PROVIDER MANUAL

Updated January 2023

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WE'RE METROPLUS**HEALTH.**
WE'RE NEW YORK CITY.

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MetroPlusHealth Phone Numbers

Department	Telephone	Fax
Member Services	800.303.9626 212.908.3780 (TTY: 711)	212.908.8701
After Hours Service (for calls after regular business hours)	800.442.2560	
Member Services for Medicare Members	866.986.0356 (TTY: 711)	
Claims	800.303.9626 212.908.3780	212.908.8789 Medical 212.908.3314 BH
Compliance Department	212.908.5100	212.908.8620
Eligibility Verification	800.303.9626	800.303.8626
Care Management Action Line for Asthma, Diabetes, MetroMom, SSI, Medicare	800.303.9626 212.908.3780	212.908.8521
Behavioral Health Case Management	1.800.303.9626 (TTY: 711)	212.908.7969 BHreferrals@metroplus.org
Partnership in Care/HIV Services	800.303.9626 212.908.8877	**CONFIDENTIAL** 212.908.8897 212.908.8525
Provider Services	800.303.9626 212.908.3780	212.908.8885
MetroPlus Main Number	212.908.8600	
Utilization Management	800.303.9629 212.908.3782	212.908.5208 212.908.8522
Utilization Review Appeals Coordinator	212.908.8816 800.303.9626	212.908.8525 212.908.5209

1. Introduction

1.1 Welcome

MetroPlus Health Plan, Inc. (MetroPlusHealth) is pleased to welcome you as a Participating Provider. MetroPlusHealth is a Prepaid Health Services Plan (PHSP) and has been certified under Article 44 of the New York State Public Health Law since 1985 to operate in the New York City boroughs of Manhattan, Queens, Brooklyn and the Bronx.

In January 2017, MetroPlus Health Plan was approved to operate in Staten Island for the following products: Medicaid, CHP, HARP, Essential Plan and QHP.

MetroPlusHealth is also an HMO plan with a Medicare contract since 2008 to operate in the New York City boroughs of Manhattan, Queens, Brooklyn, and the Bronx. In January 2019, MetroPlus Health Plan expanded its Medicare Plan service area to include Staten Island.

Participating Providers include acute care facilities, diagnostic and treatment centers, ambulatory care centers and community-based practices that offer a full range of primary, preventive, inpatient, and specialty services. MetroPlusHealth also has agreements with Providers of home health care, durable medical equipment, pharmacy, dental and other health-related services.

Participating Providers provide health care services for all members in the same manner, in accordance with the same standards and priority, regardless of the type of coverage. Some MetroPlusHealth Participating Providers may not be contracted to provide care to all lines of business. To confirm the programs that you participate in, contact Provider Services or refer to your contract agreement with MetroPlusHealth. Members choose a Primary Care Provider (PCP) who is responsible for managing and coordinating all aspects of their medical care. Physicians and Nurse Practitioners with the specialty of Internal Medicine, Family Practice or Pediatrics, or Geriatrics Medicine may be credentialed as PCPs.

MetroPlusHealth places great value on the member-Provider relationship. The ability to communicate effectively in the member's primary language, treat the member with dignity and provide access to care in a timely manner are the cornerstones of the MetroPlusHealth Managed Care Program.

1.2. Mission

The MetroPlusHealth mission is to provide a caring, high-quality customer experience to preserve and improve the health and lives of New Yorkers with our integrated healthcare system.

1.3. Governance

MetroPlusHealth is a wholly-owned subsidiary corporation of NYC Health + Hospitals. The MetroPlusHealth Board of Directors serves as the governing authority for MetroPlusHealth. MetroPlusHealth is regulated by New York City, New York State and Federal agencies and is accountable to those agencies with respect to quality assurance and financial viability. Provider Agreements are subject to approval by the New York State Department of Health

(NYSDOH), the New York City Department of Health and Mental Hygiene (NYCDOHMH), and the Centers for Medicare and Medicaid Services (CMS).

1.4. Product Overview

MetroPlusHealth offers the following managed care products:

Medicaid Managed Care, available to people who are eligible for Medicaid, is a comprehensive benefits package covering the provision of primary and preventive care, inpatient and outpatient treatment, pharmacy services, dental services and travel to health care service appointments. Some services are not included in the benefits package; members may obtain other benefits by using their regular Medicaid card. For additional information regarding covered benefits, please see *Appendix XA: Medicaid Managed Care Benefit Summary*.

Child Health Plus (CHPlus) is the New York State subsidized child health insurance program. Program goals include improved access to primary and preventive care. To be eligible, children must be under the age of 19, residents of New York State, without other health care coverage, and not eligible for Medicaid. The CHPlus benefits package is similar to that of Medicaid Managed Care, but dental care and pharmacy coverage are also included. For additional information regarding covered benefits, please see *Appendix XB: Child Health Plus Benefit Summary*.

Medicaid Special Needs Plan (SNP), Partnership in Care, is a Medicaid Managed Care Special Needs Plan approved by the New York State Department of Health to serve Medicaid members living with HIV/AIDS and their children, whether the children are HIV infected or not, to serve Medicaid members who are homeless, and to serve transgender Medicaid members. Enrollment in the SNP is voluntary. SNP members, who are HIV positive, have an HIV Specialist PCP as a primary care provider who is experienced in the management of HIV disease. SNP members receive all the benefits of Fee-for-Service Medicaid, plus special services for healthy living and management of their health concerns, including care management services, treatment adherence services, and prevention, risk reduction treatment and health education services. For additional information regarding covered benefits, please see *Appendix XC: Medicaid HIV Special Needs Plan Benefit Summary*.

MetroPlusHealth Gold is only available to employees of MetroPlusHealth, New York City Health + Hospitals, all New York City employees, non-Medicare eligible New York City Health + Hospitals retirees, their spouses or qualified domestic partners, and eligible dependents. MetroPlusHealth Gold offers a comprehensive benefits package and employees can enroll at the time they are hired, during the fall open enrollment period or during a qualifying event. For more information on MetroPlusHealth Gold please see *Appendix XD: MetroPlusHealth Gold Benefit Summary*.

MetroPlusHealth GoldCare is available exclusively to eligible NYC day care workers of the Day Care Council-Local 2015, DC 1707 Welfare Fund. GoldCare offers two low-cost high-quality plans to choose from. Members receive a comprehensive benefits package with prescription drug coverage included. For more information regarding covered benefits, please see *Appendix XJ: GoldCare Benefit Summary*.

MetroPlusHealth Medicare Advantage Plans offer all the benefits of Medicare as well as additional benefits not covered by Original Medicare. All MetroPlusHealth Medicare plans

have the same basic requirements – members must be a United States citizen or be lawfully present in the U.S., have Medicare Parts A and B; and reside in Brooklyn, the Bronx, Manhattan, Queens or Staten Island; and not have end stage renal disease (ESRD). In addition, MetroPlus Advantage Plan (HMO-DSNP) requires members to have Medicaid (full or partial). MetroPlus Platinum Plan (HMO) is a plan for anyone eligible for Medicare Parts A and B. MetroPlus UltraCare (HMO-DSNP) requires members to have full Medicaid and need nursing home level of care in a home setting.

For more information on MetroPlusHealth Medicare Advantage Plans and specific benefits, please refer to the Evidence of Coverage and Summary of Benefits available on the MetroPlusHealth web site, www.metroplusmedicare.org.

Medicaid Advantage Plus (MAP), UltraCare is a type of integrated Dual Special Needs Plan (D-SNP) designed for individuals who are dually eligible for Medicare and Medicaid and meet the criteria for enrolling in New York State's Medicaid Managed Long Term Care (MLTC) Program. The program allows dual eligible to enroll in the same health plan for most of their Medicare and Medicaid benefits. Enrollment in MAP is voluntary. To be eligible, an enrollee must be 18 years or older, must have full Medicaid coverage, be a resident of New York State, have evidence of Medicare Part A and Part B coverage, and need long term care services for more than 120 days.

MAP benefit package covers most Medicare, Medicaid, long-term care services, including doctor office visits, hospital stays, Part D benefits, home-health aides, certain behavioral health care, dental care, and nursing home care services. Some services not covered in the MAP benefit package may be covered under the Medicaid fee-for-service (FFS) Program. For additional information regarding covered benefits, please see Appendix XF Medicaid Advantage Plans: Evidence of Coverage.

For more information on MetroPlusHealth Medicaid Advantage Plus (MAP) and specific benefits, please refer to the Evidence of Coverage and Summary of Benefits available on the MetroPlusHealth web site, www.metroplusmedicare.org.

MetroPlusHealth MarketPlus Plans are offered on the NY State of Health (https://nystateofhealth.ny.gov) marketplace and are available for purchase in the Individual or the SHOP (Small Business Health Options Program) markets. These comprehensive health plans cover the Essential Health Benefits which include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, preventative and wellness services and chronic disease management, laboratory services, pediatric services including oral and vision care. There are also plans that include adult vision and adult dental benefits.

Plans are listed under MetroPlusHealth with BronzePlus, GoldPlus, SilverPlus, PlatinumPlus or MedPlus product names. For more information regarding covered benefits, please see *Appendix XG: Qualified Health Plan Benefit Summary*.

Applicants must reside in MetroPlusHealth's service area (Brooklyn, the Bronx, Manhattan, Queens, or Staten Island for certain product lines), must be a US Citizen, national or lawfully present immigrant and not incarcerated to be eligible to apply. For more information on MetroPlusHealth's MarketPlus products, please refer to our website, www.metroplus.org.

MetroPlusHealth Managed Long Term Care (MLTC) is a health care plan especially designed for people 21 years or older, who live in Brooklyn, Manhattan, the Bronx or Queens who need long term care services and have Medicaid. MetroPlusHealth Managed Long Term Care offers the assistance members need to live safely at home.

MetroPlusHealth Enhanced (HARP) Plan is a comprehensive and integrated Physical Health, Behavioral Health and Substance Use Disorder Plan with added Social Services and Supports.

MetroPlusHealth Essential Plan provides all of the covered benefits offered on the NY State of Health. The Official Health Plan Marketplace (NYSOH). It costs less than other plans and offers the same essential benefits. Eligibility is dependent on income and is available to those who don't qualify for Medicaid or Child Health Plus. For more information regarding covered benefits, please see *Appendix XH: Essential Plan Benefit Summary*.

1.5. Provider Services and the *Provider Manual*

MetroPlusHealth considers Participating Providers as partners and is committed to developing productive relationships to ensure that members receive the highest quality of care. MetroPlusHealth Provider Contracting and Provider Relations Departments serve as the link between Participating Providers and MetroPlusHealth.
Provider Relations works with Participating Providers to ensure they are informed of the responsibilities and standards to which they are held. Provider education and training is available for new and established Participating Providers to assist in the development and refinement of their managed care knowledge and to acquaint them with MetroPlusHealth policies and procedures. Provider Relations Representatives conduct initial orientation sessions for new Participating Providers and their staff and hold additional training sessions as needed. Provider Relations Representatives also make regular office visits to Participating Providers.

Provider Relations responds to inquiries and requests for information from Participating Providers and assists in the resolution of Participating Provider complaints. Provider Relations staff respond to all verbal, telephonic or written inquiries within one business day of receipt.

This *Provider Manual* is designed to furnish Participating Providers with the information necessary to establish a good working partnership with MetroPlusHealth. The guidelines and standards provided are tools to ensure that Participating Providers have the necessary support to provide quality care to members. The *Provider Manual* should be easily accessible and utilized as a reference in interactions with members. MetroPlusHealth retains the right to amend or modify the provisions contained in the *Provider Manual* in accordance with operational policy changes and agrees to provide reasonable notice prior to the implementation of any amendments or modifications.

1.6. Resources for Providers on the MetroPlusHealth Website

The MetroPlusHealth web site, www.metroplus.org, provides the following information:

- Provider search and provider directories
- The *Provider Manual*
- Provider orientation
- Provider and member newsletters
- Provider bulletins
- Formularies

- Quick reference guide
- MetroPlusHealth plan descriptions, qualification tools, member handbooks, Evidence of Coverage, Summary of Benefits

MetroPlusHealth providers who register for the Provider portal can check a member's eligibility, access membership rosters and obtain reports. To register, go to providers.metroplus.org, click on "log into MetroPlusHealth portal" and follow the instructions.

1.7. Definitions

The *Provider Manual* is an attachment to the Participating Provider Agreement. Thus, definitions contained in the Participating Provider Agreement are also applicable to the *Provider Manual*. Following are some of the key definitions of terms used throughout the *Provider Manual*:

DOHMH shall mean the New York City Department of Health and Mental Hygiene.
CMS shall mean the Centers for Medicare and Medicaid Services which is the Federal agency that administers the Medicare program and oversees Medicare Advantage plans.
NYSDFS shall mean the New York State Department of Financial Services.
OASAS shall mean the New York State Office of Addiction Services and Supports.
OMH shall mean the New York State Office of Mental Health.

Participating Provider shall mean a Provider who:
(a) is either (i) directly under contract with MetroPlusHealth to provide Covered Services to members or (ii) indirectly under contract with MetroPlusHealth to provide Covered Services to members through its affiliation with a Provider that is directly under contract with MetroPlusHealth, and
(b) has been credentialed by MetroPlusHealth.

Primary Care Provider (PCP) shall mean a Participating Provider who has been credentialed as a PCP in accordance with the credentialing policies set forth in this *Provider Manual*.

Provider shall mean a Health Professional, pharmacy, or other health care facility engaged in the delivery of health care services, which is licensed and/or certified as required by applicable state, and/ or federal law.

NYSDOH shall mean the New York State Department of Health.

Specialty Care Provider (SCP) shall mean a Participating Provider who has been credentialed as a SCP in accordance with the credentialing policies set forth in this *Provider Manual*.

HIV Specialist Primary Care Provider shall mean an HIV-experienced Primary Care Provider who has been credentialed by MetroPlusHealth as an HIV Specialist PCP to provide primary care services to HIV SNP members in accordance with the credentialing policies set forth in this *Provider Manual*.

Emergency Medical Condition shall mean a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the person afflicted with such condition in serious jeopardy, or in the care of a behavioral condition, placing the health of such person or others in serious jeopardy.
(b) serious impairment to such person's bodily functions.
(c) serious dysfunction of any bodily organ or part of such person; or
(d) serious disfigurement of such person.

Medically Necessary shall mean health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic or congenital condition, injury or disability.

2. Provider Responsibilities

2.1. Key Responsibilities

All Participating Providers contractually assume responsibility for the care of members and agree to adhere to administrative procedures, reporting requirements, medical records maintenance, quality assurance and utilization review policies, and regulatory standards. Participating Providers are also responsible for adhering to the provisions of the agreements between MetroPlusHealth and the NYSDOH, MetroPlusHealth and DOHMH, MetroPlusHealth and CMS, and any other agreement under which MetroPlusHealth administers health benefits. Participating Providers' key responsibilities include, but are not limited to, the following:

- Providing appropriate and cost-effective care in accordance with utilization management plan and protocols and clinical guidelines (see Sections 7 and 10).
- Documenting care and maintaining complete medical records in compliance with all regulatory requirements and Medical Record Documentation Standards.
- Ensuring that members (or a designee, when appropriate) give informed consent for any procedure or treatment.
- Interpreting medical test findings for members (or a designee, when appropriate) subject to confidentiality provisions.
- Providing complete current diagnosis, treatment and prognosis information to the member (or a designee, when appropriate).
- Complying with Public Health Guidelines, including statutory reporting requirements for communicable diseases.
- Providing health counseling and health education.
- Referring members to Care Management programs as appropriate (see Section 8).
- Complying with standards for appointment access.
- Reaching out to members who do not keep scheduled appointments.
- Submitting claims for all member visits (see Section 5).

2.1.1 Primary Care Provider Responsibilities

PCPs are responsible for the provision of initial and routine health care to members, as well as for the supervision of a members' overall care. PCPs coordinate specialty care and ancillary services and maintain continuity of care for their members.

