she/he will review your needs with your physician and will always discuss your services with you.

If you believe that your plan of care needs to be changed, please discuss your needs with your Care Manager. Your Care Manager will talk with you about the changes you have requested and may discuss your request with your physician and/or other members of the KALOS HEALTH staff. If KALOS HEALTH determines that the changes in services are medically necessary, your Care Manager will update your plan of care to include the change(s).

We have also set up a toll-free phone number that you may call to request additional services. The number is **1-800-894-2464** and staff is available Monday through Friday between 7:30 a.m. to 5 p.m. to assist you. If you call this number, the staff member who takes your request will discuss your needs with your Care Manager and/or other KALOS HEALTH staff who are involved in your care.

When you request additional services, we might ask your physician or other health care provider to explain to KALOS HEALTH the reasons why the service is medically necessary.

If you are ever dissatisfied with a service you are receiving, or disagree with the types of services that are included in your plan of care, we ask that you first discuss your concerns with your Care Manager. If you feel that there are any other things that you need you can ask your Care Manager for an additional service authorization, or an appeal of a previous decision.

## Can I obtain services without first talking with my Care Manager?

There are certain KALOS HEALTH services that you can obtain without first talking with your Care Manager. However, if you use any of these services we still ask that you inform your Care Manager afterwards so that we are all working together.

*The following covered services can be obtained without first talking with your Care Manager about your plan of care:*

- Whenever you need transportation to an appointment with your doctor or another health-related service, please call your Member Services Representative to make all arrangements. To ensure that transportation is available, please call us at least 2 business days before your appointment, if possible, to arrange for your transportation.
- If you need to see a dentist, you may receive preventive care and basic dental services from any dentist listed in your Provider Directory without prior approval. Your Care Manager can help you select a dentist and your Member Services Representative can always help with scheduling appointments or arranging transportation. (Please see the Services section for important information on dental care. If you need more complicated dental work, your dentist will be required to obtain approval before he begins the procedure.)
- You may receive one routine eye exam without prior approval each year at a vision care center listed in your Provider Directory. If you wish, your Care Manager or your Member Services Advisor can help you schedule an appointment or arrange transportation.
- You don't need any prior approval from KALOS HEALTH for emergency or urgent care. In an emergency, you should call "911" or get help at the closest hospital, emergency room, or doctor's office right away. (For more information, please see page 22.)

## What if I receive a bill from a provider?

As a member of KALOS HEALTH, you are not responsible for paying for the medically necessary care that you receive from the program and its providers as long as you follow the procedures in this Member Handbook. These services are covered by KALOS HEALTH, Medicare and/or Medicaid. However, once in awhile a provider may send you a bill for the services you receive. If you receive a bill for services that were authorized by the program, please let us know. KALOS HEALTH is responsible to cover the cost of the program's services and we can help to ensure that all services are billed appropriately.

Remember, the KALOS HEALTH staff is available to assist you. Whenever you have questions, please call your Care Manager or Member Services Representative. You'll find their phone numbers listed at the front of this Handbook.

# Authorization Procedures

Most of the services covered by KALOS HEALTH have authorization requirements. This means that if you need any of the services listed below, you must get approval in advance, before receiving care. The services that always require authorization in advance are home care services including nursing care, social work, rehabilitation therapies, nutritional counseling, home health aide services and the following:

- Personal Emergency Response System (PERS)
- Adult day health services
- Social adult day care
- Home delivered meals
- Outpatient rehabilitation therapy
- Chore or housekeeping services
- Audiology services
- Home safety modifications
- Respiratory therapy and oxygen
- Podiatry services
- Medical equipment
- Medical and surgical supplies
- Nursing home care

Additionally, there are certain services that require an authorization from KALOS HEALTH only in specific circumstances. These services are described below, along with any special procedures that you must follow when you need them.

