3.1- Eligibility Verification- Medicare Advantage Programs

You may obtain information on VNSNY CHOICE member eligibility by calling the Member Services contact phone number listed in the Introduction of this provider manual. Our hours are Monday through Friday from 8:00 AM to 5:00 PM Eastern Time.

You may also check claims and eligibility status via the Internet at: https://vnsproviderportal.tmghealth.com

Upon initial registration, you will be asked to complete a “Provider Portal Registration”. Upon proper completion, the registration is submitted and an assigned password will be sent to you within 2 business days.

The Provider Portal offers real-time access to member eligibility, claims status with details, and much more. In addition, the portal features self-service access (real-time registration, password reset capability, customizable quick links) and is easy to access and use, so that you can manage your patients’ information quickly and easily.

All VNSNY CHOICE members in our Medicare Advantage plans are given an identification card (sample below). Members should present their ID cards when they request any type of covered healthcare service. This card is for identification only and does not guarantee eligibility for coverage.
VNSNY CHOICE

VNSNY CHOICE- Eligibility and Membership

3.1- Eligibility Verification- SelectHealth Program

The primary care team plays a critical role in assisting VNSNY CHOICE to verify the HIV status of its members. If HIV verification is not received within 90 days of the member’s enrollment, the member may be disenrolled. Acceptable verification for HIV includes:

- Positive HIV antibody screen assay
- Positive viral identification assay (e.g. antigen assay, viral culture, DNA Polymerase chain reaction [PCR])
- CD4<200
- Attestation of the member’s HIV status by HIV PCP (only required if the member has an undetectable viral load.)

VNSNY CHOICE reimburses providers for services rendered to eligible members currently enrolled in the plan. Verification of eligibility for services may be accomplished by one of the following means:

Identification Card: VNSNY CHOICE generates an identification card to all actively enrolled members of the plan within 14 days of the member’s effective date of enrollment.

Information on the card includes: member name, CIN number, primary care provider name and telephone number, the 24-hour VNSNY CHOICE toll-free number and the behavior health phone number. Plan code on the ID card identifies if a member is eligible for HCBS services (Home and Community Based Services).

Plan code 004 denotes a member that is not eligible for HCBS services and plan code 008 denotes a member that is eligible for HCBS services. At the time of the member’s visit, providers should ask the member for his/her member identification card. Most providers make a copy of both sides of the card for their files.

EMEV (Electronic Medicaid Eligibility Verification System) or ePACES: Eligible members are verified by the code “VS” on the EMEVS/EPACES. You can find additional information on the web through the following link - https://www.emedny.org/HIPAA/QuickRefDocs/ePACES-Setting_Up_Support_Files.pdf

Member Roster: Primary care providers receive a member roster from VNSNY CHOICE each month. The roster contains information regarding the members on the PCP’s panel, including name, CIN number, and enrollment effective date.

Referral: Although members do not need a referral to seek care from an in network specialist, they should have a prescription from the primary care provider.

Member Services: If you have questions with regard to member eligibility, call Provider Services at the telephone number listed in Introduction Section of this provider manual.
Additional HCBS Services for Adults Meeting Targeting and Functional Needs
As of January 2016, additional Home and Community Based Services (HCBS) will be provided to SelectHealth members that are determined by the State to be eligible. Health Home care managers will determine eligibility for HCBS using a standard needs assessment tool.

Home and Community Based Services (HCBS) provide opportunities for Medicaid beneficiaries with mental illness and/or substance use disorders who are enrolled in the HIV SNP and are determined to be eligible to receive services in their own home or community. Implementation of HCBS will help to create an environment where managed care plans, Health Home care managers, service providers, plan members and their chosen supporters/caregivers, and government partners help members prevent, manage, and ameliorate chronic health conditions and recover from serious mental illness and substance use disorders.