In addition, PCP duties include, but are not limited to:

- Conducting baseline and periodic health examinations.

- Delivering medically necessary primary care services, in accordance with Preventive Health Guidelines (see Section 10).
- Diagnosing and treating conditions not requiring the services of a specialist.
- Arranging for inpatient care, specialist consultations, and laboratory and radiological services when necessary and coordinating follow-up care.
- Consulting with the admitting Physician and Participating in inpatient discharge planning and follow-up care when members are hospitalized.
- Reaching out to members who have not had an annual primary care appointment.
- Referring members for at least one dental visit a year and encouraging dental appointment attendance.
- Complying with standards for 24/7 coverage.
- Ensuring coverage by a Participating Provider for short and long-term leaves of absence.
- Counseling adult members regarding advance directives.
- Following MetroPlusHealth standards of care, which are reflective of professional and generally accepted standards of medical practice.

2.1.2 Specialty Care Provider (SCP) Responsibilities

SCPs have advanced training in a medical specialty and provide consultation and treatment to members in a designated specialty area. SCPs deliver specialty services to members when referred by a PCP or under other circumstances detailed later in this section. In addition, SCPs duties include, but are not limited to:

- Ensuring continuity of care by communicating all testing and treatment to the member's PCP.
- Arranging for laboratory and radiological services when necessary and coordinating follow-up care.
- Participating in inpatient treatment, discharge planning, and follow-up care, as appropriate. Medicaid/Members may self-refer for the following services:
- Mental health or substance use services with a Participating Provider.
- Vision services with a Participating Provider.
- Diagnosis and treatment of TB by public health agency facilities.
- Family planning and reproductive health from a Participating Provider or Medicaid Provider.
- Dental services with a Participating Dentist.
- Prenatal Care from a Participating Provider.
- Acute gynecological care from a Participating Provider.
- Mental health or substance use services with a Participating Provider (unlimited). However, this provision does not apply to ACT, inpatient psychiatric hospitalization, partial hospitalization, or Behavioral Health Home and Community Based Services, for which no self-referrals for assessments are permitted.

2.2. Specialty Care Providers as Primary Care Providers (PCP)

With approval, a SCP may act as the PCP for a member with a life-threatening, degenerative and/or disabling condition, or a disease requiring prolonged specialized medical care. The member or the member's PCP may initiate the request for the specialist to act as the member's PCP. Such requests should be made to the Utilization Management Department.

2.3. OB/GYN Providers

A Participating OB/GYN Provider may be an obstetrician and/or gynecologist, Nurse Midwife or Nurse Practitioner (Nurses must be Board Certified to provide care to Medicare Advantage programs patients). OB/GYN Providers are SCPs who may also provide primary care services.

Participating OB/GYN providers must comply with the presumptive eligibility standards for providing prenatal care services pending a full Medicaid eligibility determination on a potential enrollee.

Members may self-refer to a Participating OB/GYN Provider for the following services:

- Routine gynecological services (up to two visits annually).
- Prenatal and all obstetrical care.
- Primary and preventive obstetrical and gynecological services required as a result of annual examinations or as a result of an acute gynecological condition.
  Participating OB/GYNs are also required to comply with the informed consent procedures for hysterectomy and sterilization as specified in regulation and the DOHMH Public Health Guidelines (see Section 10).

2.4. Continuity and Coordination of Care

2.4.1 PCPs and SCPs

PCPs are expected to communicate the indication for a referral, along with any relevant medical information, in writing to the SCP to whom the member has been referred. It is not necessary to submit referral forms to MetroPlusHealth, and MetroPlusHealth does not accept any type of referral form for referrals to Non-Participating Providers. In response, SCPs are required to furnish consultation reports to the member's PCP. If the care is ongoing, reports should be provided on a regular basis. Participating hospitals and skilled nursing facilities are required to contact the member's PCP at the initiation of treatment to review medical history and are also required to forward a discharge summary to the PCP at the end of care. In response to these communications, PCPs are required to contact these Providers to coordinate care and schedule an appropriate follow-up with the member.

In the event that MetroPlusHealth does not have a Participating Provider with the appropriate training and expertise to meet the particular health needs of a member or medically necessary services are not available through network providers, MetroPlusHealth will make a referral to an appropriate Non- Participating Provider upon approval of a treatment plan by MetroPlusHealth in consultation with the PCP, the Non-Participating Provider and the member or member's designee. In cases where a member has been diagnosed with a life-threatening condition or disease or a disabling or degenerative condition or disease, which would require specialized medical care over a long period of time, the member may work with MetroPlusHealth's Case Management team to identify Specialty Care Centers that can most appropriately treat their condition. This coordination would occur between the MetroPlusHealth Case Management / Utilization Management team as well as the member's PCP and the Specialty Care Center. The member may not use a non-participating specialist unless there is no specialist in the network that can provide the requested treatment.

MetroPlusHealth evaluates and addresses problems that may arise in the continuity and coordination of care between PCPs and SCPs. PCPs that have 50 or more members are evaluated. The coordination of care between PCPs and hospitals, as well as home care and skilled nursing facilities, is also monitored.

- Evaluation of the coordination of care among Providers occurs through a number of measures including:
- Review of PCP medical records for evidence of consultation reports, discharge summaries or home health reports.
- Monitoring of PCP referral rates.
- Assessment of the effectiveness of discharge planning.

2.4.2 PCPs and Outpatient Behavioral Health Providers

2.4.2.1 Screening and Assessment
Routine use of a MetroPlusHealth approved standardized mental health and substance use screening tool is required at the time of the initial member assessment and at least annually or when clinically indicated. MetroPlusHealth recommends the use of the PHQ-2/PHQ-9 and CAGE tools for this purpose. Use of the Beck or Hamilton Depression Inventories as mental health screening tools is also acceptable. Copies of these tools and literature on their administration are available from the Provider Services Department. Other appropriate tools using standardized screening methods must be submitted to the Provider Services Department. The Provider Services Department will forward these to the Quality Management Department for review and approval. Formal training for Participating Providers on the use of these screening tools and on techniques for identifying individuals with unmet behavioral health care needs is periodically offered by MetroPlusHealth. Please contact the Provider Services Department to obtain information on training sessions.

Based on the results of the behavioral health screening, PCPs are required to make an appropriate referral to a Participating behavioral health Provider for members who require further assessment and evaluation. In cases when it may be of benefit to the member, the PCP may ask MetroPlusHealth or, with member consent, a Participating behavioral health Provider to contact the member directly to initiate services.

2.4.2.2 Consent and Communication
MetroPlusHealth has developed, in collaboration with Participating behavioral health Providers, a protocol for ensuring appropriate member consent and effective, timely communication between PCPs and Participating behavioral health Providers. A copy of the protocol, including recommended consent and communication forms, is contained in *Appendix VIII*. PCPs and Participating behavioral health Providers are required to use this or a similar protocol. MetroPlusHealth will periodically assess, through medical record review, adherence to the standards set forth in the protocol.

2.4.2.3 Primary Care Provider Requirements for Behavioral Health
PCPs may be able to provide behavioral health services within the scope of their practice. If an enrollee is using a behavioral health clinic that also provides primary care services, the enrollee may select his or her lead provider to be a PCP.

2.4.3 Continued Access to Terminated and Non-Participating Providers
MetroPlusHealth has established the following standards to ensure continuity of care for certain members whose Participating Provider's agreement is terminated or whose Provider does not participate with MetroPlusHealth:

- Members in active treatment for an acute episode of a chronic disease or acute medical condition (this does not include routine treatment of a chronic medical condition) will be allowed continued treatment with the same Provider for up to 90 days.
- If a new enrollee to MetroPlusHealth is engaged in an ongoing course of treatment because of a life-threatening or degenerative and disabling disease or condition at the time of enrollment, he/she shall be permitted to continue care with the current health provider for a transitional period. The transitional period continues up to sixty (60) days from the effective date of enrollment.
- If a new enrollee is pregnant and has an established ongoing course of treatment with an out of network provider at the time of enrollment and is in the second trimester of her pregnancy, an authorization for out of network service will be given. This authorization will

include the delivery and continue for a period to include provision of postpartum care directly related to the delivery.

The Utilization/Care Management Department will work with these Providers to develop a transition plan for members. The transitional period begins on the date the provider's contractual obligation to provide services to MetroPlusHealth members terminates. MetroPlusHealth may approve treatment for more or less than 90 days or beyond the postpartum period depending on the accepted transition plan. Providers excluded from this include those who are:

- Terminated due to disciplinary action by MetroPlusHealth or a professional disciplinary agency.
- Unwilling to continue treatment of the member.
- Unwilling to share information with MetroPlusHealth regarding the member's treatment plan.
- Unwilling to continue to accept the contracted rates.
- Who fail to follow utilization/care management policies and procedures.

2.5. Accessibility of Service Standards

2.5.1 Telephonic and After Hours Access Standards for PCPs and Participating OB/GYNs

- PCPs and Participating OB/GYNs are responsible for ensuring that members have access to services 24 hours per day, 7 days per week.
- PCPs and Participating OB/GYN offices must provide a working telephone number for members to access during normal business hours.
- Accommodations must be made for members who cannot receive a return call. For PCPs and Participating OB/GYNs with a live voice answering service, the answering service should instruct members that cannot receive a return call to remain on the telephone while the service attempts to reach the Participating Provider. If this service is not available, PCPs and Participating OB/GYNs must establish alternative arrangements.
- PCPs and Participating OB/GYNs must be on-call or designate a PCP or Participating OB/GYN to provide on-call coverage to respond to member concerns after hours, on weekends, and during short and long-term leaves of absence.
- On-call Providers must return all phone calls within 30 minutes.
- PCPs and Participating OB/GYNs must provide MetroPlusHealth with an after-hours contact number at which a live person can be reached.
- PCPs and Participating OB/GYNs with office phones answered by an answering machine must have a message referring members to a phone number answered by a person able to make a direct connection or alternative arrangements. Answering machines may also refer calls to the MetroPlusHealth 24-hour Healthcare Hotline whose agents can contact the PCP or Participating OB/GYN or make alternative arrangements.

2.5.2 Appointment Access and Availability Standards

2.5.2.1 Primary Care Provider Standards

- Emergency care must be provided immediately for a member with a medical emergency presenting at a PCP service delivery site.
- Urgent medical care must be provided within 24 hours of request.
- Non-urgent "sick" visits must be provided within 48 to 72 hours of request, as clinically indicated.

- Routine, non-urgent, preventive health visits must be provided within four weeks (28 calendar days) of request.
- Adult baseline and routine physicals must be provided within 12 weeks (84 calendar days) of the date of enrollment.
- Initial PCP visits for newborns must be provided within two weeks (14 calendar days) of hospital discharge.
- Well-child visits must be provided within four weeks (28 calendar days) of request.
- Initial family planning visits must be provided within two weeks (14 calendar days) of request.
- Health assessments of a member's ability to work must be provided within 10 calendar days of request.

2.5.2.2 HIV Specialist PCP Standards for HIV Special Needs Plan Members

- Emergency care must be provided immediately for a member with a medical emergency presenting at a PCP service delivery site.
- Urgent medical care must be provided within 24 hours of request.
- Non-urgent "sick" visits must be provided within 48 to 72 hours of request, as clinically indicated.
- Routine, non-urgent, preventive health visits must be provided within four weeks (28 calendar days) of request.
- Adult baseline and routine physicals must be provided within four weeks (28 calendar days) from the date of enrollment.
- Initial PCP visits for newborns must be provided within 48 hours of hospital discharge.
- Well-child visits must be provided within four weeks (28 calendar days) of request.
- Initial family planning visits must be provided within two weeks (14 calendar days) of request.
- Health assessments of a member's ability to work must be provided within 10 calendar days of request.

2.5.2.3 Specialty Care Provider Standards

- Emergency care must be provided immediately when a member with a medical emergency presents at a SCP service delivery site.
- Urgent medical care must be provided within 24 hours of request.
- Non-urgent "sick" visits must be provided within 48 to 72 hours of request, as clinically indicated.
- Non-urgent specialty care visits must be provided within four to six weeks (28 to 42 calendar days) of request.
- Health assessments of a member's ability to work must be provided within 10 calendar days of request.

2.5.2.4 OB/GYN Provider Standards

- Initial family planning appointments must be scheduled within two weeks (14 calendar days) of the request.
- First-trimester initial prenatal care appointments must be scheduled within three weeks
- (21 calendar days) of the request. This appointment must be with the designated Participating OB/GYN Provider who will perform the ongoing coordination of care for the remainder of the pregnancy.
- Second-trimester prenatal care appointments must be scheduled within two weeks (14 calendar days) of the request.

- Third-trimester prenatal care appointments must be scheduled within one week (7 calendar days) of the request.

2.5.2.5 Behavioral Health Provider Standards

- Members with a life-threatening emergency must be seen immediately upon request.
- Members with a non-life-threatening emergency must be seen within six hours of the request.
- Members with urgent behavioral health care needs must be seen within 24 hours of the request.
- Providers will assist members who present for unscheduled non-urgent care on how to access appropriate care
- Follow-up visits pursuant to an emergency encounter or hospital discharge must be provided within five calendar days of the request, or as clinically indicated.
- Non-emergent routine mental health or substance use disorder visits with a Participating Provider that is a mental health and/or substance use disorder outpatient clinic including a PROS clinic: within one week of request.
- Mental health and substance use assessments of a member's ability to work must be provided within 10 calendar days of the request.
- Members discharged from inpatient mental health and substance use settings must be seen within one week (7 calendar days) of discharge for therapeutic or medication follow-up, as appropriate.
- Members missing post-discharge appointments must be contacted by phone and/or writing to encourage appointment attendance. MetroPlusHealth must be notified if a member is unable to be reached or if a member is continually non-compliant with the recommended appointment schedule.
- For continuing day treatment, intensive psychiatric rehabilitation treatment programs and rehabilitation services for residential substance use disorder treatment services; within two to four weeks of request
- For PROS programs other than clinic services; within two weeks of request.

2.5.3 Office Waiting Time Standards

- Waiting room times must not exceed one hour for scheduled appointments.
- Members who walk in with urgent needs must be seen within one hour.
- Members who walk in with non-urgent "sick" needs must be seen within two hours or must be scheduled for an appointment to be seen within 48 to 72 hours, as clinically indicated.

NOTE: Providers are required to schedule appointments in accordance with the aforementioned appointment and availability standards. Providers must not require a new patient to complete prerequisites to schedule an appointment, such as a copy of their medical record, a health screening questionnaire, and/or an immunization record. The provider may request additional information from a new member if the appointment is scheduled at the time of the telephonic request.

2.5.4 Facility Access Requirements

MetroPlusHealth requires that all members have access to health care facilities, regardless of physical limitations. Members may not be discriminated against on the basis of disability, illness or condition. All hospital and outpatient facilities must maintain full compliance with the Americans with Disabilities Act (ADA) and municipal requirements. Participating Providers must comply with ADA guidelines for members who are visually, hearing or cognitively impaired, including providing access to sign language interpreters. Wheelchair accessible

sites are indicated in the *Provider Directory*.

2.5.5 Medical Language Interpreter Services
Language interpreter services must be provided during scheduled appointments and scheduled encounters by a third-party interpreter who is either employed by or contracts with the medical provider. These services may be provided either face-to-face or by telephone and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible. Members are entitled to receive language interpretation upon request at no charge.

2.6. Advance Directives
Advance directives are verbal or written instructions made before an incapacitating illness or injury. Advance directives include, but are not limited to, health care proxies, do-not-resuscitate (DNR) orders and living wills. New York Public Health Law permits individuals to sign a Health Care Proxy form (see *Appendix XIV*), which appoints someone to act as their Health Care Agent to make treatment decisions if they lose the ability to decide for themselves. This document also may express the wishes or instructions regarding organ and/or tissue donation for transplantation, research or educational purposes. A DNR order informs medical professionals not to perform CPR if the patient's breathing or heart stops. A living will is a written document that expresses specific instructions and choices about various types of medical treatments and conditions. Living wills are recognized as evidence of a person's wishes if the person is seriously ill and not able to communicate.