**Dental care:** You do not need an authorization to see your dentist for a check-up twice a year and basic dental services. However, if you need a more complex dental service, it will require authorization in advance. Your dentist will obtain these authorizations for you.

**Optometry and eyeglasses:** You do not need an authorization to have an eye exam from an optometrist once a year or to get new glasses every two years. However, an authorization is required if you need these services more frequently.

**Podiatry:** For most members, podiatry care is covered by Medicare. However, an authorization is required if the services you need are not covered by Medicare.

Please talk with your Care Manager if you have any questions about your services and our authorization procedures. As described earlier in this Handbook, KALOS HEALTH provides all services based on medical necessity. If you believe you need any of the services that require approval in advance, you must get authorization from your Care Manager.

**You can also request additional services from KALOS HEALTH by calling us toll-free at 1-800-894-2464.**

Your provider can also request services on your behalf. If you (or your provider) call the above number, the staff member who takes your request will discuss your needs with your Care Manager and/or other KALOS HEALTH staff who are involved in your care. When you request additional services, we might ask your physician or other health care provider to explain to KALOS HEALTH the reasons why the service is medically necessary. (The only exception to this is dental care. In this case, your dentist will obtain all needed authorizations for you.)

## We have tried to keep our authorization procedures as simple as possible.

There are specific types of requests called Prior Authorizations or Concurrent Review, which can be handled as either standard or expedited. The following are definitions for each of these:

**Prior Authorization Request -** A request by you, or a provider on your behalf, for a new service or a request to change a service as determined in the plan of care for a new authorization.

**Concurrent Review Request -** A request by you, or a provider on your behalf, for additional services (more of the same) that are currently authorized in the plan of care.

**Expedited and/or Standard reviews -** Most requests are handled using standard time frames unless the Care Management Team, in conjunction with the Medical Director determine, or the provider indicates, that a delay would seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function. You may request an expedited review of a Prior Authorization or Concurrent Review. If the Care Management Team in conjunction with the Medical Director feel that a delay would not jeopardize your life, health, or ability to attain, maintain, or regain maximum function, the request for an expedited review will be denied in writing.

There are specific time frames that Kalos Health must adhere to for reviewing your requests, based on whether the request is a Prior Authorization or a Concurrent Review. These time frames are:

**Prior Authorizations**

- **Expedited** - 3 business days from your request for service
- **Standard** - Within 3 business days of receipt of all necessary information, but no more than 14 days of receipt of your request for services.

**Concurrent Review**

- **Expedited** - Within 1 business day of receipt of necessary information, but no more than 3 business days of receipt of your request for services.
- **Standard** - Within 1 business day of receipt of necessary information, but no more than 14 days of receipt of your request for services.
- 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 request for services falls on a weekend or holiday, seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the request for services.

**Extensions -** Extensions of expedited or standard time frames may be requested up to 14 days by you or a provider on your behalf (written or verbal to our Care Management Team). Kalos Health may also initiate an extension if we can justify the need for additional information and if the extension is in your best interest. If we request an extension, the Care Management Team will notify you in writing.

You will be notified verbally and in writing regarding your request. Kalos Health will respond to your request for a change in service as per the above time frames.

Your Appeal Rights have recently changed. Please refer to the inserted notification in this handbook or follow the process described in the Complaint Section of this handbook or follow the instructions on the letter sent with our decision.

**If you have any questions about whether authorization is necessary, please talk to your Care Manager or your Member Services Advisor.**

# Your KALOS HEALTH Team

At KALOS HEALTH there are many people working together to ensure that you receive the services you need. Some of these individuals will visit you in your home, some may talk with you on the telephone, and some work behind the scenes to provide assistance to the professionals who care for you.

## The KALOS HEALTH team is made up of highly qualified individuals, including:

**Care Manager:** Your nurse consultant or social work care consultant is a professional who is experienced in caring for older adults. As your Care Manager, your nurse consultant or social work care consultant will know your needs and preferences and she/he will coordinate all the care you receive. She/he will work with you and develop a plan of long term care especially for you. She/he will work closely with your doctor as well as other health care professionals (for instance, social workers and therapists) to make sure you receive the services you need.