Newborn Enrollment
All newborn children of VNSNY CHOICE SelectHealth members are enrolled in this program, effective from the first day of the child’s month of birth. The infant may be disenrolled at any time at the mother’s request.
VNSNY CHOICE

3.1- Eligibility Verification- Managed Long Term Care Program

VNSNY CHOICE MLTC coordinates all of our member’s home and community-based services as well as their medical care. Upon enrollment, our members work closely with a Care Manager whose responsibility is to understand all of their health care needs and coordinate the necessary services.

The Care Manager works with the providers to make sure that the overall plan of care meets the health care needs of our members. If a member needs to receive care in a hospital or nursing home, our Care Managers will work with the staff of the facility to be sure that our member’s needs are met.

Verifying Member Eligibility

While the member’s Care Manager orders most services, providers are encouraged to verify member eligibility before providing the service. Providers are prohibited from billing VNSNY CHOICE MLTC members for covered services. However, if a provider wishes to provide a non-covered service to a member, the provider must inform the member in writing prior to the initiation of the service, indicating the cost and the member’s responsibility for payment.

VNSNY CHOICE may determine which covered services are medically necessary for each member. Medical necessity is defined as necessary to prevent, diagnose, correct or cure conditions in the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee’s capacity for normal activity, or threaten some significant handicap.

To verify eligibility for all of the covered services listed above, with the exception of dental services, please call our Provider Services Line 1-866-783-0222 or Member Services 1-866-783-1444.

To verify eligibility for dental services, please contact Healthplex, Inc.

VNSNY CHOICE will reimburse providers only for services rendered to currently eligible members. It is the responsibility of the provider to verify eligibility prior to providing services.
Verifying Member Eligibility
You may obtain information on VNSNY CHOICE member eligibility by calling the Member Eligibility contact phone number listed in the introduction portion of this provider manual. Our hours are Monday through Friday from 8:00 AM to 5:00 PM Eastern Time. You may also check claims and eligibility status via the Internet at: https://vnsproviderportal.tmghealth.com

The Provider Portal offers real-time access to member eligibility, claims status with details, and much more. In addition, the portal features self-service access (real-time registration, password reset capability, customizable quick links) and is easy to access and use, so that you can manage your patients’ information quickly and easily.

Upon initial registration, you will be asked to complete a “Provider Portal Registration”. Once completed, the registration is submitted and an assigned password will be sent to you within 2 business days.

All VNSNY CHOICE members in our FIDA plan are given an identification card. Members should present their ID cards when they request any type of covered healthcare service. This card is for identification only and does not guarantee eligibility for coverage.

VNSNY CHOICE FIDA covers all Medicare and Medicaid medically necessary physical and behavioral healthcare services and all necessary long-term supports and services at no cost to the participant.

Copayments/Deductibles
VNSNY CHOICE FIDA pays all Medicare enrollee cost sharing, encompassing all deductibles, co-pays and co-insurance amounts, as well as any subscriber premiums.
VNSNY CHOICE

VNSNY CHOICE- Eligibility and Membership

3.2- Marketing, Advertising, Outreach, and Enrollment

Medicare Advantage Plans

Participating providers may not develop and use any materials that market VNSNY CHOICE Medicare Advantage plans without the prior written approval of VNSNY CHOICE in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization and its participating providers may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are prior approved by CMS or are submitted to CMS and not disapproved within 45 days.

Providers must make member records and encounter data available to VNSNY CHOICE to the extent permitted by law and necessary for pre-authorization and concurrent utilization review activities, quality assurance, claims processing and payment to the NYSDOH, NYC Human Resources Administration and The Centers for Medicare and Medicaid Services (CMS), at no charge to these agencies, for the purpose of inspection and copying related to quality of care, monitoring, audit and enforcement and any other legally authorized purpose.

Medicare Advantage Enrollment

VNSNY CHOICE Medicare ensures that enrollment applications are completed and processed as required by CMS. Applicants are visited by a Community Liaison (CL) to ensure plan benefits are presented in accordance with CMS guidelines regardless of the source through which the enrollment was initiated (e.g. Managed Long Term Care (MLTC) leads, external marketing broker leads, Walk-in, etc.). Applications can also be obtained telephonically by VNSNY CHOICE external brokers. Other sources of receiving applications are via fax, mail or VNSNY CHOICE and CMS websites.