PCPs and other Participating Providers, as appropriate, are expected to inform adult members about their right to execute advance directives. If a member chooses to execute an advance directive, the Participating Provider should document the decision and place copies of the signed advance directive form in the member's medical record. If the member decides not to execute an advance directive, the Participating Provider should document in the medical record that the member was given written information and advised of their right to execute an advance directive.

2.7. Confidentiality Requirements
All medical record related data secured by MetroPlusHealth in connection with the performance of its quality, utilization management, claims payment, and Member Services functions shall not be revealed or disclosed by any MetroPlusHealth employee, except to the member's attending Physician, a government agency or as otherwise permitted by law. MetroPlusHealth has implemented several mechanisms to ensure that the confidentiality of member records and related information is maintained:

- All MetroPlusHealth staff receive privacy training upon employment and must sign a confidentiality agreement. Employees are subject to discipline, up to and including termination, for violation of policies and procedures for protecting member confidentiality.
- As part of the medical record review process, MetroPlusHealth verifies that Participating Provider's offices have established systems of maintaining member records in a confidential manner.
  In addition, Participating Providers must develop policies and procedures to assure confidentiality of HIV-related, behavioral health, and substance use information. The policies and procedures must include:
- An initial and annual in-service education of staff and contractors
- Identification of staff allowed access to information and the limits of access

- Procedures to limit access to trained staff and contractors
- Protocols for secure storage including electronic storage
- Procedures for handling requests for HIV-related, behavioral health, and substance use information
- Protocols to protect members with, or suspected of having, HIV, behavioral health and/or substance use disorder from discrimination
  Providers may not discriminate against members in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

2.8. Provider Complaint Process

The Provider Network Operations Department investigates and resolves Participating Provider complaints not involving claim payment disputes or utilization review determinations. Any Participating Provider may submit a complaint in writing, or have it put in writing by the staff person taking the complaint, to the Director of Network Management. The staff person designated to handle the complaint will send the Participating Provider a written acknowledgment of the complaint within five business days of receipt. All complaints will be investigated and resolved within 30 business days.

Once a resolution is achieved, the Network Management Department will notify the Participating Provider in writing of the final outcome of the investigation. If the Participating Provider is not satisfied with the determination, an appeal may be filed within 60 business days.

2.9. Disciplinary Action

Disciplinary action may be taken against Participating Providers for quality of care complaints and concerns, noncompliance with program standards and guidelines, unsatisfactory utilization management, or fraudulent practices. Depending on the nature and severity of the situation, MetroPlusHealth may decide to limit, suspend or formally terminate a Participating Provider's participation. Disciplinary actions are instituted based on the review and decision of the Credentialing Committee.

Participating Providers cannot be prohibited from the following actions, be terminated or have a contract renewal refused solely for the following:

Advocating on behalf of an enrollee
Filing a complaint against MetroPlusHealth
Appealing a decision of MetroPlusHealth
Providing information or filing a report regarding prohibitions of plans or requesting a hearing or review.

2.9.1 Provider Sanction Levels

There are three levels of sanctions for disciplinary actions. A Level I sanction is initiated when a Participating Provider is found to be non-compliant with:

- Policies and procedures or guidelines related to medical record audits.
- Protocols for referring to non-Participating Providers.
- Obtaining required pre-authorization of services.
- Coding of claims.
- Access and Availability standards, including after-hours and 24-hour access.

- Minor quality issues not having an adverse effect on the member.

The Medical Director, on behalf of the Credentialing Committee, issues a letter to the Participating Provider advising them of the adverse findings and requesting a plan of correction, if applicable. Depending on the response, one of three possible events may occur:

- The plan of correction is acceptable, and no further action is taken.
- The plan of correction is conditionally accepted, and a follow-up plan is established.
- The plan of correction is unacceptable, or the Provider remains non-compliant with the request and a Level II sanction is initiated.

When MetroPlusHealth is satisfied that the action has resulted in correcting the problem, the Participating Provider is notified that the issue is resolved. MetroPlusHealth will initiate a Level II disciplinary action when the plan of correction requested in Level I is unacceptable, or the Participating Provider remains non-compliant with the request. The Medical Director, on behalf of the Credentialing Committee, may elect to subject the medical claims from the Participating Provider to pre-payment review, freeze the Participating Provider's panel or prohibit referrals to a SCP without prior authorization from the Utilization/Care Management Department. The Medical Director, on behalf of the Credentialing Committee, may also elect to make the provider ineligible to receive a Quality Incentive payment. A corrective action plan will also be requested from the Participating Provider.

Depending on the response, one of three possible events may occur:

- The plan of correction is acceptable, and no further action is taken.
- The plan of correction is conditionally accepted, and a follow-up plan is established.
- The plan of correction is unacceptable, or the Participating Provider remains non-compliant with the request and Level III disciplinary action is initiated.

When MetroPlusHealth is satisfied that the action has resulted in correcting the problem, the Participating Provider is notified that the issue is resolved.

MetroPlusHealth will initiate a Level III sanction when the plan of correction requested in Level II is unacceptable or the Participating Provider remains non-compliant with the request. The Medical Director, on behalf of the Credentialing Committee, may recommend actions ranging from the initiation of practice limitations (i.e. restriction of certain procedures) to termination of the Participating Provider. In situations where severe quality issues may threaten member safety, the Credentialing Committee may elect to recommend that the Participating Provider's participation be terminated. In such cases, sanction Level I and II would be bypassed and MetroPlusHealth would automatically initiate disciplinary actions as specified under Level III. Depending on the nature of the situation, two possible events may occur:

- The outcome of the Participating Provider's case is maintained on internal reports only and the Participating Provider is subject to reassessment at a specified future date.
- MetroPlusHealth terminates the Participating Provider's participation.

The President & CEO will send a letter when a Participating Provider's participation is to be terminated. All letters will include an explanation of the actions taken and information regarding the Participating Provider's right to appeal. The effective date of the termination will be determined according to the terms of the Participating Provider's agreement. MetroPlusHealth will report to the National Practitioner Data Bank and New York State regulatory agencies as required by regulation. If the Participating Provider is to be assessed at a later date, they will receive notification of that decision. When the Credentialing Committee

is satisfied that the action has resulted in the correction of the problem, the Participating Provider is notified that the issue has been resolved.

2.9.2 Suspension
MetroPlusHealth may elect to suspend Participating Providers who have been charged and/or arrested until final resolution of the charges or that are subject to an OPMC or other regulatory agency investigation/ action. Providers who are suspended are excluded from participation in all MetroPlusHealth programs and cannot treat MetroPlusHealth members during their suspension.

2.9.3 Right of Appeal
Participating Providers have the right to appeal any disciplinary action. A Provider who is terminated due to a case involving imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice is not eligible for a hearing or a review. Eligible Providers must request a hearing in writing within 30 calendar days of receipt of the notification. The plan must include in the termination notice the reasons for the proposed action and notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by the MCO; and a time limit for a hearing date which must be held within thirty days after the date of receipt of a request for a hearing.

The hearing panel will be comprised of three persons appointed by MetroPlusHealth and at least one person on the panel from the same discipline or same specialty as the person under review. The panel can consist of more than three members, provided the number of clinical peers constitutes one-third or more of the total membership.

The hearing panel will render a decision in a timely manner. Decisions will include one of the following and will be provided in writing to the healthcare professional: reinstatement; provisional reinstatement with conditions set forth by the MCO, or termination. Decisions of termination shall be effective not less than 30 days after the receipt by the healthcare professional of the hearing panel's decision. In no event shall determination be effective earlier than 60 days from receipt of the notice of termination. These hearing rights apply to all health care professionals licensed, registered or certified under Title 8 of the New York State Education Law.

2.10. Government Program Standing
MetroPlusHealth requires all Participating Providers to hold a valid undisciplined license to practice and to remain in good standing with government programs, including Medicare and Medicaid. When notified, or upon discovery, that a Participating Provider's license has been revoked, suspended or surrendered or that a Participating Provider has been excluded from participating in government programs, MetroPlusHealth terminates their participation. If the termination is based on a license suspension for reasons that would not support permanent exclusion from participation, the termination letter will advise the Participating Provider that they may re-apply upon license reinstatement.

Compliance with 42 CFR 455.105 and 42 CFR 455.106
MetroPlusHealth ensures compliance with 42 CFR 455.105 and 42 CFR 455.106 by requesting providers, at the time of initial application and re-credentialing, attest to their compliance. MetroPlusHealth also has a process to review CMS and Medicaid excluded providers on a monthly basis. MIS generates a report on a monthly basis, which is compared

electronically to MetroPlusHealth participating provider file. Potential matches are reviewed by the Credentialing Department for appropriate action. MetroPlusHealth has also implemented a process, to inquire at the time of re-credentialing, whether a provider has an ownership or control interest (5% or more) in MetroPlusHealth or if they act as agent of the plan, and also asks if the provider has any ownership of subcontractors working in your practice and/or wholly-owned suppliers with business transactions totaling more than $25,000 during the last fiscal year. MetroPlusHealth also requires the provider to disclose any person who (1) Has ownership or control interest in the provider or is an agent or managing employee of the provider; and (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. In cases where this is reported, MetroPlusHealth will report this information directly to the Inspector General within 20 working days from receipt of this information.

2.11. Public Transit Coverage and Reimbursement

The New York State Department of Health has contracted with Medical Answering Services LLC (MAS) to manage Medicaid non-emergency medical transportation services (NEMT) in New York City. This change went into effect on April 23, 2017. MAS can be contacted at **844.666.6270** to arrange and coordinate services.

Non-emergency ambulance and ambulette service may also be an approved means of transportation for Medicaid Managed Care members and **must** be coordinated through MAS. The PCP or Participating Provider who is referring the member for services is responsible for arranging the transportation. For additional information, please visit https://www.medanswering.com/medical-practitioners/.

Medicaid beneficiaries in New York City who can use mass transit can receive a pre-paid MetroCard for this purpose. Medicaid expects that NYC Medicaid enrollees will use public transit if their appointment is within ten (10) city blocks of a bus or subway stop, so long as their medical condition permits this.

Medicaid-enrolled facilities and practitioners may voluntarily participate in a web-based application established by the Department of Health called Public Transportation Automated Reimbursement System (PTAR). Facilities and practitioners participating in PTAR purchase MetroCards directly from the MTA, and when a patient enrolled in Medicaid uses public transportation to travel to a medical appointment covered by Medicaid, the participating facility or practitioner will distribute a pre-paid MetroCard to the enrollee. The facility or practitioner is then reimbursed by the State. Public transportation is only reimbursed through the PTAR system.

Medicare does not generally cover NEMT except under certain circumstances. For Medicare Advantage and Medicaid Advantage Plan (MAP) members, the first 14 trips are covered by MetroPlusHealth. Once members complete use of 14 trips, Medicaid covers unlimited rides. If a member has a non-emergent medical condition and requires non-emergency transportation by ambulance to access medical care, the provider must contact Member Services. Member Services will arrange for appropriate transportation based on the member's medical needs. To learn more about Medicare transportation benefits please review the Summary of Benefits or call Member Services at 1-800-303-9626

2.12. Approved In-Office Lab Tests

The Primary Care Physician (PCP) In-Office Laboratory Testing and Procedures List is a list of testing/ laboratory procedure codes that MetroPlusHealth will consider for reimbursement to our Network PCPs (Family Practice, Internal Medicine, Pediatrics, Geriatrics and Adolescent Medicine) when performed in their office. This listing went into effect on **January 15, 2021**. MetroPlusHealth has contracts in place with several reference laboratories to ensure that our members receive the highest quality diagnostic testing available. MetroPlusHealth also understands that there are certain times when it is clinically appropriate and more efficient to administer tests while the member is in the provider's office. The services below are allowed by Primary Care Physicians (PCP) for all MetroPlusHealth lines of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full-service laboratory offering a comprehensive test menu that includes routine, complex, drug, and genetic testing and pathology. Note that for providers contracted under capitated arrangements, these testing services are included in your monthly capitation payment.

Claims for tests performed in the physician's office but not listed below will be denied

CPT Code	Test Description
81000	Routine urinalysis
81001	Urinalysis, automated, w/microscopy
81002	Urinalysis, non-automated w/o microscopy
81003	Urinalysis, automated, w/o microscopy
81025	Urine Pregnancy test
82043	Urine, microalbumin, quantitative
82044	Urine, microalbumin, semiquantitative
82247	Bilirubin, total
82270	Fecal occult blood testing
82271	Fecal occult blood testing
82272	Fecal occult blood testing
82947	Glucose; quantitative
82948	Glucose, blood, reagent strip
82962	Blood glucose by FDA approved glucose monitoring devices
83014	Helicobacter pylori, breath test analysis; drug administration
83036	Hemoglobin; glycosylated (A1C)
83037	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
83655	Lead (finger stick lead testing only)
84703	hCG, qualitative
85018	Hemoglobin
85025	CBC with differential
85027	CBC without differential
85610	Prothrombin/INR
85651	Sedimentation rate, erythrocyte; non-automated
86140	C-reactive protein
86308	Mononucleosis test/heterophil antibody test
86580	Tuberculosis, intradermal
86701	Antibody HIV-1 test (with modifier 92)
86702	Antibody; HIV-2
86703	Antibody HIV-1 and HIV-2 single assay (with modifier 92)
87210	Wet mount w/simple stain

87220	KOH prep
87804	Rapid Influenza test
87880	Infectious agent detection by immunoassay-streptococcus group A
88738	Hemoglobin (Hgb), quantitative, transcutaneous
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
G2023	Specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source

For more information about In-Network Laboratory Providers, please consult the *MetroPlusHealth Provider Directory* at www.MetroPlus.org.

2.13. Marketing Activities

2.13.1 Managed Long-Term Care
Participating Providers who wish to communicate with their patients about managed care options must direct patients to the State's Enrollment broker for education on all plan options. Participating Providers are prohibited from displaying the Plan's outreach materials.

Participating Providers shall not advise patients in any manner that could be construed as steering towards any Managed Care product type.

2.13.2 All Other Lines of Business
Participating Providers who wish to communicate with their patients about managed care options must advise patients taking into consideration only the Managed Care Organization that best meets the health needs of the patient. Such advice, whether presented verbally or in writing must be individually based and not merely a promotion of one plan over another.

Participating Providers may display the contractor's outreach materials provided the appropriate material is conspicuously posted for all other MCOs with whom the Participating Provider has a contract.

If you have members in your practice who are interested in or eligible for a MetroPlus program, you may refer them to MetroPlus Member Services.
For providers interested in on-site marketing, MetroPlus will schedule a time for a representative to be available at your office or facility for the convenience of your patients. Please call **212.908.3636** for more information.

2.14 Homeless Members
PCPs should assess patients for homelessness and evaluate for co-morbidities, including substance use, mental illness, hepatitis, tuberculosis, and sexually transmitted infections. Linkages to treatment interventions that are culturally, developmentally and linguistically appropriate are necessary to develop a comprehensive plan of assessment and treatment.

PCPs are responsible to identify new and existing members who are homeless by:

- Completing a comprehensive assessment at the member's first office visit, including inquiries about the member's housing status and documenting the housing status in the member's medical record; reassessment should occur at least annually.

- Notifying MetroPlusHealth care management staff who will conduct targeted outreach efforts to members who do not present for an appointment with the Provider within three consecutive months of the effective date of enrollment.

In order to facilitate access for a member who is identified as homeless, PCPs must:

- Ensure that members are seen within one hour of their appointment time or within two hours of presenting without an appointment, and
- Assign a designated case manager who will assist the member with:
  - Obtaining needed support services.
  - Scheduling and keeping appointments.
  - Arranging transportation.
  - Obtaining, taking as directed and arranging for the safe storage of medications.
  - Accessing all entitlements.
  - Create an individualized multi-disciplinary comprehensive care plan that is updated minimally every 180 days.
- Ensure that a Physician is responsible for the medical management of the member if in the hospital and, in consultation with the member's case manager, that they will:
  - Assess the member's post-discharge medical, mental health, substance use and housing needs, and
  - Develop a discharge plan for the member that identifies appropriate interventions, including safe placement in the community or a recuperative facility and specifies first post-discharge appointment.