**Member Services Advisor:** KALOS HEALTH is designed so that there's always someone available to help you. If your Care Manager is out of the office, a Member Services Advisor will assist you whenever our offices are open. Your Member Services Advisor is just a phone call away when you need services, wish to request any changes in your service plan, or if you encounter any problems.

### Network Contractors working with KALOS HEALTH

**Nurse:** Registered professional nurses are contracted members of your care management team. They help manage your illness and your medications. If you have a home health aide, the nurse will occasionally visit your home to supervise your home health aide.

**Home Health Aide or Personal Care Aide:** For most members, this is the person who comes to the house most frequently to ensure that your day-to-day needs are met. The home health aide or personal care aide might help you take a bath or prepare your food. He or she might also assist you with dressing, housekeeping, or getting to a medical appointment.

**Social Worker:** The social worker assesses each member's need for additional financial benefits, assistance with housing, and other related support services that can affect your health. The social worker will help you apply for other benefits that you are eligible for and may provide counseling to you and/or your family.

**Rehabilitation Therapists:** The physical therapist or occupational therapist assesses each participant's need for physical exercises to repair physical weakness due to injury or illness, strengthen muscles, and improve coordination and balance. The rehabilitation therapist may recommend aids such as canes, walkers, and wheelchairs, as medically necessary, so that you can remain as independent as possible.

**Nutritionists:** KALOS HEALTH's contracted providers includes nutritionists who can assess your dietary needs and help you to be sure that your diet is consistent with your personal needs.

# KALOS HEALTH
# Provider Network

***The KALOS HEALTH team also includes a medical director.***

Only qualified health care professionals and organizations are in the KALOS HEALTH Provider Network. Rest assured, these health care providers must meet our strict licensure and operating standards before they can become part of our service network. As a member of KALOS HEALTH, you must get your covered services from one of these network providers.

You may choose a new provider at any time. The easiest way to change providers is to ask your Care Manager or Member Services Representative for help. On your own, you can choose any dentist, optometrist, or podiatrist listed in the Provider Directory. If you make a change, please remember to tell your Care Manager so that she/he can continue to coordinate your care. If you wish to change your Care Manager, please call us at the number listed at the front of this handbook. We will talk with you about the reasons for requesting a change and, if possible, will assign a different Care Manager for you.

If you need a service that is covered by KALOS HEALTH but there is not a provider in our network with the specific expertise that you require, KALOS HEALTH will find an appropriate provider, even if that provider is outside the network. With the exception of your home care services, you may also see a provider who is outside the network in two other circumstances, as long as your provider agrees to work with KALOS HEALTH to coordinate and pay for your care:

- **At the time your enrollment takes effect:** If you are in the process of receiving treatment for a health problem at this time, you may continue to see the same provider to complete the course of treatment for up to 90 days.

- **After you become a KALOS HEALTH member:** If you are in the process of receiving treatment for a health problem when your provider ends its relationship with KALOS HEALTH, you may continue to see the same provider to complete the course of treatment for up to 90 days.

**You can ask your Care Manager for help in arranging for the care that you need at any time.**

KALOS HEALTH pays providers in our service network for each service you receive. A list of the providers who are in the KALOS HEALTH Provider Network was given to you before you enrolled in KALOS HEALTH and you will automatically receive an updated Provider Directory each year. Please ask your Care Manager or Member Services Advisor if you would like a new directory at any time.

# Responsibilities as a KALOS HEALTH Member

As with any membership program, you have certain rights and responsibilities when you join KALOS HEALTH. Your rights are discussed in the next section. Here, briefly, are your key responsibilities.