The Community Liaison will:
1. Obtain the potential member’s signature on the Scope of Appointment, permitting the Community Liaison to present the plan to him/her. The scope of appointment is done either by completing the form or by completing a recorded and scripted phone call.

2. Confirm that the applicant has Medicare by reviewing Medicare Part A and Part B eligibility on the Medicare card or supportive documentation.

3. For the Special Needs Plan (SNP) - confirm that the applicant has Medicaid by reviewing the Medicaid card or supportive documentation and validate Medicaid eligibility via NY State Medicaid/eMedNY. If applicant does not have Medicaid, explain other options.

4. Confirm that the applicant does not have diagnosis of end stage renal disease (ESRD).

5. Confirm that the applicant is eligible to enroll under one of the CMS valid election types- Annual Election Period (AEP), Initial Election Period (IEP or ICEP), or Special Election Period (SEP). If the SEP is used, the CL also confirms a valid SEP reason and completes Exhibit 1A, Attestation of Eligibility for an Enrollment Period.
VNSNY CHOICE

VNSNY CHOICE- Eligibility and Membership

3.2- Marketing, Advertising, Outreach, and Enrollment

Medicare Advantage Enrollment (cont.)

The Community Liaison will:

6. Present the plan benefits, options and answer questions as referenced in the VNSNY CHOICE Medicare Sales Training materials. If the prospective member is interested in pursuing completion of the application, the Community Liaison will:

a) Check if the Primary Care Physician (PCP) is in the network. All applicants are required to choose an in network (INN) PCP.
   • If PCP is INN, enter physician’s name and doctor ID number on application.
   • If PCP is out of network, community liaison must assist prospect with choosing an INN PCP and enter new physician’s name and doctor ID number on application.

b) Review the application with him/her and assist as necessary in its completion.

c) Co-sign if assistance is provided per Medicare Managed Care Manual Enrollment/Disenrollment Section 2: 40.

d) If application is signed by someone other than the applicant, confirm that the person is an authorized representative.

e) Provide member with a print out of the application (when using a pen tablet) or provide member with yellow portion of hard copy application.

f) Submit completed applications daily to MEU.

Note- all data for paper applications must be entered into Salesforce.com by the CL prior to submission to MEU and all applications must be received in MEU within 24 hours of the CL receiving the application.

NOTE: Community Liaison will not inquire about a person’s health status or medical conditions that could be construed as health screening, with the exception of ESRD.
3.2- Marketing, Advertising, Outreach, and Enrollment

SelectHealth Plan

The VNSNY CHOICE SelectHealth is contracted with the New York City Department of Health (NYCDOH) and is subject to contractual terms and conditions including comprehensive marketing guidelines. By CDOH definition, marketing encompasses written literature and conversations with a potential SNP member that may persuade the potential member to choose a particular SNP.

1. Written Marketing Materials

• Written marketing materials generated by providers must be approved by CDOH, Division of Health Care Access.

• Written marketing materials must contain certain specified information to ensure that potential HIV SNP members receive basic information. The CDOH has developed a model letter for use by providers to communicate information about HIV SNPs to their patients. No further review is required if the model letter is used. Any modifications to this letter, however, must be approved by CDOH.

2. Marketing Encounters

• Marketing encounters are defined to be any conversation or activity with a potential SNP member for the purpose of persuading that person to enroll in a particular HIV SNP.

• All marketing encounters must communicate at least the following information:
  • A statement that participation in an HIV SNP is voluntary and that persons with HIV/AIDS may choose instead to join or remain in a mainstream Medicaid managed care plan.
  • The potential member has a choice among several alternative HIV SNPs.
  • Upon enrollment in a SNP, the member is required to use his/her HIV Specialist
  • PCP and other plan providers exclusively for medical care, except in certain limited circumstances.
  • Newborns of a mother enrolled in a SNP are automatically enrolled in the mother’s HIV SNP. The infant may be disenrolled at any time at the mother’s request.
  • Providers may market to persons enrolled in the mainstream health plan operated by the same organization as the HIV SNP, but must inform the member that the change is optional and the members who change from a mainstream health plan to an affiliated SNP must sign a new enrollment form.
  • Providers who wish to let their patients know of their affiliation with one or more HIV SNPs must list each HIV SNP with whom they hold contracts.
3.2 Marketing, Advertising, Outreach, and Enrollment

SelectHealth Plan (cont.)