2.15 Restricted Recipient Members

- Medicaid consumers in the Restricted Recipient Program are required to enroll in a Medicaid Managed Care Plan
- Restricted Recipients are individuals with a pattern of misusing or abusing benefits package services and are restricted to one or more providers to receive their services
- Restrictions may include PCPs, specialists, dentists, podiatrists, hospitals, pharmacies, and durable medical equipment (DME) vendors
- MetroPlusHealth is responsible for enforcing the restrictions and assessing the members to determine if the restrictions should remain in place and also for identifying the need for restrictions for our members
- Primary Care rosters contain a two-digit code field to identify restricted members and it will include their specific restrictions
- MetroPlusHealth Restricted Recipients have an "R" on their ID card
- Providers must verify member eligibility before every encounter in order to identify any restrictions
- If a member is restricted to a particular provider, the member cannot be seen by another provider without a prior authorization; claims without an authorization will be denied

2.16. Cultural Competence

Providers must ensure that services and information about treatment are provided in a manner consistent with the member's ability to understand what is being communicated. Members of different racial, ethnic, and religious backgrounds, as well as individuals with disabilities, should receive information in an understandable manner that is responsive to their specific needs. If there are foreign language issues, a family member, friends, a healthcare professional who speaks the same language as the member may be used (at the member's discretion) as a translator. In addition, the MetroPlusHealth Member Services and Medical Management Departments can provide assistance for members who do not speak English, either through their multi-lingual staff or by facilitating a connection with a telephone-based

language interpretation service. It is essential that all efforts be made to ensure that the member understands diagnostic information and treatment options and that language, cultural differences or disabilities do not pose a barrier to communication. Providers are required to complete cultural competence trainings to meet the National Cultural and Linguistically Appropriate Services in Health and Health Care (CLAS) standards as detailed in the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model contract section 15.10(c,). Organizations and facilities must attest that the annual cultural competency training provided to their clinical staff incorporates material and/or is equivalent to the material contained in the training offered by the United States Department of Health and Human Services (HHS), Office of Minority Health education program, *Think Cultural Health*.

2.17. Vaccines for Children (VFC) Program Update: Fee Schedule Code Revisions

MetroPlusHealth requires all eligible Child Health Plus (CHP) and Medicaid providers to participate in the Vaccines for Children (VFC) Program. The VFC Program is a federally funded program offered through the New York State Department of Health (NYSDOH) and New York City Department of Health and Mental Hygiene (NYCDOHMH) that distributes free vaccines to eligible providers that serve Medicaid/CHP[1] members under 19 years of age within New York City (Bronx, Kings, New York, Queens and Richmond counties). Members that meet these criteria are commonly referred to as VFC- eligible members.

[1]There may be some limitations to eligibility for underinsured children in the CHP program. Please see the NYSDOH and the NYCDOHMH Vaccines for Children Program websites.

As providers are expected to receive vaccines at no cost through the Vaccines for Children program, MetroPlusHealth will not be responsible for the cost of vaccines for CHP/Medicaid members.

MetroPlusHealth will only reimburse Fee for Service providers for the cost of administering vaccines to VFC-eligible members. Providers are required to bill vaccine administration code 90460 for the administration of vaccines supplied by VFC, including influenza and pneumococcal administration. For reimbursement purposes, the administration of the components of a combination vaccine continues to be considered as one vaccine administration. The administration of more than one vaccine is reimbursable under vaccine administration code 90460 on a single date of service.

The following is a list of the CPT codes for vaccines that will be auto-denied when administered to any VFC-eligible members under age 19:

CPT Code	Description
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
90644	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months, for intramuscular use
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3-dose schedule), for intramuscular use

90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use
90651	Human Papillomavirus vaccine types 6,11,16,18,31,33,45,52,58, nonvalent (HPV), female/male ages 9-26 yrs.
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90680	Rotavirus vaccine, pentavalent, 3-dose schedule, live, for oral use
90681	Rotavirus vaccine, human, attenuated 2-dose schedule, live, for oral use
90685	Influenza, inactivated virus vaccine, seasonal, quadrivalent, split virus, preservative-free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza, inactivated virus vaccine, seasonal, quadrivalent, split virus, preservative-free, when administered to individuals 3 years and older, for intramuscular use
90687	Influenza virus vaccine, quadrivalent, split virus, 0.25 ml dosage when administered to children 6-35 months of age, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, 0.5 ml dosage when administered to individuals for intramuscular use. Age varies by product
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DtaP-Hib-IPV), for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DtaP), when administered to individuals younger than 7 years, for intramuscular use
90707	Measles, mumps, and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use
90714	Decavac, tetanus and diphtheria toxoids absorbed for adult use
90715	Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals 7 years or older, for intramuscular use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3-dose schedule), for intramuscular use

2.18 Qualified Medicare Beneficiary Program (QMB)

- Federal law bars Medicare providers and suppliers, including pharmacies, from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. (Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.).
- The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including

deductibles, coinsurance, and copays.

- Providers and suppliers, including pharmacies, may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States may limit Medicare cost- sharing payments, under certain circumstances.
- Persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

2.19 Availability of Documentation

Providers will ensure that pertinent contracts, books, documents, papers and records of their operations are available to the Department, OMIG, DHHS, the Comptroller of the State of New York and the Comptroller General of the United States and the New York State Office of the Attorney General and/or their respective designated representatives, for inspection, evaluation and audit, through ten (10) years from the final date of the Provider Contract or from the date of completion of any audit, whichever is later.

3. Member Services

3.1. Member Services Functions

The Member Services Department functions as a centralized resource for members and providers. Member Service Representatives help to facilitate member access to appropriate medical and preventive health services and help providers with claim status, member eligibility, prior authorizations, updating provider contact information and plan benefits. The Member Services Call Center is available 24 hours per day, 7 days per week at **1.800.303.9626** for Medicaid/CHPlus/Medicaid HIV SNP, **1.866.986.0356** for MetroPlusHealth Medicare and Medicaid Advantage Plus (MAP) **1.877.475.3795** for MetroPlusHealth Gold, 1.855.355.6582 for Managed Long Term Care (MLTC) and **711** for TDD/TTY.

MetroPlusHealth provides support and assistance to members with disabilities or special language needs. Bilingual staff and language line services are available to assist our non-English-speaking members. A complete listing of MetroPlusHealth phone numbers can be found on page 6.

In addition to member and Provider support services, Member Services assures that all members receive member ID cards and Welcome Packets.

All members receive a new member Welcome Packet consisting of the member ID card and MetroPlusHealth Member Guide or Welcome Letter. For MetroPlusHealth Child Health Plus, Gold, GoldCare and UltraCare plans, the Welcome Packet will also include the Member Handbook or subscriber contract, depending on which product the member is enrolled in. The Member Guide or Welcome Letter includes information on how to access member materials such as the Member Handbook, Evidence of Coverage, Provider Directory, and Formulary online or request a printed copy.

The welcome packet for Medicare beneficiaries includes information on how to access the *Evidence of Coverage*, *Provider Directory* and *Formulary* online or how to request a printed copy to be mailed.

MetroPlusHealth has partnered with Cyracom International, Inc., a language interpreting company. Cyracom International, Inc. offers a variety of services that will help with any of your

language needs, including qualified interpreters. More information can be found at their official website, https://interpret.cyracom.com/

3.2. Choosing and Changing a Primary Care Provider
The Member Services Department can assist members with the selection of a PCP. If members do not choose a PCP during the enrollment, MetroPlusHealth will assign a PCP and corresponding Health Center site to the member. The name of the PCP and Health Center are listed on the member ID card.

Members enrolled in the Partnership in Care HIV Special Needs Plan may choose an HIV Specialist primary care provider as a primary care provider.

Members (except Medicare) may change their PCP for any reason twice in a twelve- month period. After the second time in a twelve-month period, they must show good cause. Medicare members may change their PCP for any reason, at any time. A new PCP confirmation letter and member ID card are sent to members who change their PCP.

3.3. Member Health Assessments
The Member Services Department staff makes reasonable efforts to complete a voluntary health assessment for new members. The health assessment is designed to assist in the identification of potential medical conditions that may necessitate care management such as visual, hearing, physical mobility, cognitive impairments, mental health or behavioral problems, and chronic diseases or conditions. Upon completion, the health assessment forms are forwarded to the Care Management Department to determine the need for follow-up by Care Managers.

3.4. Member Complaint Process
All member complaints are thoroughly investigated and resolved within the applicable State and/or Federal timelines. The timelines for resolution vary with the nature of the complaint and by product line.

For Medicaid and CHPlus, MetroPlusHealth utilizes complaints as an important source of information for continuous quality improvement. Members have the right to file a complaint, without the risk of retaliation, about any matter associated with MetroPlusHealth services or its Participating Providers. The plan will not take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal. Member Services Department staff may take complaints in writing or by telephone by calling **800.303.9626** or TTY **711**. With the member's written consent, a provider or an authorized representative may file a grievance on the member's behalf. All complaints are forwarded upon receipt to the Complaint Manager for resolution. If a complaint cannot be resolved within 24 hours, the Complaint Manager mails an acknowledgment letter to the member within 15 calendar days of receipt of the complaint.

- When a delay in addressing a complaint could involve a risk to a member's health, the complaint is investigated and resolved within 48 hours of receipt. Notice of the decision will be given immediately by telephone with written follow-up mailed within three business days.
- Complaints involving requests for authorization of medical services or medical benefits will be resolved within 30 calendar days of receipt.
- All other complaints will be resolved within 45-60 calendar days of receipt.

For Medicaid HIV SNP members, more stringent timeframes for complaint resolution apply:

- When a delay in addressing a complaint could involve a risk to a member's health, the complaint is investigated and resolved within 24 hours of receipt. Notice of the decision will be given immediately by telephone with written follow-up mailed within three business days.
- Complaints involving requests for authorization of medical services or medical benefits will be resolved within 15 calendar days of receipt.
- All other complaints will be resolved within 30 calendar days of receipt. Once a determination regarding a complaint is made, a letter will be mailed to the member within the timeframes noted above. If a member is not satisfied with the attempt to resolve the complaint, they may file an appeal. Appeals must be submitted to the Complaints Manager in writing within 60 business days. Members can also file complaints with the NYSDOH (**1.800.206.8125**) or New York Medicaid CHOICE (**1.800.505.5678**). When the outcome of a complaint is a denial of an authorization request, a member may have the right to appeal or request a fair hearing (for more information regarding fair hearings, please see *Section 7.15.8*) in this manual.

MetroPlus Advantage Plan and MetroPlus Platinum Plan Grievances
Medicare members must file a complaint/grievance within 60 days of the time the event occurred. Grievances will be resolved within 30 days of receipt. Upon request, we may extend the timeframe by up to 14 days in order to obtain additional documentation. MetroPlusHealth will immediately notify the member in writing regarding the reasons for the delay. MetroPlusHealth will respond to a grievance regarding our decision to extend or not to extend the timeframe for making an organization determination or decision on appeal within 24 hours.

Medicaid Advantage Plus (MAP) Complaints and Complaint Appeals
If a member has a problem or concern with the care or treatment, he/she is receiving, he/she can file a complaint with MetroPlusHealth by calling or writing to Member Services. Members can also ask someone they trust to file the complaint for them. If a member's designee makes a request, the plan may ask for the enrollee´s written consent for representatives to request plan appeal, grievance, or fair hearing on their behalf.

If a member needs our help because of a hearing or vision impairment or if he/she needs translation services, we can help. We will not make things hard for the member or take any action against the member for filing a complaint.
If a member needs our help because of a hearing or vision impairment or if he/she needs translation services, we can help. We will not make things hard for the member or take any action against the member for filing a complaint.

If a member calls us with a complaint, we may be able to resolve the problem right away over the phone. For problems that are not resolved right away over the phone, and any complaint received via mail, MetroPlusHealth will work to resolve the complaint according to our complaint procedure as described below.

How to File a Complaint with MetroPlusHealth
To file by phone, a member can call Member Services at **1.866.986.0356** (TTY: 711), 24 hours a day, 7 days a week.

If the member does not wish to call, the member can put his/her complaint in writing and mail it to us at: **MetroPlusHealth, Attn: Complaints Manager, 50 Water Street, 7th Floor, New York, NY 10004** or fax to **1.212.908.5196**.

What Happens Next?
If we don't solve the member's problem right away over the phone, we will send him/her a letter within 15 business days. The letter will tell the member who is working on the complaint, how to contact this individual, and whether more information is needed.

A member's complaint will be reviewed by one or more qualified people. If the complaint involves clinical matters, the case will be reviewed by one or more qualified healthcare professionals.

If additional information is needed from the provider to help resolve the submitted complaint, MetroPlusHealth will make reasonable efforts to contact the provider. Additional informational documents should be submitted within 10 calendar days and can be faxed to the MetroPlusHealth Complaints Manager at fax number: **1.212.908.5196**.

After We Review the Complaint
We will let the member know our decision within 30 calendar days. We will let the member know in writing of our decision.

If we need more information and the delay is in the member's best interest or if the member asks for more time, we can take up to 14 more calendar days (44 calendar days total) to answer the complaint. If we decide to take extra days, we will tell the member in writing.

If the member is making a complaint because we denied his/her request for a "fast service authorization" or a "fast appeal," we will automatically give the member a "fast" complaint. If the member has a "fast" complaint, we will let the member know of our decision within 24 hours.

For Medicaid covered benefits, we will inform the member how to appeal our complaint decision if he/ she is not satisfied.

Complaint Appeals
If the complaint is for a Medicaid covered benefit and the member is not satisfied with our decision about his/her complaint, the member or his/her designee can file a complaint appeal with MetroPlusHealth.

How to Make a Complaint Appeal
If a member is not satisfied with what we decide, the member has 60 business days after hearing from us to file a complaint appeal. A member must make the complaint appeal in writing and can mail it to us at: **MetroPlusHealth, Attn: Complaints Manager, 50 Water Street, 7th Floor, New York, NY 10004** or fax to **1.212.908.5196**.

If a member submits a complaint appeal by phone, we will send a form containing a summary of their appeal which must be signed and returned to MetroPlusHealth.

What Happens After We Receive the Member's Complaint Appeal?
After we get a member's complaint appeal, we will send him/her a letter within 15 business

days. The letter will tell him/her who is working on the complaint appeal, how to contact this individual, and whether more information is needed.

The complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about the complaint. If the complaint appeal involves clinical matters, the case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer who was not involved in making the first decision about the complaint.

If we have all the information we need, the member will receive our decision in 30 business days. If a delay would risk the member's health, he/she will receive our decision within 2 business days of when we have all the information we need to decide the appeal. The member will be given the reasons for our decision and our clinical rationale, if it applies.

If the member is still not satisfied, he/she or someone on their behalf can file a complaint at any time with the New York State Department of Health at **1.866.712.7197**.

Medicare Quality of Care Complaints
Medicare members, including Medicaid Advantage Plus members, may also file a quality of care complaint with Livanta at any time. Livanta is the New York State Quality Improvement Organization (QIO) – a group of doctors and health professionals that reviews medical care and handles certain types of complaints from patients with Medicare in NY State. These include complaints about the quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. The QIO is paid by the federal government.

Members may contact Livanta at:

Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701
Tel: 1.866.815.5440
(TTY: 1.866.868.2289)

3.5 Member Rights and Responsibilities

Members have the **right** to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, or sexual orientation.
- Be told where, when, and how to get services from MetroPlusHealth.
- Be informed of their diagnosis, appropriate or medically necessary treatment options for their condition(s) and their prognosis by their PCP in language they understand. See section 2.5.5 on the interpreter services requirement.
- Receive a second opinion about their care
- Give consent for any treatment or care plan after the plan has been fully explained prior to start of any procedure or treatment
- Refuse care and be advised of the potential risks of doing so prior to start of any procedure or treatment
- Obtain a copy of their medical record and discuss it with their PCP
- Know that their medical record information is private and is not shared with anyone except

as required by law, contract or with their consent
- Utilize the member complaint process to settle any complaints or notify the NYSDOH or New York Medicaid CHOICE about dissatisfaction with the plan (Medicaid, CHPlus members).
- Appoint a relative, friend or another person they trust, as a representative if a member is unable to make decisions regarding their own care and treatment.