## As a member of KALOS HEALTH you must:

- Receive all of your covered benefits through the KALOS HEALTH Provider Network.
- Use the providers listed in the Provider Directory to obtain covered services.
- Talk with your Care Manager about the services you need. In most cases, the services you receive from KALOS HEALTH require the approval (or "authorization") of your Care Manager before you can receive care.
- Let your Care Manager know if you plan to travel out of town. She/he will temporarily cancel the services you are receiving in your home and in your community. In addition, if you need assistance while you are away, she/he may be able to arrange for care while you travel.
- Get care immediately if you have an emergency. However, please try to let us know within 24 hours, or as soon as possible, so that we can be sure that the services you receive from KALOS HEALTH are adjusted for any changes in your health status.
- Pay KALOS HEALTH any Medicaid Surplus that you owe. Your surplus amount is based on Medicaid eligibility rules and is determined by Medicaid. You may want to contact Medicaid to discuss Medicaid eligibility rules and how your Medicaid surplus is determined. Your Care Manager or social worker will be glad to help with this. Just call the KALOS HEALTH phone number at the front of this handbook during regular business hours.
- Call KALOS HEALTH whenever you have a question regarding your membership or need assistance.

We want to make KALOS HEALTH the very best long term care program. To do that, we need your help and your ideas. We invite you to call or write us at any time. Tell us what you like and give us suggestions. Our address and telephone number are listed on the back cover of this handbook. 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 KALOS HEALTH. Please tell 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 easy way for you to take part in improving KALOS HEALTH policies, providers and services.

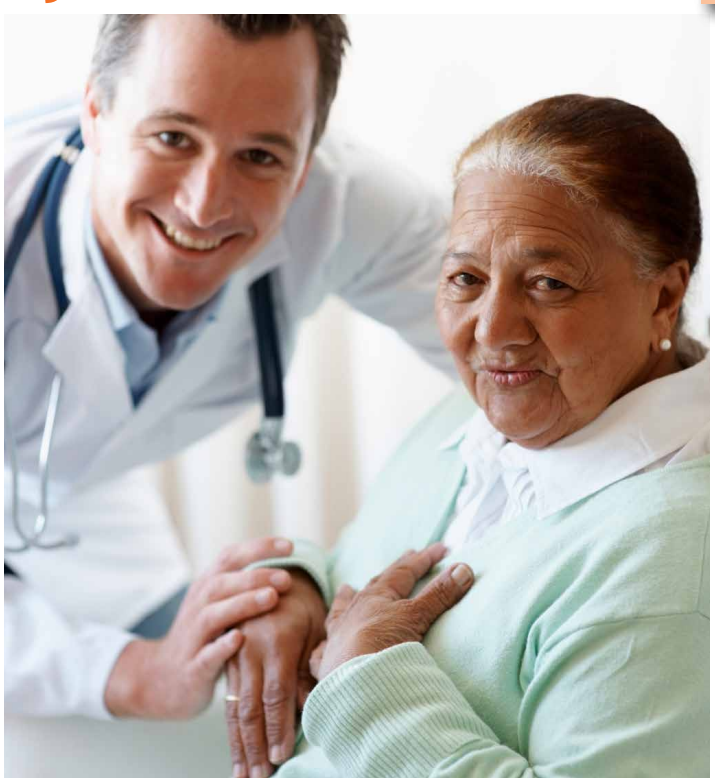
# KALOS HEALTH
# Member Rights

Your health, safety, and well being are the main concern for the team of dedicated KALOS HEALTH staff who care for you in this program. As a member, you have certain rights that are important for you to understand. Please ask your Care Manager or Membership Coordinator to explain these to you if you have any questions.