3. Marketing Conduct

• Marketing encounters are to be conducted in a manner that does not disclose nor breach the confidentiality of the potential member’s HIV status.

• Providers may not give mailing lists of patients to HIV SNPs.

• Providers may not target mailings to HIV/AIDS patients or patients with a significant probability of having HIV/AIDS unless the patient has consented in writing to mail contact. This is to protect patient confidentiality. Some providers, such as facilities specializing in HIV/AIDS care, should consider handouts of literature rather than a mailing to avoid confidentiality problems.

• Providers should inquire as to whether the prospective member is currently enrolled in another HIV SNP. If so, providers may not market to persons who are enrolled in another HIV SNP.

SelectHealth Plan Enrollment

All SelectHealth members are enrolled telephonically by New York Medicaid Choice-Maximus. If a potential enrollee is referred to the plan or contacts the plan directly re: enrollment, he/she will be advised to call Maximus.

Maximus is responsible for managing the enrollment process for HIV Special Needs Plans (SNP), which includes confirming eligibility criteria (valid Medicaid status and verbal confirmation from the client of HIV positive status).

Telephone Enrollments:

Enrollments are processed by New York Medicaid Choice (Maximus) telephonically. Once the enrollment is confirmed, Maximus may transfer the client to SelectHealth Member Services via telephone or advise the enrollee to call VNSNY CHOICE Member Services.


When the call is received from the new enrollee the Member Services Representative does the following:

• Collects additional information regarding the current PCP and any case manager
• Updated address and contact information
• Conducts orientation (if member has the time)

The Membership and Eligibility Unit (MEU) will receive confirmation of the enrollment via the Maximus e-file, New York State Department of Health enrollment roster or by an ePACES eligibility clearance. Enrollment is reconciled monthly by the MEU.
VNSNY CHOICE

VNSNY CHOICE- Eligibility and Membership

3.2- Marketing, Advertising, Outreach, and Enrollment

SelectHealth Plan Enrollment (cont.)

Referrals:
Prospective members may also contact VNSNY CHOICE SelectHealth directly and inquire about enrollment. The Member Services Representative speaks to them about the program. If the applicant is interested in enrolling, the call is transferred to New York Medicaid Choice (Maximus) or the client is given the number to call Maximus directly during normal business hours.

Managed Long Term Care

VNSNY CHOICE ensures that all Marketing Materials meet all Marketing Requirements regarding accessibility and format, including those requirements respecting translation for non-native English speakers.

VNSNY CHOICE distributes Marketing Materials, consisting at minimum of a Pre-Enrollment Kit, to all interested individuals (including potential members, members, family members and potential referrers) across its Service Area.

VNSNY CHOICE provides each MLTC plan member with a current Member Handbook and Provider Directory.

VNSNY CHOICE provides, with a potential MLTC plan member’s consent, for the participation of his or her informal caregivers (e.g., family members) in Marketing Activities.

VNSNY CHOICE solicits the willing participation of health care providers and community influencers to develop its referral base.

VNSNY CHOICE follows all Marketing Requirements in processing inquiries regarding, and referrals to, its MLTC plan and other plans.

VNSNY CHOICE trains all Marketing staff in MLTC concepts and the details of VNSNY CHOICE’s health plan offerings.

VNSNY CHOICE ensures, through its contracts with network providers and subcontractors, that these network providers and subcontractors comply with all Marketing Requirements.

VNSNY CHOICE does not pay its Marketing staff members, network providers or subcontractors any commission, bonus, or similar compensation that uses numbers of Medicaid eligible persons enrolled in the VNSNY CHOICE MLTC plan as a factor in determining compensation.