Members have the **responsibility** to:
- Participate with their PCP to guard and improve their health
- Learn about how their health system works
- Listen to their PCP's advice and ask questions about things they do not understand
- Contact or re-visit their PCP if their condition does not improve or seek a second opinion
- Treat health care staff with the same respect they themselves expect
- Contact MetroPlusHealth if they encounter problems with any health care staff
- Keep appointments or, if necessary, cancel appointments as soon as possible
- Use the emergency room for true emergencies only
- Call their PCP when medical care is needed

4. Eligibility
A member's eligibility must be confirmed before all non-emergent services are provided. Members must be eligible on the date of service for payment to be rendered.

Step 1. At the time of each service, the member should present a MetroPlusHealth ID card.
- If a patient presents for services without a member ID card and claims to be a member, the Provider must call MetroPlusHealth Member Services and advise the Member Services Representative (CSR) that the member cannot produce a member ID card. The CSR will ask to speak directly to the member to verify their identity and will give the Provider the member's identification number that can be used for claim submission and written confirmation of eligibility.
- The PCP's name is included on the member ID card. A member who has recently transferred from one PCP to another may have not yet received their new card that shows the name of their new PCP. Eligibility for these members must be verified through MetroPlusHealth Member Services.

Member ID cards for Medicaid Managed Care, HARP and the HIV SNP will contain a Medicaid Client Identification Number (CIN). Medicaid Managed Care, HARP and HIV SNP members will also have a Medicaid card. CHPlus, QHP, Essential Plan, Medicare, Medicaid Advantage Plus (MAP), MLTC, Gold Care I, Gold Care II and MetroPlusHealth Gold cards will have a MetroPlusHealth-generated membership number.

Step 2. One or more of the methods for verifying eligibility in *Section 4.1* must be performed before each service, regardless of how frequently the member is seen, since possession of a member ID card does not guarantee coverage. Providers that see members with dual Medicare and Medicaid eligibility must verify both. Coverage may terminate, or members may switch PCPs at any time.

4.1. Eligibility Verification Methods
Information obtained from any of the following sources is valid on the date of request only.
4.1.1 Online Verification
Eligibility can also be verified by logging on to the MetroPlusHealth portal at

www.metroplus.org, selecting the "Search Page" and then "Member Eligibility." Up to ten members may be verified at one time.

4.1.2. Electronic Medicaid Eligibility Verification System
For Medicaid Managed Care, HARP and HIV SNP members, the Medicaid CIN may be used to check eligibility through the Electronic Medicaid Eligibility Verification System (EMEVS) web site. EMEVS provides real-time information about the member's eligibility status. EMEVS is available from 9 a.m. to 7 p.m. daily. EMEVS does not identify a member's PCP. Eligibility information may also be obtained by calling the automated EMEVS telephone verification line at **1.800.997.1111** and entering the MetroPlusHealth Provider Number 01529762 and the Plan Code 092. For questions regarding EMEVS, call **1.800.343.9000**. Providers who see dual members with Medicare and Medicaid must verify Medicare and Medicaid eligibility. Providers may bill Medicare cost-sharing not covered by Medicare to NY Medicaid.

4.1.3 Member Roster
PCPs may refer to the most recent member roster to verify eligibility. PCPs can view and print rosters by logging on to the portal at providers.metroplus.org, selecting the "Reports" tab on the right and then select "Patient Rosters." The member roster, updated online monthly, contains key information about eligible members as well as members whose participation has been terminated. The date and reason for termination are also included on the member roster. Due to frequently changing member status, information on the roster is not guaranteed to be accurate after the date of printing. Some members may not appear on the roster. PCPs must verify eligibility by using the other methods mentioned above. The Provider Services Department can be contacted for a detailed explanation of the roster data elements.

4.1.4 Member Services Department
If further clarification of eligibility information is needed, Member Services Representatives can be reached 24 hours per day, 7 days per week. Eligibility can be verified via the IVR system by calling **1.800.303.9626** and following the prompts or by visiting the MetroPlusHealth website at www.metroplus.org.

4.2 Disenrollment

4.2.1 Voluntary Disenrollment

- MetroPlusHealth is committed to the provision of quality services and the retention of members. To support MetroPlusHealth in this effort, Participating Providers must ensure members have appropriate access to care. If clinical or administrative problems cannot be resolved at the care site, the member may contact the Member Services Department for assistance. If the problem persists and the member remains dissatisfied with MetroPlusHealth, the member has the right to disenroll.
- Medicaid Managed Care, HARP and HIV SNP members who enrolled prior to January 1, 2014 and want to disenroll are required to call MAXIMUS. All others must contact the New York State of Health (NYSOH) to disenroll.
  CHPlus and Essential Plan members may discontinue membership at any time and must contact the New York State of Health (NYSOH) to disenroll. If the enrollee requests disenrollment by no later than the 15th day of the month, the member will be disenrolled by the last day of that month. If the request is received after the 15th of the month, the child will be disenrolled effective the last day of the following month.

- MetroPlusHealth Gold, GoldCare I and Goldcare II, and Qualified Health Plan members may change coverage or disenroll only during the annual open enrollment period or special qualifying event.
- Medicare Advantage Plan members may have limits to when they can switch or disenroll from their plan. Members may change plans during the Annual Election Period (AEP) from October 15 through December 7. Enrollment elections made during the AEP will take effect on January 1 (some exceptions apply; for more information contact MetroPlusHealth Member Services or visit www.metroplus.org). Medicare Advantage members may make a one-time switch from one Medicare Advantage plan to a different one or may return to original Medicare during the Medicare Advantage Open Enrollment Period (MA-OEP) from January 1 through March 31. Members may also change their plan election if they have a Special Election period (SEP). For example, anyone with Medicaid or who receives Low Income Subsidy (LIS) can make changes once per quarter during the first nine months of the year.

4.2.2 Involuntary Disenrollment

4.2.2.1 MetroPlusHealth Initiated Disenrollment

MetroPlusHealth may disenroll a member under the following circumstances:

- The member is habitually non-compliant with MetroPlusHealth policies and procedures, i.e. repeatedly fails to keep appointments, refuses to accept medically necessary treatment or frequently seeks care in the emergency room for non-emergent conditions.
- The member is physically or verbally abusive to MetroPlusHealth employees or Participating Providers, excluding abusive behavior provoked by medical conditions. Such behavior must be documented, and reasonable efforts made to resolve the problems presented by the member.

4.2.2.2 Involuntary Disenrollment from Medicaid Programs

MetroPlusHealth is required to initiate disenrollment from Medicaid programs when a Medicaid Managed Care or HIV SNP member falls into one or more of the following excluded categories making them ineligible for enrollment in MetroPlusHealth or any other Medicaid managed care plan:

- Medicare/Medicaid dually eligible (member may be eligible for and apply to MetroPlusHealth Medicare Advantage plans).
- Individuals with a County of Fiscal Responsibility Code 98 in MMIS until further directions from the State.
- Individuals receiving family planning services who are not otherwise eligible for medical assistance and whose net available income is <200% FPL.
- Individuals who are eligible for Medical Assistance pursuant to the Medicaid buy-in for the working disabled and who are required to pay a premium.
- Individuals who are eligible for Medical Assistance, under 65 years of age, have been screened for breast and/or cervical cancer under CDC Breast and Cervical Cancer Early Detection Program and need treatment, and are not otherwise covered under creditable coverage.
- Individuals who become eligible for Medicaid only after spending down a portion of their income.
- Residents of State-operated psychiatric facilities or residents of State-certified or voluntary treatment facilities for children and youth.
- Patients of Residential Health Care Facilities (RHCF) at the time of enrollment, and

members whose stay in a RHCF is classified as permanent upon entry into the RHCF or is classified as permanent at a time subsequent to entry except for short-term rehabilitative stays anticipated to be less than 30 days.
- Medicaid-eligible infants living with incarcerated mothers.
- Individuals with access to comprehensive private health care coverage. Such coverage must be determined to be cost-effective by the local social services district.
- Certified blind or disabled children living or expected to live separate and apart from their parents for 30 or more days.
- Individuals expected to be Medicaid eligible for less than six months i.e., seasonal agricultural workers, except for pregnant women.
- Youths in the care and custody of the Commissioner of the New York State Office of Children and Family Services.
- Individuals in receipt of long-term care services through Long Term Home Health Care programs, or Child Care Facilities except for Intermediate Care Facilities services for the Developmentally Disabled.
- Individuals eligible for medical assistance benefits only with respect to tuberculosis-related services.
- Individuals temporarily residing out-of-district, i.e., college students, will be exempt until the last day of the month in which the purpose of the absence is accomplished.
- Individuals placed in New York State Office of Mental Health licensed family care homes pursuant to New York State Mental Hygiene Law.
- Individuals who are eligible for Medical Assistance pursuant to the Medicaid buy-in for the working disabled and who are not required to pay a premium.
- Individuals admitted to a Hospice program at the time of enrollment.
- Individuals with a County of Fiscal Responsibility Code 97 in MMIS.
- Individuals who moved Out of Service Area
- Individuals who became incarcerated

Participating Providers are required to notify the Member Services Department if a member falls into one or more of these categories. Please complete the form in *Appendix XIII* and fax it to the Member Services Department.

4.2.2.2.1 Disenrollment of Uninfected Children from HIV SNP
The uninfected child(ren), up to the age of 20, of a qualified HIV SNP-enrolled head of household, may remain enrolled in the SNP only if the head of household remains enrolled in the SNP. If the head of household does not maintain eligibility in the SNP, or when the child(ren) reaches 21 years of age, the child(ren) will be transferred to the MetroPlusHealth Medicaid managed care program.

4.2.2.3 MetroPlusHealth Child Health Plus (CHPlus) Involuntary Disenrollment
MetroPlusHealth may disenroll a CHPlus member under the following circumstances on the last day of the month:
- of the grace period if the member fails to pay the required monthly premium contribution by the end of the grace period.
- in which they learn that the enrollee is enrolled in Medicaid.
- in which they learn that the enrollee has access to state health insurance benefits or becomes enrolled in other health insurance.
- of a 12-month enrollment period if the enrollee fails to re-certify his or her eligibility prior to that date.
- in which the enrollee reaches age 19.

- in which the health plan learned that an enrollee has moved outside the plan's service area.
- in which the health plan learned that an enrollee has become an inmate of a public institution as defined at §435.1009 of 42 CFR Chapter IV or a patient in an institution for mental diseases, as defined at §435.l009 of 42 CFR Chapter IV.

4.2.2.3.1 MetroPlusHealth QHP and Essential Health Plan Involuntary Disenrollment
MetroPlusHealth may disenroll a QHP or Essential Plan member under the following circumstance on the last day of the month:

- of the grace period if the member fails to pay the required monthly premium contribution by the end of the grace period

4.2.2.4 MetroPlusHealth Medicare Advantage Plans
MetroPlusHealth is required to disenroll a Medicare Advantage Plan member if any of the following situations occur:

- If the member no longer has Medicare Part A and or Part B.
- For dual eligible special needs plans: If the member is no longer eligible for Medicaid. As stated in Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. If the member loses their Medicaid eligibility, the member will no longer qualify for MetroPlusHealth Advantage Plan (HMO SNP) and will be disenrolled.
- If the member does not pay the medical spenddown, if applicable.
- If the member moves out of our service area.
- If the member is away from our service area for more than six months for MetroPlus Advantage and MetroPlus Platinum plans and thirty days for MetroPlus UltraCare (MAP) plan.
- If the member moves or takes a long trip, the member will need to call Member Services to find out if the place the member is moving or traveling to is our plan's service area.
- If the member becomes incarcerated.
- If the member is not a United States citizen or lawfully present in the United States.
- If the member lies about or withholds information about other insurance the member has that provides prescription drug coverage.
- If the member intentionally gives us incorrect information when the member is enrolling in our plan and that information affects the member's eligibility for our plan. (We cannot make a member leave our plan for this reason unless we get permission from Medicare first.)
- If the member continuously behaves in a way that is disruptive and makes it difficult for us to provide medical care for the member and other members of our plan. (We cannot make the member leave our plan for this reason unless we get permission from Medicare first.)
- If the member lets someone else their membership card to get medical care. (We cannot make the member leave our plan for this reason unless we get permission from Medicare first.)
- If the member does not pay the plan premiums for 90 days.
- If the member is required to pay the extra Part D amount because of their income and the member does not pay it, Medicare will disenroll the member from our plan.

5. Claims Submission and Reimbursement
MetroPlusHealth requires every provider to submit claims/encounters detailing all services rendered for all capitated and fee-for-service encounters/claims. MetroPlusHealth prefers that you submit your claims electronically.

For CHPlus, Medicaid, Medicaid Advantage Plus Plan (MAP), HARP, SNP, Essential Plan, MetroPlusHealth Gold, and Gold Care I and II Programs Submit claims electronically: **Emdeon Payer ID# 13265** Submit CMS 1500 or UB-04 Forms: **MetroPlus Health Plan, Inc.** **P.O. Box 830480 Birmingham, AL 35283-0480**
For Medicare Advantage Plans Submit claims electronically: **Emdeon Payer ID# 13265** Submit CMS 1500 or UB-04 Forms: **MetroPlus Health Plan, Inc.** **P.O. Box 381508 Birmingham, AL 35238-1508**
For MarketPlus Plans Submit claims electronically: **Emdeon Payer ID# 13265** Submit CMS 1500 or UB-04 Forms: **MetroPlus Health Plan, Inc.** **P.O. Box 830480 Birmingham, AL 35283-0480**

All electronic or paper/encounter claim submissions must be fully completed. Valid ICD-10 Diagnosis codes, coded to the highest digit, CPT-4, and HCPCS service codes must be valid and current on the date of service, for timely claims processing.

Providers with questions concerning claim payment or any other claims related matter should contact the MetroPlusHealth Customer Service Hotline at **1.800.303.9626**. To expedite the inquiry, please have the following information readily available:

- Member identification number
- Date of Service
- Claim number
- Provider's Name and MetroPlusHealth ID Number

5.1 Explanation of Payment

An Explanation of Payment (EOP) will be issued for every submitted and adjudicated claim, whether payment or denial is rendered. The EOP provides a summary of billed services and payment and/or denial information.

5.2 Claims Payment Reconsideration or Appeals

The Claims Department handles payment reconsiderations relative to reconsideration of claim payment amounts or claim denial, in whole or part. However, all appeals resulting from a claim denial due to authorization or medical management issues should be appealed as outlined in *Section 7.15*.

At times, a provider may be dissatisfied with MetroPlusHealth's decision regarding a claim determination for reasons including, but are not limited to:

- incorrectly processed or denied claims.
- untimely submission of claims.
- failure to obtain prior authorization.