## As a member of KALOS HEALTH:

- You have the right to receive medically necessary care.
- You have the right to timely access to care and services.
- You have the right to privacy about your medical record and when you get treatment.
- You have the right to get information on available treatment options and alternatives, presented in a manner and language that you understand.
- You have the right to get information in a language that you understand and the right to get oral translation services free of charge.
- 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 healthcare, including the right to refuse treatment.
- You have the right to be free of 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, veteran's status, marital status, or religion.
- You have the right to be told where, when, and how to get the services you need from KALOS HEALTH, including how you can get benefits from out-of-network providers if KALOS HEALTH does not have the services you need in our network.
- You have the right to complain to the New York State Department of Health or your local Department of Social Services by calling 1(866) 712-7197. You also have the right to use the New York State Fair Hearing system or, in some instances, request a New York State External Appeal.
- 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.
- In addition, as a KALOS HEALTH member, you may be receiving care from a home care agency, hospital, adult day program, and/or a nursing home. In each of these settings, 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 KALOS HEALTH and our provider network.
- You also have the right to access a free participant Ombudsman, who will help you.

# Can I continue to use my own doctor?



**Yes.** With KALOS HEALTH, you can choose your own doctor. Your Care Manager will work along with your doctor by assisting in developing your plan of care and writing orders for services provided by KALOS HEALTH. Your Care Manager will also work with other providers to coordinate all of your health care needs.

If you need help finding a doctor, we can help you locate a qualified physician in your neighborhood. If you decide to change doctors while you are a member of KALOS HEALTH, please tell your Care Manager. She/he will introduce KALOS HEALTH to your new doctor and be sure that the doctor has all the information needed to work with the program.

# Advanced Directives

Advanced Directives are a very important part of planning for your healthcare. A Health Care Proxy form or Medical Order for Life Sustaining Treatment (MOLST) form, that allow you to designate a trusted family member or loved one to make decisions for your care, when you cannot. Copies of these forms are included in your enrollment packet and will be reviewed with you by Kalos Health's Care Management Team. When complete, your Advanced Directives will be added to your electronic medical record. Please know that you can change these directives at any time. If you need new copies of these forms, please contact Kalos Health or ask your doctor.

# What happens if I'm hospitalized?

You or your family (or another person who you designate) must contact KALOS HEALTH within 24 hours or as soon as possible. You can call and leave a message any time of the day or night. While you are in the hospital, your home care services will be suspended and health care appointments must be cancelled. Your Member Services Advisor will do this for you.

If you do go into the hospital, be sure to ask your doctor or hospital discharge planner to contact KALOS HEALTH. We will work with them to plan for your care following your hospital stay.

## REMEMBER:

**Your Care Manager is available to coordinate all your health care services - please call whenever you need assistance.**

# Will Medicaid and/or Medicare still pay for services not covered by KALOS HEALTH?

**Yes.** Even though you have chosen to enroll in KALOS HEALTH, your Medicaid benefits are still in effect. You receive many of the services that are part of Medicaid through KALOS HEALTH. Other Medicaid services that are not covered by KALOS HEALTH, you will continue to receive by using your Medicaid card.

In addition, if you are a Medicare beneficiary when you join KALOS HEALTH, you will continue to be covered by Medicare for your doctor visits, hospitalizations, lab tests, ambulance, and other Medicare benefits. Keep in mind that whenever Medicare covers a service, Medicare will be billed first. For most Medicare services, you will receive a letter of explanation from Medicare called the Explanation of Medicare Benefits (EOMB). We are here to help you. Please ask your Care Manager if you need help understanding the information you receive from Medicare, Medicaid, or your Medicare prescription drug plan.

For most services that are not covered by KALOS HEALTH, you may choose any provider participating in Medicare or Medicaid. One important exception to this concerns prescription drug coverage for individuals who have Medicare. KALOS HEALTH members who have Medicare must be enrolled in a Medicare prescription drug plan. When filling a prescription, you must then use the Medicare prescription drug card from your prescription drug plan.

Your Care Manager can help you determine if your prescription drug plan covers the specific medications that your doctor has prescribed for you. If you wish to change to a different prescription drug plan, your Care Manager can also assist you.