VNSNY CHOICE maintains a robust Compliance Program that includes, among other things, oversight of Marketing Activities.

VNSNY CHOICE complies with all DOH requests for reports on MLTC Marketing compliance, and submits all reports within thirty (30) days of receiving any such request.
3.2- Marketing, Advertising, Outreach, and Enrollment

**Marketing Plan** is a document describing all Marketing Activities planned by VNSNY CHOICE, which is submitted to DOH for approval. The Marketing Plan must include but is not limited to:

- VNSNY CHOICE’s goals and general marketing strategy for its MLTC plan;
- A description of Marketing Activities and copies of all draft Marketing Materials;
- A staffing plan, including methodology and levels of training, compensation, evaluation and supervision;
- A description of how VNSNY CHOICE will meet the informational needs of eligible persons, including those with special needs, so as to enable their voluntary and informed choice of VNSNY CHOICE’s MLTC plan;
- Evidence that Marketing Materials are written in minimum 12-point type and at a fourth- to sixth-grade reading level;
- Identification of the forums where Marketing Activities will occur;
- VNSNY CHOICE’s method and timetable for distributing its list of network providers to MLTC plan members;
- A discussion as to if or how VNSNY CHOICE intends to provide nominal gifts to the target population of potential MLTC plan members;
- A description of how VNSNY CHOICE will ensure that it complies, and that network providers and subcontractors comply, with all applicable Marketing Requirements.

**Marketing Process** shall refer to span of time and set of actions during which Marketing takes place, including the development and deployment of all Marketing Activities, the development and dissemination of all Marketing Information and the development and distribution of all Marketing Materials. The goal of the Marketing Process is to encourage or induce Medicaid recipients to enroll in the CHOICE MLTC plan in accordance with all applicable legal, regulatory, sub regulatory and contractual requirements, and with CHOICE's mission. The Marketing Process extends no later than the point at which a VNSNY CHOICE clinical professional, following a visit to perform an MLTC eligibility assessment of a potential member, submits a complete set of enrollment documentation to CHOICE’s enrollment staff on behalf of that potential member. Subsequent enrollment processes do not form part of the Marketing Process and are addressed in separate policies.
Managed Long Term Care Enrollment

• Enrollment in VNSNY CHOICE MLTC is available to all individuals currently participating in a Medicaid community based long term care program and mandatorily transitioned by DOH.

• Enrollment and retention in VNSNY CHOICE MLTC is available to all individuals who meet the MLTC eligibility criteria, are not excluded from membership because the individual meets the mandatory or discretionary exclusion criteria, and agree to receive all covered benefits and services through the plan.

• VNSNY CHOICE MLTC does not discriminate, or make enrollment or retention decisions, based on race, creed, color, sex, sexual orientation, age, gender identity, gender expression or national origin.

Mandatory Enrollment. Enrollment in VNSNY CHOICE MLTC is available to all individuals currently participating in a Medicaid community based long term care program and mandatorily transitioned by DOH.

• Such individuals are presumed to satisfy the eligibility criteria without pre-enrollment or start of enrollment assessment, and are enrolled pursuant to VNSNY CHOICE MLTC Policy 6.04 (Mandatory Enrollment).

• If, however, VNSNY CHOICE determines at a subsequent assessment that a mandatorily enrolled member no longer satisfies the eligibility criteria as described in Section 2 of this Procedure, below, VNSNY CHOICE may initiate disenrollment of the member pursuant to VNSNY CHOICE MLTC Policy 7.01 (Disenrollment).