All requests, including attachments, must be mailed to the following locations:

For Medicaid, Medicaid Advantage Plus Plan (MAP), SNP, HARP, MLTC, CHPlus, Essential Plan, MetroPlus Gold, and Gold Care I and II Programs **MetroPlus Health Plan, Inc.** **P.O. Box 830480 Birmingham, AL 35283-0480**
For Medicare Advantage Plans **MetroPlus Health Plan, Inc.** **P.O. Box 381508 Birmingham, AL 35238-1508**
For MarketPlus Plans **MetroPlus Health Plan, Inc.** **P.O. Box 830480 Birmingham, AL 35283-0480**

All requests for payment reconsideration should include the following information:

- A written statement explaining why you disagree with MetroPlusHealth's determination as to the amount or denial of payment,
- A copy of the original claim,
- A copy of the EOP,
- An AOR form (INN) or a WOL statement (OON)(Medicare Only); and
- Supporting documentation

Examples of information or supporting documentation that should be submitted with the requests for reconsideration include:

- Provider's identification number (NPI and/or TIN)
- Provider's name, address, and contact number
- Member's name and MetroPlus member identification number
- MetroPlus claim number
- Date(s) of service
- Evidence of prior authorization issued by MetroPlusHealth's Utilization Management Department
- Evidence of timely filing

Providers can view claims status on MetroPlusHealth's website at www.metroplus.org or providers may call **Provider Services** at **1.800.303.9626 or 1.212.908.4780**, **Monday to Friday**, **9:00 a.m. – 5:00 p.m.**

REGARDING THE PRACTICE OF BALANCE BILLING BY PARTICIPATING PROVIDERS
Participating providers are prohibited from seeking payment from billing, or from accepting payment from any member, for fees that are the legal obligation of MetroPlusHealth

Except for deductibles, copayments, or coinsurance, all payments for services provided to MetroPlusHealth members constitute payment in full, and participating providers may ***not*** balance-bill members for the difference between their actual charges and the reimbursed amounts.

Any such billing is a violation of the provider's contract with MetroPlusHealth and applicable New York State law. Where appropriate, MetroPlusHealth will refer providers who willfully or repeatedly bill members to the relevant regulatory agency for further action.

Additionally, per requirements set forth by the Centers for Medicare & Medicaid Services (CMS), dual- eligible members will not be held responsible for any cost-sharing for Medicare services when the state is responsible for paying those amounts. Providers must accept MetroPlusHealth's payment as payment in full or bill the appropriate state agency. For example, participating providers should bill Fee-for- Service (FFS) Medicaid, for Medicare dual-eligible individuals whose entitlement status is Full Medicaid, QMB+ or SLMB+ (i.e. Medicaid FFS).

OTHER IMPORTANT INFORMATION
The Explanation of Payment (EOP) details the adjudication of the claims describing the amounts paid or denied and indicating the determinations made on each claim. Therefore, it is important that you review and reconcile your accounts promptly upon receipt. If there is a change in your practice (i.e. address, tax ID#, telephone #, participation), please notify MetroPlusHealth as soon as possible and submit a W-9, as appropriate.

5.2.1 Medicaid, HIV SNP, HARP, MLTC, CHPlus, Essential, MarketPlus, Gold and GoldCare I&II Lines of Business:
Requests for reconsiderations (claim appeals of an initial determination) can be made via telephone, mail, or provider portal. Written appeals must explain the reason for the appeal and include all pertinent information as well as a copy of the original claim. All claim determination appeals must be received within 45 calendar days of the date of the initial check or denial notification. Payment adjustments may be made retrospectively by adding or subtracting the adjustment amount from subsequent payments. A revised EOP accompanied by a check, if applicable, will be sent indicating the adjustment reason. All requests for reconsideration will be handled within 60 calendar days of receipt. MetroPlus will allow providers to ask for reconsideration of rejected claims submitted after the deadline and are permitted to reduce payment up to 25%. MetroPlusHealth may pay the claim if the provider shows that the disagreement was due to an unusual action and the provider usually submits claims on time.

5.2.2 Medicare Lines of Business
Participating Providers (INN) do not have payment reconsideration or appeal rights. However, INN providers may request that a claim determination be reconsidered *on behalf of the member*. To request a reconsideration on behalf of a member, INN providers must be designated by the member as a representative by submitting an *Appointment of Representative (AOR)* form and submit a **written** request with all supporting documentation to MetroPlusHealth within sixty **(60)** calendar days from the paid date on the provider's Explanation of Payment (EOP).

Non-Participating Providers (OON) who are dissatisfied with an adverse claim determination made by MetroPlusHealth, may submit a reconsideration/appeal on his or her own behalf only if the OON provider provides a *Waiver of Liability (WOL)* statement, which confirms that the OON provider will hold the member harmless regardless of the outcome of the appeal. The OON provider must submit a **written** request for reconsideration with a WOL and all supporting documentation within sixty **(60)** calendar days from the initial denied date on the provider's Explanation of Payment (EOP).

MetroPlusHealth will process all requests for reconsideration/appeal and issue a written explanation that the claim has been reprocessed or the initial denial has been upheld within sixty **(60)** calendar days from the date of receipt of the provider's request for reconsideration/appeal. If the initial denial is upheld, MetroPlusHealth will send the case to the Independent Review Entity (IRE).

MetroPlusHealth will not consider reconsideration/appeal requests that are not submitted or appealed according to the procedures set forth above. If a provider submits a request for reconsideration/appeal after the sixty **(60)** calendar day timeframe or if the required information is not submitted within the sixty **(60)** calendar day timeframe, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute if the request is not timely filed. In such cases, providers may not bill members for services rendered.

5.3 Claims Review Software

MetroPlusHealth utilizes *Change Healthcare* software as part of its claims editing process to ensure proper reimbursement of claims. *Change Healthcare* compares submitted claims to standard American Medical Association (AMA) CPT® coding and CMS-approved NCCI (National Correct Coding Initiatives) guidelines. If the submitted coding does not meet current CPT/NCCI standards, the software provides the most appropriate coding. *Change Healthcare* is designed to detect coding discrepancies automatically.

5.4. Adverse Reimbursement Changes

For providers licensed, registered, or certified under Title 8 of the New York State Education Law, MetroPlusHealth shall notify the provider within ninety (90) days' prior written notice of any amendment that modifies reimbursement in a manner that can be reasonably expected to have a material adverse impact on the aggregate level of payment to the provider for covered services rendered to members (other than Medicare Advantage members). If the provider objects to such amendment, the provider may give notice of such objection and intent to terminate the agreement effective upon the implementation date of such amendment within thirty (30) days of provider's receipt of such notice. MetroPlusHealth may accept such termination or modify or withdraw the amendment. This shall not apply where such change is required by law, regulation or applicable regulatory authority, or is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by a government agency or by the American Medical Association's Current Procedural Terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion of or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism.

5.5. Overpayment and Recoupments

Pursuant to New York State Insurance Law 3224-b, Rules relating to the processing of health claims and overpayments to health care professionals, other than recovery for duplicate payments, MetroPlusHealth shall provide thirty days written notice to health care providers before engaging in additional overpayment recovery efforts. A health care professional under this section is one who is licensed, registered or certified under Title 8 of the New York State Education Law.

This notice shall state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment. MetroPlusHealth shall provide a health care provider with the opportunity to challenge an overpayment recovery and will upon request share claims information for the purposes of challenging an overpayment recovery. This policy establishes written procedures for health care providers to follow to challenge an overpayment recovery initiated by MetroPlusHealth. When challenging an overpayment, the provider must set forth the specific grounds on which the provider is challenging the overpayment recovery. MetroPlusHealth shall not initiate overpayment recovery efforts more than 24 months after the original payment was received by a health care provider, except in the case of the Medicaid Managed Care program, as the

overpayment recovery period for such programs is six years from the date payment was received by the health care provider. However, no such time limit applies to overpayment recovery efforts which are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, (ii) required by, or initiated at the request of, a self-insured plan, or (iii) required or authorized by a state or federal program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees, or members. Notwithstanding the aforementioned time limitations, in the event that a health care professional asserts that a health plan has underpaid a claim or claims, MetroPlusHealth may defend or set off an assertion of underpayment based on overpayments going back in time as far as the claimed underpayment. For the purposes of this policy, “abusive billing” is defined as a billing practice that results in the submission of claims that are not consistent with sound fiscal, business, or medical practices and at such frequency and for such a period of time as to reflect a consistent course of conduct.
In addition to the above requirements set forth in the New York State Insurance Law, MetroPlusHealth has confirmed with the New York State Department of Health Division of Managed Care on January 12, 2010 that providers are not required to be notified prior to recovery efforts pursuant to retroactive changes to provider reimbursement, where such reimbursement is based on rates established by the New York State Medicaid program (e.g. retroactive DRG changes).

Providers must challenge the overpayment recovery in writing with supporting documentation within 30 calendar days of the date of a notice to recover funds. These challenges should be directed to the corresponding party listed on the original recoupment notice.

Participation with MetroPlusHealth and government plans, subjects participating providers to audits, investigations and review by the NYS Office of the Attorney General (OAG), DOH, OMIG, and the State Comptroller (OSC), including the right to recover penalties resulting from any audit or investigation. The audits can be combined efforts between the Plan and the OMIG.

Participating Providers shall provide the OAG, DOH, OMIG OSC, DHHS, CMS and/or their authorized representatives with access to all the provider’s or provider’s subcontractor’s premises, physical facilities, equipment, books records, contracts, computer or other electronic systems relating to MetroPlusHealth’s members. The provider shall, at minimum, give access to such records on two (2) business days prior notice, during normal business hours. When records are sought in connection with an audit, inspection evaluation or investigation, all costs associated with production or reproduction are the responsibility of the provider.

Participating providers must promptly report any overpayment related to claims submitted to MetroPlusHealth.

If claims that are the subject of an audit or investigation were already recovered as overpayments by MetroPlusHealth, the Plan will not attempt to recover those monies again.

MetroPlusHealth requires that both Participating and Non-participating providers report to the Plan when they have received an overpayment, to return the overpayment within 60 days of the date of the identification of the overpayment, and to notify MetroPlusHealth in writing of the reason for the overpayment.

OMIG or the DOH has the right to request that MetroPlusHealth recover an overpayment, penalty or other damages owed to the government program, including any interest or collection fees, from its Participating Provider consistent with the requirements of Insurance Law § 3224-b.

5.6. Readmission Reimbursement Policy
MetroPlusHealth will conduct a hospital readmission review to determine if a readmission is considered clinically related to the previous admission. Readmissions determined to be related to the previous admission will not be separately reimbursed. This applies to facilities for readmissions that have occurred within thirty (30) calendar days of a previous discharge within the same hospital.
A clinical review overseen by a Medical Director will determine if the readmission was clinically related to the previous admission based on clinical criteria. This medical record review is to determine if the admission is related and not an assessment of medical necessity or appropriateness of the setting.

In the case of a related readmission, MetroPlusHealth will issue a letter that will guide the admitting facility to submit a single claim that combines the ICD-10 codes from the initial admission and subsequent admission and also reflects a length of stay that combines the days of service of the initial and subsequent admission.

MetroPlusHealth reserves the right to perform concurrent or retrospective medical record reviews and retract payment. The standard complaint process is applicable in cases in which MetroPlusHealth determines a readmission is related to the previous admission and the provider disagrees with the determination.

A participating provider may not generally request a reconsideration or appeal based on their Provider/ Hospital contract with MetroPlusHealth.

5.7 Guidance for Hospitals to Code Discharge Status on a DRG Inpatient Claim
Hospitals are required by CMS to code the discharge/transfer status of patients accurately. As noted by CMS: “The discharge status code identifies where the patient is being discharged to at the end of their facility stay or transferred to such as an acute/post-acute facility. The discharging facility should ensure that documentation in the patient’s medical record supports the billed discharge status code.”

Resources for Providers include:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1411.pdf
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf
https://www.health.ny.gov/statistics/sparcs/sysdoc/appc.htm
https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Policy_Guidelines.pdf

5.8 Transfer Reimbursement Policy
Per New York Codes Rules and Regulations Title 10: Section 86-1.21 - "Outlier and transfer cases rates of payment", MetroPlusHealth will conduct a hospital transfer review to determine appropriate reimbursement for members transferred from one facility to another.

Transfers to or from a hospital that is not part of the same hospital
1. If a transfer occurs among two or more hospitals that are not part of the same hospital

system, claims shall be reimbursed as follows:
   i. the facility which discharges the patient shall receive the full DRG payment; and
   ii. all other facilities in which the patient has received care shall receive a per diem rate unless the patient is in a transfer DRG. then a reduced DRG payment will be received
2. A transferring facility must bill with a discharge status code for transfer in order to be paid the appropriate DRG reimbursement.

Transfers to or from a hospital that is part of the same hospital system:

3. Transfers among non-exempt hospitals or divisions that are part of the same hospital system shall be reimbursed as of the hospital that first admitted the patient had also discharged the patient. Transfers within the same hospital system shall be reimbursed under one claim that covers the entire date of service.

Neonatal Specialty Services:

4. Services provided to neonates discharge d from a hospital providing neonatal specialty services to a hospital reimbursed under the case payment system for purposes of weight gain shall be reimbursed and assigned to the applicable APR-DRG upon admission or readmission.

MetroPlusHealth reserves the right to perform concurrent or retrospective medical record reviews and retract payment. The standard claim reconsideration/appeal process is applicable in cases in which MetroPlusHealth determines a transfer occurred which was not reflected in the claim submission.

A participating provider may not generally request a reconsideration or appeal based on their Provider/Hospital contract with MetroPlusHealth.

For additional details and to see the most up-to-date information on Title 10, please visit the State website: https://regs.health.ny.gov/content/section-86-121-outlier-and-transfer-cases-rates-payment

6. Credentialing

6.1 Credentialing Criteria

MetroPlus Health Plan (MetroPlusHealth) credentials and re-credentials providers in accordance with New York State Department of Health and other regulatory guidelines. Practitioners must meet the criteria for enrollment as outlined in MetroPlusHealth credentialing policy.

MetroPlusHealth must, upon request, make available and disclose to facilities written application procedures and minimum requirements that a facility must meet to be considered by MetroPlusHealth for participation in MetroPlusHealth's network.

MetroPlusHealth is required to maintain procedures for professional and health care facility applications and terminations.

Within 60 days of receiving a facility's completed application to participate in MetroPlusHealth's network, MetroPlusHealth shall notify the facility as to: (1) whether facility is credentialed; or (2) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation, in which case MetroPlusHealth must make "every effort" to obtain any missing third-party information and then must make a determination within 21 days of receipt of such information.

MetroPlusHealth shall consult with appropriately qualified facilities in developing its qualification requirements.

Practitioners complete an application with CAQH Proview and submit a request for initial credentialing with all supporting documents requested by MetroPlusHealth Credentialing Department. The Credentialing Department reviews and verifies the practitioner's training, licensure, work history, malpractice claims history, Medicaid/Medicare sanction/exclusion history, ability to perform essential functions, lack of present illegal drug use, loss of license, felony convictions, loss of privileges, termination, current malpractice insurance coverage, Medicaid/Medicare enrollment, and current attestation confirming the accuracy and completeness of the application. MetroPlusHealth requires HIV Specialist PCPs to meet the qualifications of HIV Specialist as defined by the New York State Department of Health. MetroPlusHealth also requires HIV Specialist PCPs to participate annually in at least ten (10) hours of continuing medical education that is consistent with the guidelines for HIV specialty care as defined by the AIDS Institute.

Organizational providers are subject to initial credentialing and re-credentialing. Qualifications for organizational providers include but are not limited to: licensure or certification required by New York State Department of Health or other regulatory agency, accreditation (where applicable), Medicare/ Medicaid participation, commercial general liability insurance coverage, approved site visits for Social Adult Day Care and Urgent Care providers, absence of Medicaid/Medicare exclusion. Skilled Nursing Facilities must have a CMS Star rating of at least 3 and primary care provider on site 24 hours daily to be eligible for participation. Urgent Care centers must be certified by the Urgent Care Association of America to be deemed eligible for initial credentialing/enrollment.

Organizational providers complete a MetroPlusHealth organizational provider application and submits the application with all supporting documents as noted on the application form.