## Services not Covered by KALOS HEALTH but still covered by Medicare and/or Medicaid

- Inpatient hospital care
- Outpatient hospital care
- Physician services
- Laboratory tests
- Radiology
- Prescriptions and over-the-counter medications (Please note that if you have Medicare, you must fill your prescriptions at a pharmacy that participates in your Medicare Prescription Drug Plan)
- Emergency transportation
- Chronic renal dialysis
- Mental health services
- Alcohol and substance abuse services
- Services for persons with developmental disabilities
- Family planning services

## What about services not covered by KALOS HEALTH?

Our goal at KALOS HEALTH is to assist you in understanding and obtaining services that you may need. your Care Manager and our Social Workers will help you coordinate services that are covered, and are not covered by KALOS HEALTH. Please discuss any needs that you may have along with any programs or services that you currently use, with your Care Manager.

## Ways that KALOS HEALTH can help you get all the health care you need

### Our staff will:

- Help you find a qualified doctor (if you don't have one already or if you wish to make a change)
- Help you whenever you want to find a new provider for any kind of health service
- Schedule doctor's appointments for you and arrange transportation
- Arrange laboratory, x-ray, or diagnostic tests that are ordered by your doctor, as well as provide transportation for medical appointments
- Provide you with home-based laboratory tests, if needed
- Visit you in the hospital if you've been hospitalized, and work with your doctor and the hospital to arrange for a smooth transition following a hospital stay
- Arrange for Medicare-covered home care services
- Help you determine if your medications are covered by your Medicare Prescription Drug Plan and find a pharmacy in your prescription drug plan's network
- Answer any questions you have about healthcare bills you receive

## How do I get help?

Just call your Care Manager or your Member Services Advisor. Their phone numbers are listed at the front of this handbook. They'll be happy to assist you in arranging for care and services, plus answer any questions you might have.

## REMEMBER:

***If you need transportation for health related services, be sure to call us at least two business days in advance if possible.***

# What should I do in an emergency?

If you think your problem is an emergency, you should call **911** or get help at the closest hospital, emergency room, clinic or doctor's office right away. They will evaluate your health and make sure you get the care that is needed in order to stabilize your condition. If you have an emergency medical condition, you do not need to contact KALOS HEALTH before getting care. You don't need to worry about whether the emergency service is authorized or if the provider is part of the KALOS HEALTH provider network.

An emergency medical condition is a health problem that happens suddenly or very rapidly. To be considered an emergency, the problem will include pain or other symptoms that are so severe that an average person - that is, someone like a KALOS HEALTH member without special knowledge of health or medicine - would believe that there would be serious consequences if he/she did not get immediate help. These consequences could include serious jeopardy to your health, damage to your bodily functions or organs, or serious disfigurement.*

* The official New York State definition of an emergency medical condition is a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

## What to do After an Emergency

Once the emergency is over, and your condition is stabilized, please be sure to notify your doctor and KALOS HEALTH within 24 hours or as soon as possible. (You or a family member or friend can call and leave a message any time of the day or night.) We want to understand your changing medical needs so that we can coordinate all your care during this stressful time. This is also important because we may need to make adjustments to your long term care services to better meet your health care needs.

# Getting Help During Non-business Hours

If you need Non-emergent help after business hours, on a weekend, or over a holiday, one of the nurses in our special after-hours unit will assist you. These specially trained nurses will answer your questions regarding your medical condition. If they feel your condition is an emergency, they will be sure you get the help you need as quickly as possible.

The nurse can also refer you to a hospital, contact your doctor and Care Manager for you, and follow up if there is a problem with an in-home provider or service. To contact the after-hours unit during nights, weekends, or holidays, just call the phone number of your Care Manager. Your call will be automatically forwarded to one of our professional nurses in the after-hours unit.

If you are planning to visit friends or family who live outside the KALOS HEALTH area, you must let your Care Manager or Member Services Advisor know as soon as possible.