Voluntary Enrollment. Enrollment and retention in VNSNY CHOICE MLTC is available to all individuals who meet the MLTC eligibility criteria, are not excluded from membership and agree to receive all covered benefits and services through the plan.
VNSNY CHOICE

VNSNY CHOICE - Eligibility and Membership

3.2- Marketing, Advertising, Outreach, and Enrollment

FIDA Complete Program Enrollment

**Passive enrollments:** VNSNY CHOICE FIDA COMPLETE sends the following to the Participant 30 days prior to the effective date of coverage:

- VNSNY CHOICE FIDA COMPLETE Summary of Benefits
- VNSNY CHOICE FIDA COMPLETE Participant Handbook (Evidence of Coverage)
- A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by VNSNY CHOICE FIDA COMPLETE
- VNSNY CHOICE FIDA COMPLETE provides a directory notice on how to obtain a combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits;
- Proof of health insurance coverage that includes the 4Rx prescription drug data necessary to access benefits so that the Participant may begin using VNSNY CHOICE FIDA COMPLETE services as of the effective date of enrollment.

VNSNY CHOICE FIDA COMPLETE sends the following to the Participant no later than the last calendar day of the month prior to the effective date of coverage:

- A single ID card for accessing all covered services under VNSNY CHOICE FIDA COMPLETE

**For opt-in enrollments**, VNSNY CHOICE FIDA COMPLETE provides the following materials to the Participant no later than eight calendar days from receipt of enrollment confirmation (i.e. Enrollment E-file) or by the last calendar day of the month prior to the effective date, whichever occurs later.

- VNSNY CHOICE FIDA COMPLETE Summary of Benefits
- VNSNY CHOICE FIDA COMPLETE Participant Handbook (Evidence of Coverage)
- A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by VNSNY CHOICE FIDA COMPLETE
- VNSNY CHOICE FIDA COMPLETE will provide a directory notice on how to obtain a combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits.
- Proof of health insurance coverage that includes the 4Rx prescription drug data necessary to access benefits so that the Participant may begin using VNSNY CHOICE FIDA COMPLETE services as of the effective date of enrollment
3.3- Member Rights & Responsibilities

Member Rights

The health and safety of all VNSNY CHOICE members is important to everyone who is involved in their care. VNSNY CHOICE members have the following rights and responsibilities.

• To receive medically necessary care and treatment

• To be treated with dignity and respect and to have the privacy of a member’s health information protected

• To exercise these rights regardless of the member’s race, physical or mental ability, ethnicity, gender, gender identity, gender expression, sexual orientation, marital status, economic status, veterans’ status, creed, age, religion or national origin, cultural or educational background, English proficiency, reading skills, health status, source of payment for care

• The choice of qualified physicians, specialists and facilities so members can get the health care they need

• Timely access to quality care and services, network physicians, referrals (if necessary) and recommendations to specialists when medically necessary

• To be told where, when and how to get the services they need from VNSNY CHOICE, in a language that they understand, including how they can get covered benefits from out-of-network providers if VNSNY CHOICE does not have network providers available

• To receive information as necessary to give informed consent prior to the start of any procedure or treatment

• A candid discussion of appropriate or medically necessary treatment options and alternatives for a member’s condition, presented in a manner and language that they understand, regardless of cost or benefit coverage and a treatment plan of care from their doctor. The member has the right to get oral translation services regarding this information free of charge.

• To receive emergency services where and when you need it when the member, as a prudent layperson, acting reasonably would believe that an emergency medical condition exists

• To actively participate in decisions regarding health and treatment options

• To get a second opinion about their care

• To receive urgently needed services when traveling outside the VNSNY CHOICE service area or in the VNSNY CHOICE service area when unusual or extenuating circumstances prevent the member from obtaining care from a participating provider
VNSNY CHOICE

VNSNY CHOICE- Eligibility and Membership

3.3- Member Rights & Responsibilities

Member Rights (cont.)

• To confidential treatment of all communications and records pertaining to the member’s care except as required by law, contract or with a member’s consent

• To get a copy of and/or request amendment to the member’s medical records consistent with the terms of HIPAA and discuss this information with their physician

• To appoint any person (relative, friend, lawyer, etc.) who may have legal responsibility to make decisions on the member’s behalf regarding the member’s medical care and treatment

• To refuse treatment or leave a medical facility, even against the advice of physicians, provided the member accepts the responsibility and consequences of the decision, and be told what they may risk if they do.