When credentialing OMH-licensed, OMH-operated and OASAS-certified providers, MetroPlusHealth accepts OMH and OASAS licenses, operation and certifications in place of, and not in addition to, any MetroPlusHealth credentialing process. Additionally, MetroPlusHealth collects and accepts program integrity-related information from these providers and requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

When credentialing BHHCBS providers, MetroPlusHealth accepts the State-issued BHHCBS designation in place of, and not in addition to, any MetroPlusHealth credentialing process for individual employees, subcontractors or agents of such providers. MetroPlusHealth also collects and accepts program integrity-related information from these providers and requires that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.
In accordance with the New York State Children's Health and Behavioral Health Benefit Administration Medicaid Managed Care Organization Children's System Transformation Requirements and Standards, when credentialing with NYS-designated providers, MetroPlusHealth accepts State-designation of providers for credentialing and does not separately credential individual staff members in their capacity as employees of these programs. MetroPlusHealth conducts program integrity reviews to ensure that provider staff

are not disbarred from Medicaid or any other way excluded from Medicaid or any other way excluded from Medicaid reimbursement. MetroPlusHealth also collects and accepts program integrity-related information from these providers, as required in the Medicaid Managed Care Model Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program. In accordance with New York State Department of Health guidelines, MetroPlusHealth requires Mental Health Providers to certify that they will not seek reimbursement from MetroPlusHealth for Conversion Therapy provided to an Enrollee.

Practitioners and Organizational Providers excluded from participation in Medicaid or Medicare programs are not eligible for enrollment/continued participation in the MetroPlusHealth network. Additionally, practitioners with final disciplinary action taken by the State licensing board or other government agency that impairs the practitioner's ability to practice are not eligible for enrollment/ continued participation in the MetroPlusHealth network. Providers may forward credentialing/re- credentialing concerns to credentialing@metroplus.org.

MetroPlusHealth requires the credentialing of Providers who meet all of the following criteria:

- Are licensed, certified and/or registered by New York State to practice independently.
- Possess a valid, unencumbered license, which is currently registered to practice medicine/health care in New York State.
- Currently enrolled in the New York State Medicaid program.
- Successfully completed an ACGME/AOA accredited residency training in specialty or has specialty certification by ABMS/AOA.
- Possess admitting privileges in a MetroPlusHealth participating facility, where applicable.
- Possess current certification, granted by the American Board of Medical Specialist (ABMS) or the American Osteopathic Association (AOA) in their practicing specialty.
- Meet all other credentialing requirements as outlined in the MetroPlusHealth credentialing policy.
- Have an independent relationship with MetroPlusHealth, defined as having been selected and designated by MetroPlusHealth to receive referrals of members specifically to the named individual Provider or a named individual Provider within a group of Providers, including those that are hospital-based.

MetroPlusHealth does *not* require the credentialing of Providers who meet any of the following criteria:

- Practice exclusively within freestanding ambulatory facilities and provide care to members only as a result of the member being directed to the named facility, rather than a named Provider. Examples of this type of facility include, but are not limited to, mammography centers, urgent care centers, and freestanding ambulatory behavioral health care facilities.
- Dentists who provide primary dental care only under a dental plan or rider.
- Pharmacists who work for a pharmacy benefits management organization to which MetroPlusHealth delegates utilization management functions.
- Providers who do not provide care for members in a treatment setting.
- All other Providers not meeting the criteria for requiring credentialing as stated above.

Provider Data Validation During the Credentialing Process:

- Practitioner's Education or Professional Training
- Board Certification Status
- Current State Licensure and Registration
- Current NY DEA, if applicable
- Medicaid and Medicare Participation
- Professional Disciplinary History
- Hospital Privileges, if applicable
- NPI Number
- Liability Insurance
- Work History
- Liability Claims History
- Sanctions History
- Malpractice History
- History of Limitations of Privileges

MetroPlusHealth will complete credentialing activities and notify providers within 60 days of receiving a completed application. The notification will inform the provider whether they are credentialed, whether additional time is needed, or that MetroPlusHealth is not in need of additional providers. By the 60th day, MetroPlusHealth will either notify the provider as to whether he or she is credentialed or whether additional time is necessary because of lack of documentation. If additional information is necessary, the notice to the provider will identify all additional information needed by MetroPlusHealth to make its determination. Upon receipt of the requested information, MetroPlusHealth will make its final determination regarding credentialing of the provider within 21 days of receipt of such required information.

Compliance with 42 CFR 455.105 and 42 CFR 455.106
MetroPlusHealth ensures compliance with 42 CFR 455.105 and 42 CFR 455.106 by requesting providers, at the time of initial application and re-credentialing, attest to their compliance. MetroPlusHealth also has a process to review CMS and Medicaid excluded providers on a monthly basis. MIS generates a report on a monthly basis, which is compared electronically to MetroPlusHealth participating provider file. Potential matches are reviewed by the Credentialing Department for immediate action, where necessary. MetroPlusHealth has also implemented a process, to inquire at the time of re-credentialing, whether a provider has an ownership or control interest (5% or more) in MetroPlusHealth or if they act as agent of the plan, and also asks if the provider has any ownership of subcontractors working in your practice and/or wholly-owned suppliers with business transactions totaling more than $25,000 during the last fiscal year. MetroPlusHealth also requires the provider to disclose any person who (1) Has ownership or control interest in the provider or is an agent or managing employee of the provider; and (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs. In cases where this is reported, MetroPlusHealth will report this information directly to the Inspector General within 20 working days from receipt of this information.

6.2 Primary Care Provider (PCP) Credentialing
Only Providers who meet panel capacity and availability requirements may be credentialed as PCPs. The maximum-pooled capacity for Medicaid Managed Care members is the maximum number of members that may be assigned to one PCP. This number is set by DOHMH at 1500 members for a full- time (40 hours per week) Physician alone and 2400 for a full-time Physician working in conjunction with a Physician Assistant or Nurse Practitioner. Nurse Practitioners practicing alone may not exceed 1000 members. Capacities are prorated for PCPs that work fewer than 40 hours per week.

In addition, a PCP must be available at each of their primary care office sites for patient care appointments at least 16 hours per week. The hours must be distributed among at least two

days of the week.

The maximum-pooled capacity for the HIV PCP is 350 SNP members based on a full-time, 40-hour workweek. An HIV PCP practicing in combination with a Physician Assistant or Nurse Practitioner may be assigned no more than 500 members. These numbers are prorated for HIV PCPs who work fewer than 40 hours per week.

6.2.1 HIV Specialist Primary Care Providers
HIV-experienced PCP providers in Family Practice, Pediatrics, Internal Medicine, Adolescent Medicine or Infectious Disease may be designated as HIV Specialist PCPs. For a full description of the credentialing criteria for HIV Specialist PCPs, please see *Section 9.1*.
In accordance with New York State Department of Health requirements, MetroPlusHealth assesses annually that HIV Specialist PCPs meet the qualifications for HIV Specialist PCPs. HIV Specialist PCPs must complete at least ten (10) hours of continuing medical education that is consistent with the guidelines for HIV specialty care as determined by the AIDS Institute.

6.3 Collaborative Practice Agreements
Nurse Practitioners, in accordance with New York State law, are required to have a collaborative agreement/relationship with a physician. Midwives must have a collaborative relationship with a MetroPlusHealth participating physician who is board-certified as an obstetrician-gynecologist by the American Board of Medical Specialist (ABMS) or American Osteopathic Association (AOA). Physicians who are not board-certified must successfully complete obstetrics-gynecology residency training accredited by the ACGME or AOA. MetroPlusHealth requires Nurse Practitioners and Midwives to provide a signed attestation indicating they have established a collaborative agreement/ relationship as required by New York State law and MetroPlusHealth Credentialing policy.

6.4 Office Standards
Offices of all Participating PCPs, Urgent Care Centers, and Social Adult Day Care Centers (as determined by MetroPlusHealth) must meet a uniform standard. Prior to being approved as a Participating Provider, the office sites of such Providers are reviewed by a Provider Services Representative. Site visits are conducted to evaluate standards of physical accessibility (see *Section 2.5.4*), appointment availability (see *Section 2.5.2*), wait and exam room adequacy, and physical appearance. The credentialing application is discontinued for providers who fail to meet the office standards.

6.5 Credentialing Files
The credentialing files contain applications and all supporting documentation, as well as performance data specific to each Participating Provider's MetroPlusHealth experience and professional competence. The files include, at minimum, documentation of incidents and quality of care issues, member complaints and grievances, and written notifications of terminations.

Credentialing files are considered confidential and access to them is strictly limited. Participating Providers may access their own files, and certain government or regulatory entities have access as provided by applicable law.

6.6 Recredentialing
Participating Providers are re-credentialed at least once every three years. The re-credentialing cycle begins with the date of the initial Credentialing Committee decision.

The Credentialing Committee reviews all information (including but not limited to provider performance, quality of care concerns, complaints and certifications required by the contract) contained in the Participating Provider's credentialing file in its recredentialing review process.

Participating Providers are responsible for informing MetroPlusHealth of any changes in information between re-credentialing cycles. In addition, Participating Providers may receive a request for any time-sensitive information 30 days prior to its expiration date. This includes, but is not limited to:

- New York State license registration renewal
- DEA registration renewal
- Malpractice coverage renewal
- Changes to a Participating Provider's name
- Medicaid and/or Medicare participation status
- License disciplinary status/sanction
- Changes in office hours
- Change to open/closed status
- Annual verification of HIV specific continuing medical education for those Participating Providers credentialed as HIV Specialists
- Medicaid and/or Medicare sanction/exclusion
- Any certifications required by contract or 18 NYCRR § 521.3 completed by the Participating Provider since the last credentialing cycle

Upon notice of any of the following items, appropriate documentation will be requested for review by the Credentialing Committee:

- Change or addition of a specialty
- Change in location or addition of an office
- Request for an increase in panel capacity for a PCP
- Any claim, suit or other action or proceeding involving a member and alleging medical malpractice against the Participating Provider that is pending or has resulted in a judgment against or has been settled on the basis of any payment by, or on behalf of, the Participating Provider

Any additional information that impacts or may impact a Participating Provider's ability to practice must be submitted for review. Any Participating Provider who fails to supply requested information may have their agreement terminated in accordance with the terms of such agreement.

6.7 Delegation of Credentialing and Re-Credentialing

MetroPlusHealth may choose to delegate one or more credentialing and re-credentialing functions to a Provider group, hospital, management services organization, Credentialing Verification Organization or other similar entity. MetroPlusHealth is ultimately accountable for credentialing and re-credentialing of Providers and therefore maintains the responsibility for ensuring that the delegated functions are being performed according to MetroPlusHealth standards.

7. Utilization Management

7.1 Utilization Management Program and Plan

The Utilization Management Program is intended to ensure timely access to medically necessary health care in the most appropriate setting, and to promote efficient, effective, and coordinated use of medical services and behavioral health services. A written Utilization Management Program description clearly defines the MetroPlusHealth utilization management structures and processes. It includes the responsibilities of staff assigned to specific activities within the Utilization Management Program.

MetroPlusHealth also has a Utilization Management Plan that outlines Program goals for the year. The Chief Medical Officer is responsible for oversight of the Utilization Management Program and Plan. MetroPlusHealth ensures that a Psychiatric Physician Advisor has substantial involvement in all behavioral health aspects of the Behavioral Health Program and Plan.

MetroPlusHealth committees inclusive of Utilization and Care Management staff meet regularly to monitor key indicators and evaluate the performance of vendors to whom Utilization Management functions are delegated. These Committees refine utilization review policies and procedures and track progress toward the Utilization Management Program goals. On an annual basis, the Utilization Management Programs and Work-Plans are evaluated and revised before being submitted to the Quality Management Committee and the Quality Assurance Committee of the Board of Directors, which includes provider representatives, for review and approval.

7.2 Utilization Management Staff

The Utilization Management staff consists of qualified, licensed health professionals whose education, training and experience are commensurate with the type of utilization review they conduct. A licensed Physician makes medical necessity determinations for all authorization requests that have not met the clinical criteria (see *Section 7.11*). All Behavioral Health services are made by a U.S. behavioral health practitioner with a minimum of three years of clinical experience in a BH setting. The Behavioral Health Utilization Department utilizes Physician Advisors who are Board Certified in General Psychiatry. A Physician Advisor certified in addiction treatment reviews all denials for inpatient SUD treatment. MetroPlusHealth ensures that adverse determinations are made by clinicians with the appropriate training experience and stratified by age as required by the New York Public Health Law.

Medically Necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. For children and youth, "medically necessary" means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury or disability.

Utilization Review decisions are based solely on the appropriateness of care and service and the availability of coverage. MetroPlusHealth does not reward or provide financial incentives to its utilization review staff for limiting or denying requests for authorization of payment for services or for posing barriers to coverage, service, or care. All adverse determinations are

made by a clinical peer reviewer.

Health professionals that conduct peer clinical review are available to discuss review determinations with attending physicians or other ordering providers. If an adverse determination is rendered without discussion with the health care Provider who specifically recommended the health care under review, the attending physician is entitled to request a reconsideration which must be performed within one (1) business day of the request. The reconsideration will be conducted by the clinical peer reviewer that made the initial determination. If the provider that made the initial determination is not available, a designated clinical peer reviewer will conduct the review.

7.3 Covered Services and Benefits Packages

Each MetroPlusHealth product line has a separate benefits package that specifies the types of services covered or not covered by MetroPlusHealth. The benefits package also outlines any limitations on the number or frequency of services allowed. Members in Medicaid Managed Care, Medicaid HIV Special Needs Plan (Partnership in Care), MetroPlusHealth Enhanced Plan (HARP), MetroPlusHealth Advantage Plan (HMO SNP) and MetroPlus UltraCare (HMO-DSNP) retain eligibility for some additional services through Medicaid Fee-for- Service. These services must be billed directly to Medicaid. Summaries of covered services and benefits packages for each of the product lines can be found in *Appendices XA-XJ*. Providers may also call the Member Services Department with the member's identification number to obtain specific information about covered services and inquire about benefit limitations.

MetroPlusHealth is prohibited from treating a claim from a network hospital as out-of-network solely on the basis that a non-participating health care provider treated the member. Likewise, a claim from a participating health care provider cannot be treated as out-of-network solely because the hospital is non-participating with MetroPlusHealth. "Health care provider" in this section means an individual licensed, certified or registered under Title 8 of the Education Law or comparably licensed, registered or certified by another state.

MetroPlusHealth will provide home health services to pregnant or postpartum women when medically necessary. This includes skilled nursing home health care visits to pregnant or postpartum women designed to assess; medical health status, obstetrical history, current pregnancy-related problems, and psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills; and to provide skilled nursing care for identified conditions requiring treatment, counseling, referral, instructions or clinical monitoring. The criteria are:

- High medical risk pregnancy as defined by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) Guidelines for Prenatal Health (Early Pregnancy Risk Identification for Consultation); or
- The need for home monitoring or assessment by a nurse for a medical condition complicating the pregnancy or postpartum care; or
- Woman otherwise unengaged in prenatal care (no consistent visits) or postpartum care; or
- The need for home assessment for suspected environmental or psychosocial risk including, but not limited to, intimate partner violence, substance use, unsafe housing and nutritional risk.

All women enrolled are presumed eligible for one medically necessary postpartum home health care visit which may include assessment of the health of the woman and newborn, postoperative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the attending

physician and/or health plan case manager of the pregnant woman or infant shall be made as needed. Other than the initial postpartum visit, additional home health visits must meet one of the four medical necessity criteria listed above.

7.4 Benefits Management Services
Benefit managers administer pharmacy, durable medical equipment, and dental coverage on behalf of MetroPlusHealth. The contact information for the pharmacy benefits managers is included on the member's identification card. Participating Providers can find the contact information for the benefits managers in *Appendix XXXIV* or they may contact MetroPlusHealth to obtain the benefits managers' contact information. Participating Providers may obtain a copy of the benefits managers' Utilization Review processes by contacting the benefits managers directly using the contact information found in *Appendix XXXIV*.

7.4.1 Dental Services
MetroPlusHealth provides dental services for Plans, as outlined in the benefit summaries found in *Appendices XA-XJ*. While all utilization management activities are delegated to our dental benefits manager, MetroPlusHealth retains ultimate responsibility for those activities. At least annually, the dental benefits manager's utilization management program descriptions and annual plans including authorization, denial and appeal policies and procedures are reviewed for approval.

Requests for authorization of payment for dental services must be submitted directly to the benefits manager. All authorization denials and requests for internal or external appeals are reported to MetroPlusHealth. Members and Participating Providers may direct complaints and authorization appeals to MetroPlusHealth or directly to the benefits manager.