# What if I leave the KALOS HEALTH service area?

We will temporarily stop the services you are receiving at your home or in your local community and attempt to arrange appropriate services while out of the service area. If you leave our service area for more than 30 days, you will be required to disenroll from KALOS HEALTH.

## Getting care outside of the area:

If an urgent or emergency situation occurs while you're out of the area, please seek care immediately. If you receive urgent or emergency care while you are away, you (or someone you designate) must contact KALOS HEALTH within 24 hours or as soon as possible.

Urgent care is provided for an illness or injury that occurs unexpectedly. Urgent care includes services that are needed to prevent a serious change in your health condition before you return to the service area. For example, if you need dental care while you are away, KALOS HEALTH will pay a provider who is not in the KALOS HEALTH Provider Network for services that are part of the KALOS HEALTH benefit package.

- If you need emergency care or urgent care while you are outside the area, you should get help at the closest hospital, emergency room, or doctor's office right away.
- If an urgent or emergency situation occurs while you're out of the area, please seek care immediately.

# What if I decide to end my membership?

**KALOS HEALTH values you as a member.** We want you to be completely satisfied with your long term care. If you have any concerns or problems with our services or your membership, we want to hear about it. Please call your Care Manager or Member Services Coordinator at the telephone number in the front of this handbook. We will do everything we can to help resolve your issue, even if you have already decided to disenroll.

If you are considering ending your enrollment, we hope that you will call the Members Services line or your Care Manager and talk about why you wish to leave. If you agree to discuss your situation with us, your Care Manager or Member Services Coordinator will meet with you to help resolve any unmet needs.

To end your enrollment, we ask that you submit your request in writing to Membership Services, or ask your Care Manager for and sign a KALOS HEALTH Disenrollment Request Form. You may also request your disenrollment orally, by discussing it with your Care Manager or another KALOS HEALTH staff member. If you decide to end your membership in KALOS HEALTH, you may be required to choose an alternate plan. We will help you arrange to be transferred to a new plan in order to obtain the services that you require in order to meet your needs whether it be another Managed Long Term Care Plan, Medicaid Managed Care Plan, or Waivered Service Program (such as a Nursing Home Transition and Diversion Waiver Program or Traumatic Brain Injury Waiver Program). The goal at KALOS HEALTH is to keep you safe and coordinate the home and community based services you need such as: Private Duty Nursing, Nursing Services in the Home, Therapies in the Home (Occupational, Physical, Speech), Home Health Aide Services, Personal Care Services in the Home, Adult Day Health Care, or Consumer Directed Personal Assistance Services.

If you request disenrollment within the first 10 days of the month, your disenrollment usually will take effect on the first day of the next month.

However, if you ask to be disenrolled after the tenth of the month, your disenrollment normally won't take effect until the following month. For instance, if you request disenrollment between April 1st and April 10th, your disenrollment will take effect on May 1st. But if you request disenrollment between April 11th and April 30th, your disenrollment will take effect on June 1st. You will receive written notification of the date of your disenrollment.

# Can my membership be canceled?

**Yes.** In certain circumstances, KALOS HEALTH may no longer be the right program to meet your long term care needs. However, please be assured that KALOS HEALTH will not discriminate against you or request your disenrollment because of your health status or because your needs have changed.

If KALOS HEALTH believes it is necessary to disenroll a member, we must obtain the approval of New York Medicaid Choice or the local Department of Social Services. And, to ensure your care continues after you leave KALOS HEALTH, we will work with New York Medicaid Choice or local Department of Social Services to transfer you to another plan or otherwise ensure you can continue to receive your needed long term care services.