• Right to be free from any form of restraint of seclusion used as a means of coercion, discipline, convenience or retaliation

• To complete and give an Advance Directive, living will or other directive to the member’s medical providers. Please be sure that you understand all of your rights, in each setting of care, as you receive services from VNSNY CHOICE and our provider network.

• To coverage information or a coverage decision from VNSNY CHOICE before getting services.

• To request an appeal to resolve differences with VNSNY CHOICE about health care payment, coverage of services or prescription drug coverage.

• To use the VNSNY CHOICE grievance process to settle any complaints. Members also have the right to complain to the regulatory agency that governs their plan, i.e. New York State Department of Health, local Department of Social Services or Center for Medicare and Medicaid Services (CMS). Depending on the plan in which the member is enrolled, he/she also has the right to use the New York State Fair Hearing System

• To request the following from VNSNY CHOICE: (a) the number of grievances and appeals and dispositions in the aggregate, (b) information regarding physician compensation, and (c) information concerning the financial status of VNSNY CHOICE
Member Responsibilities

- To work with their physician to guard and improve their health
- Find out how their healthcare system works
- Receive all of their covered benefits from the VNSNY CHOICE program in which they are enrolled
- Use the providers listed in the VNSNY CHOICE Provider Directory for covered services
- Listen to their physician’s advice and ask questions when they are in doubt
- Call or go back to their physician if they do not get better or ask for a second opinion
- Treat healthcare staff with respect
- Inform VNSNY CHOICE if they have problems with any healthcare staff by contacting Member Services
- Keep their appointments. If they must cancel, call as soon as they can.
- If a member has any emergency, to get care immediately
- Use the emergency room only for true emergencies
- Call their physician when they need medical care, even if it is after hours.
- Talk with their Care Manager about the services they need. In most cases, the services a member receives from VNSNY CHOICE require the approval of their physician or Nurse Consultant before a member can get care. (Applies to VNSNY CHOICE Managed Long Term Care members only)
- If a member travels out of town, to let their Care Manager know before they leave. The Nurse Consultant will temporarily cancel the services a member is receiving in their home and community. In addition, if a member needs assistance while he/she is away, the Nurse Consultant may be able to arrange for care while they travel. (Applies to VNSNY CHOICE Managed Long Term Care members only.)
- Make every effort to pay VNSNY CHOICE any surplus that is owed. Surplus is based on Medicaid eligibility rules and is determined by a member’s Local Department of Social Services (also known as HRA in New York City). A member may want to contact their local DSS or HRA to discuss Medicaid eligibility rules and how their surplus is determined. A member’s Nurse Consultant or Social Worker will be glad to help with this. (Applies to VNSNY CHOICE Managed Long Term Care members only.)
VNSNY CHOICE

VNSNY CHOICE- Eligibility and Membership

3.4- Member Services & Education

The Member Services department provides members with an extensive array of customer service, outreach, orientation, and educational programs, including translation services to assist members who do not understand English.

**New Member Outreach and Orientation**

Member orientations focus on explaining the enrollment process, benefits, and rights and responsibilities to new members. Member orientations include presentations on covered benefits and services, the role of the PCP, free access services, and access to “carved out” services.

All members receive a new member enrollment kit and Provider Directory that lists primary care, OB/GYN, specialists, and ancillary service providers. The new member enrollment kit contains a member handbook and subscriber contract or EOC, depending on which product the member enrolls in. Members also receive copies of our member newsletter and health education materials.

As part of the mandatory Medicaid managed care program, Maximus, the enrollment broker, issues health risk assessment questionnaires to newly enrolled individuals and families as part of the enrollment process. VNSNY CHOICE also sends health risk assessment forms to new members and once annually to all existing Medicare Special Needs Plan (SNP) members.

VNSNY CHOICE uses these self-reported health assessment tools to better understand the member's health and lifestyle, their wellness, or specific service needs. VNSNY CHOICE encourages these members to visit their PCP as soon as possible to obtain services. In addition, VNSNY CHOICE Case Managers call members with complex medical needs to ensure that they receive appropriate attention and care.