## KALOS HEALTH must cancel your membership if:

- You move out of the KALOS HEALTH service area.
- You are out of the KALOS HEALTH service area for more than 30 days in a row.
- You are hospitalized for more than 45 consecutive days.
- You are placed in a residential program sponsored by the Office of Mental Health, or the Office of Alcoholism and Substance Abuse Services, or the Office for People with Developmental Disabilities for more than 45 days.
- You require long term nursing home care and are not eligible for institutional Medicaid.
- You are no longer eligible for the Medicaid program.
- You are incarcerated.
- You are no longer eligible for MLTC because you were assessed to no longer demonstrate a functional or clinical need for community-based long term care services or, for non-dual eligible Enrollees, in addition no longer meets the nursing home level of care as determined using the assessment tool prescribed by the Department. An Enrollee whose sole service is identified as Social Day Care must be disenrolled from the MLTC plan. The contractor shall provide the LDSS or entity designated by the Department the results of its assessment and recommendations regarding disenrollment within five (5) business days of the assessment making such determination.
- Your enrollment in Kalos Health will be ended if Kalos Health looses it's contract with the New York State Department of Health, which allows Kalos Health to offer health care services. Kalos Health has a contract with the New York State Department of Health that is subject to renewal on a periodic basis. Failure of Kalos Health to maintain this contract will result in termination of enrollment in the program.

## We may also cancel your membership if:

- You knowingly provide KALOS HEALTH with false information or behave in a deceptive or fraudulent way.
- You or a member of your household is abusive or engages in behavior that seriously harms the safety of our staff or a network provider, or seriously disrupts our ability to care for you safely in the community.
- You or your family knowingly fails to complete or submit any consent form or other document that KALOS HEALTH needs in order to obtain services for you.
- You fail to pay or make efforts to pay KALOS HEALTH any Medicaid surplus amount, (spenddown) that you owe within 30 days after this amount is due.

# Complaint Process

Kalos Health 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 Kalos Health 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: *1-800-894-2464* or write to: *Kalos Health MLTC, 2424 Niagara Falls Blvd, Niagara Falls, NY 14304*. 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 Kalos Health 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 *1-800-894-2464* or writing to *Kalos Health MLTC, 2424 Niagara Falls Blvd, Niagara Falls, NY 14304*. 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
- 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**
14 Boerum Place, 1st Floor
Brooklyn, New York 11201

**Albany**
40 North Pearl Street, 15th Floor
Albany, New York 12243

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

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# Other Ways to Express a Complaint or Concern

**We hope you will always discuss your concerns with us.** However, if you are dissatisfied with KALOS HEALTH, or if you disagree with the way we have handled your complaint, you also have the right to file a complaint with the New York State Department of Health. You can call them or write to them at any time at the following location:

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

## You also can reach a Participant Ombudsman

The Participant Ombudsman is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. These services include, but are not necessarily limited to:

- Providing pre-enrollment support, such as unbiased health plan choice counseling and general program related information
- Compiling enrollee complaints and concerns about enrollment, access to services, and other related matters,
- Helping enrollees understand the fair hearing, complaint and appeal rights and processes within the health plan and State level, and assisting them through the process if needed/requested, 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 request Participant Ombudsman services by contacting the, Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800 or on line at www.icannys.org. TTY users: call 711 and follow the prompts to dial 844-614-8800.

# 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 & 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.

# More Information

You can get more information about KALOS HEALTH if you wish. Ask your Care Manager or call the main phone number at the front of this handbook. The following items that describe the structure and operation of the program are available upon request:

- Names, addresses, and positions of the Officers and Governance of KALOS HEALTH
- Most recent KALOS HEALTH annual certified financial statement
- Information on consumer complaints
- Procedures for confidentiality of member information
- Quality management program and procedures
- Clinical review criteria for particular conditions or diseases, and other clinical information that is used in utilization review (information must be requested in writing)
- Application procedures and minimum qualification requirements for KALOS HEALTH MLTCP's providers

# 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.

Kalos Health

*The **BEST** choice*

Phone (Toll Free): (800) 894-2464
TTY/TDD: (800) 662-1220 or 711
Fax: (716) 731-2013
www.KalosHealth.org