7.4.2 Pharmacy Services
MetroPlusHealth provides Prescription Drug Coverage to its plan members as outlined in the benefit summaries found in *Appendices XA-XJ*. This includes MetroPlusHealth Gold members who have enrolled in the MetroPlusHealth Gold Optional Prescription Drug Rider. The formularies can be accessed online at https://www.metroplus.org/Member/pharmacy

MetroPlusHealth provides Medicare Prescription Drug Coverage (Part D) to MetroPlusHealth Advantage Plan MetroPlus UltraCare MetroPlusHealth Platinum Plan members. Providers may access the Medicare Formulary, changes to the Formulary and Part D related information online at www.metroplusmedicare.org.

MetroPlusHealth is an active participant in the utilization management of pharmacy services. In conjunction with our Pharmacy Benefit Manager (PBM), MetroPlusHealth works to develop all pharmaceutical utilization management procedures and approves all formulary decisions. Additional information on these programs can be found on the MetroPlusHealth website. To request authorization forms, contact the benefits manager as outlined at www.metroplus.org.

Effective December 1, 2020, certain classes of medical benefit injectables covered under Medicare Part B require step therapy. Each class of medical injectables will include preferred therapies that do not require prior authorization. Authorization for a non-preferred therapy will generally require a history of use of a preferred therapy within the same medical benefit injectable class, among other criteria.

Note: The step therapy requirement does not apply to patients who have already received

treatment with the non-preferred drug within the past 365 days. Some preferred products may require prior authorization.

Except where otherwise prohibited by law, MetroPlusHealth allows immediate access without prior authorizations to a seventy-two (72) hour supply of a prescribed drug or medication for an individual with a behavioral condition who experiences an emergency condition. MetroPlusHealth will immediately authorize a seven-day supply of a prescribed drug or medication associated with the management of opioid withdrawal and/or stabilization.

Please visit www.metroplus.org/Provider/Tools/Medical-Policies for the latest list of Drug Classes and list of non-preferred and preferred products.

7.4.3 Durable Medical Equipment (DMEs)
MetroPlusHealth provides Durable Medical Equipment services to its plan members, as outlined in the benefit summaries found in *Appendices XA-XJ*. All utilization management activities are delegated to our DME benefits manager for all lines of business except Managed Long Term Care (MLTC) and UltraCare. MetroPlusHealth retains ultimate responsibility for those activities. At least annually, the benefits manager's utilization management program descriptions and annual plans – including authorization, denial and appeal policies and procedures – are reviewed for approval.

Requests for authorization of DME services must be submitted directly to the DME benefits manager, except for MLTC and UltraCare, which are submitted directly to MetroPlusHealth. All authorization denials and requests for internal or external appeals are reported to MetroPlusHealth by the DME Benefits Manager. Members and Participating Providers may direct complaints to MetroPlusHealth or directly to the DME benefits manager. Visit www.metroplus.org/provider/forms for the latest list of DME items that require prior authorization.

7.4.4 Abortion Services
Prior authorization is not required from the MetroPlusHealth to access abortion services. Members are not required to obtain a referral from their Primary Care Provider to access abortion services.

The following services are not considered abortion services:

- Treatment for spontaneous abortion (miscarriage)
- Termination of ectopic pregnancy
- Drugs or devices to prevent implantation of the fertilized ovum
- Menstrual extraction

Medicaid covers family planning and reproductive services provided by a qualified providers if the provider accepts NYS Medicaid and offers needed services. A member can use their MetroPlusHealth member ID if they are seeking services from a MetroPlusHealth participating provider. Member can use their Medicaid Care to access these services from non-participating providers that accept Medicaid. Providers can bill for contraceptives provided on the same day abortion services were provided.

7.5 Evaluation of New Medical Technology
MetroPlusHealth has a procedure for evaluating new technologies and the new application of

existing technologies for possible inclusion within the benefits packages. Such medical technologies include medical procedures, behavioral interventions, pharmaceuticals, and medical equipment.

A new medical technology or new application of an existing technology may be identified through a member or provider authorization request or a medical publication. When this occurs, the clinical literature is reviewed and confirmation that the appropriate regulatory bodies have assessed the new technology (when law requires such assessment) is obtained. Hayes, an independent health technology assessment organization, is licensed by MetroPlusHealth. The Hayes evidence-based assessments of health technologies are reviewed or an inquiry is sent to Hayes directly as needed. Providers with the appropriate expertise are asked to participate in the review and evaluation of health outcomes, risks and benefits associated with the new technology, particularly as compared to established technologies. Technology that clearly falls outside of the benefits package will not be subjected to this evaluation. This review can result in three types of outcomes:

- A policy decision to include the technology as a covered service,
- A decision on whether the requested service will be authorized for an individual member,
- A decision that the technology is considered experimental/investigational and is not a covered service.

MetroPlusHealth has established a Medical Policy Subcommittee to review new medical technology, as outlined in *Section 7.10 : Clinical Criteria for Utilization Review Decisions*.

7.6 Medical Specialty Outpatient Referrals To Participating Providers

MetroPlusHealth does not require written notification and authorization when a Participating Provider refers to another Participating Provider for medical specialty outpatient services except as noted below. Although authorization is not required, members should be referred for these services by their PCP. Participating Providers may use their own methods for conveying the indication for the referral and the member's relevant medical history. Clinical findings should be returned to the referring PCP or other Participating Provider.

7.7 Outpatient Perinatal Care Notification Requirements

Outpatient perinatal care services provided by a Participating Provider do not require authorization. However, notification of a member's initiation into prenatal care is required. Participating Providers are encouraged to submit a "Notification of Pregnancy Form" or the initial obstetrical risk assessment. At minimum providers must submit encounter data corresponding to pregnancy related services rendered. Encounter information must include corresponding clinical diagnosis. This notification ensures that the member is evaluated for enrollment into the high-risk obstetrics care management and education program. This notification/encounter data also enables the facilitation of enrollment of eligible unborn children into the Medicaid program and ensures prompt claims payment.

7.8 Emergency Room Visits

MetroPlusHealth does not require prior authorization in a medical or behavioral health emergency. MetroPlusHealth will not deny payment for treatment of an emergency condition.

Payment for services provided in a general hospital emergency department is not based on whether such services meet the definition of Emergency Medical Condition. MetroPlusHealth does not:

- Limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms; or

- Refuse to cover emergency room services based on the failure of the Provider or the member to give MetroPlusHealth notice of the emergency room visit; or
- Require members to obtain emergency services from Participating Providers.

MetroPlusHealth advises members to call 911 or go to the nearest emergency room for emergency medical conditions.

Members who call MetroPlusHealth after normal business hours have access to a live operator who will take messages or link members with providers, as needed.

ER claims should not be submitted for:

- Members who “walk-out” prior to triage or clinical assessment.
- Members who present to the ER in labor and are then transferred to the labor and delivery area.
- Members who are directly admitted to inpatient services from the ER (authorization must be requested, and claims should be submitted for the inpatient admission only).
- Routine, non-urgent care at a participating hospital (i.e., primary care clinic walk-ins, prescription refills, suture removal, dressing changes, etc.).
- Care or treatment that is not rendered in the actual ER (i.e., care rendered in an urgent care clinic adjacent to the emergency room).

Members found to have non-emergent conditions after a complete triage assessment in the ER should be redirected to their PCP.

7.8.1. Behavioral Health Emergency Screening/Crisis Evaluations

MetroPlusHealth promotes access to Emergency care without requiring prior authorization or notification from the member. MetroPlusHealth, however, does require a face-to-face evaluation by a licensed clinician for all members requiring acute services. There is no level of care criteria for ESP services.

7.8.2 Comprehensive Psychiatric Emergency Program (CPEP)

Comprehensive Psychiatric Emergency Program (CPEP) is a licensed, hospital-based psychiatric emergency program that establishes a primary entry point to the mental health system for individuals who may be mentally ill to receive emergency observation, evaluation, care and treatment in a safe and comfortable environment. Emergency visit services include provision of triage and screening, assessment, treatment, stabilization and referral or diversion to an appropriate program. Brief emergency visits require a psychiatric diagnostic examination and may result in further CPEP evaluation or treatment activities, or discharge from the CPEP program. Full emergency visits, which result in a CPEP admission and treatment plan, must include a psychiatric diagnostic examination, psychosocial assessment and medication examination.

Extended Observation Beds operated by the CPEP Program are usually located in or adjacent to the CPEP emergency room, are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and comfortable environment for up to 72 hours for persons, who require extensive evaluation, assessment, or stabilization of their acute psychiatric symptoms. There is no level of care criteria for CPEP services. While prior authorization is not required, MetroPlusHealth is available to assist with coordination of admissions to, and discharge planning to assure seamless transition to aftercare services.

7.8.3 Mobile Crisis Intervention

Mobile Crisis Intervention services are provided as part of a comprehensive specialized psychiatric services program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i)-like authority resulting from an identified behavioral health diagnosis. Mobile Crisis Intervention services are provided to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis including a preliminary assessment, immediate crisis resolution and de-escalation.

Services will be geared towards preventing the occurrence of similar events in the future and keeping the person as connected as possible with environment/activities. The goals of Mobile Crisis Intervention services are engagement, symptom reduction, and stabilization. All activities must occur within the context of a potential or actual psychiatric crisis. There is no level of care criteria for Mobile Crisis Intervention.

7.9 Services Requiring Authorization

The following services require authorization for payment (see *Appendices XA-XJ* for benefits information and authorization requirements):

- Services provided by a Non-Participating Provider (except in an emergency)
- Behavioral Health and Substance Use Services
  - Outpatient Substance Use Disorder
  - Outpatient Behavioral Health Assertive Community Treatment (ACT), Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), Neuropsychological/Psychological Testing
  - Outpatient Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Continuing Day Treatment (CDT)
- Inpatient Admissions (except maternity)
- Inpatient Private Duty Nursing
- Home Health Care
- Certain Elective Procedures (see benefit grid/code lookup tool)
- Personal Care and Consumer Directed Personal Care Services
- Outpatient Speech Therapy
- Chiropractic Services
- Effective 1/1/2023, Outpatient Occupational Therapy (benefit limits by LOB)
- Effective 1/1/2023, Outpatient Physical Therapy (benefit limits by LOB)
- Hospice Services
- Prenatal or Genetic Testing
- Transgender Services
- Organ Transplants
- Personal Emergency Response System (PERS)
- Skilled Nursing and Acute Rehab Facility Care
  - Under MetroPlusHealth's community-based Skilled Nursing Facility agreements, each facility is financially responsible for all medical services (with some limitations) provided to a resident. Therefore, Providers who administer services to MetroPlusHealth members in Skilled Nursing Facilities must seek reimbursement from the facility. If you have questions regarding this policy, please contact your Provider Relations Representative. Before seeking payment from MetroPlusHealth, authorization would be required.
- Durable Medical Equipment, including Orthotics and Prosthetics, and Enteral Formula and Supplies
- Erectile Dysfunction Treatments
- Potentially Cosmetic Procedures (see *Section 7.20*)

- Experimental/Investigational or Rare Disease Treatment
- Physical Therapy, Occupational Therapy and Speech Therapy
  - For Medicaid members, Physical Therapy, Occupational Therapy and Speech Therapy visits more than 20 visits for each service require prior authorization. Providers must provide clinical documentation of visits provided, progress and expected goals for the initial 20 visits when requesting additional services.
  - For all other Lines of Business (LOBs) providers should check the benefit grid/lookup tool for benefit limitations per LOB.
- For drugs requiring prior authorization and specialty drugs, contact the pharmacy benefits manager at the number listed on metroplus.org and the *Provider Quick Reference Guide*. Restricted members who are restricted to a particular Provider cannot be seen by another Provider (of the same specialty) without prior authorization.
  - Certain classes of medical benefit injectables covered under Medicare Part B will require step therapy.
- Habilitative Services
- Chiropractic Services
- House Calls (Home Provider Visits)

The authorization procedures for each of these service types are delineated below. Services that are not listed above do not require authorization except for some pharmacy and dental services as previously outlined in *Section 7.4: Benefits Management Services*.

7.9.1 Services Requiring Authorization per MetroPlusHealth Medical Policies

As part of an ongoing effort to decrease physicians' administrative burden and ensure prompt access to care for our members, we regularly review and update our UM Medical Policies and applicable services requiring prior authorization review. Please refer to the Provider Section on our website under Tools for the most current list of Medical Policies and services requiring Prior authorization at https://www.metroplus.org/provider/tools.

7.9.2 Fertility Benefits

New York State has mandated changes for infertility benefits for our Medicaid, QHP and Commercial members. Effective October 1, 2019, changes for Medicaid are limited to female infertility and offer certain drug coverage. Commercial and QHP benefits, effective January 1, 2020, also cover additional services and the male population.

Medicaid Fertility Coverage: Effective 10/1/2019:

New York State has mandated changes for infertility benefits for Medicaid members. These changes are limited to female infertility and offer certain drug coverage. Benefits will include office visits, hysterosalpingograms, pelvic ultrasounds, blood testing, medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs for individuals 21 through 44 years of age experiencing infertility.

For details about infertility and the state's demonstration project, see the infertility information on the DOH website and the New York State Medicaid Update – June 2019 Volume 35 – Number 7. Please refer to the Provider Section on our website under Tools for the most current list of Medical Policies https://www.metroplus.org/provider/tools.Refer

Commercial Plan Fertility Coverage

New York State (NYS) recently passed legislation that requires insurers like MetroPlusHealth to update the infertility services coverage they provide to members as policies issue, renew or are amended on and after January 1, 2020. MetroPlusHealth will comply with the NYS mandate for IUI/IVF and fertility preservation by creating a new Medical Policy for Commercial

Plans for IVF and adding pre- authorization requirements to specific CPT codes; please refer to our website for the latest Medical Policy and list of codes within that will require prior authorization. The IVF law requires large group medical plans to cover three cycles of IVF used in the treatment of infertility including all treatment that starts when preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer. The fertility preservation law requires individual, small, and large group insurance policies or contracts to provide coverage of fertility preservation services for iatrogenic infertility including medical treatment for gender dysphoria that will directly or indirectly result in iatrogenic infertility.

7.9.3 Services Requiring Authorization for Special Populations
Children's Home and Community-Based Services (HCBS): HCBS offers personal, flexible support services for eligible children, youth, and families at home and in the community. Authorization is required for these services; a MetroPlusHealth Children's Special Services (CSS) care manager will help members get the services that are right for them.
For more information, please see the Medicaid State Plan Children and Family Treatment and Support Services Provider Manual for Children's Behavioral Health Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/updated_spa_manual.pdf

Children and Family Treatment and Support Services (CFTSS):

These mental health and substance use services, available through Medicaid, give children/youth (under age 21) and their families services to improve their health, well-being and quality of life. These services are provided at home or in the community.

1. **Community Psychiatric Support & Treatment** – Services to help members learn about their behavioral health needs and receive supportive therapy.
2. **Psychosocial Rehabilitation** – Behavioral health services designed to support a child's/youth's ability to reach appropriate developmental functioning.
3. **Other Licensed Practitioner** – Non-physician licensed behavioral health therapist who provides clinical services to help members with their behavioral health needs. As of 7/1/22, Other Licensed Practitioner (OLP) Designated Providers may include licensed PhD Psychologists.
4. **Family Peer Support Services** – Activities and supports for families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral health issues in the home, school or in the community.
5. **Crisis Intervention –** Behavioral Health treatment provided to children and youth experiencing serious psychological/ emotional issues that require urgent attention.
6. **Youth Peer Support and Training –** Services for youth experiencing social, medical, emotional, substance use, and/or behavioral challenges in their home, school or the community.

Children's Home & Community-Based Services (HCBS):

These services give children and their families the ability to improve their care and their quality of life by identifying needs early and providing support in the home or community.

1. **Respite (planned & crisis) –** Short term assistance and/ or relief for children with disabilities. Direct care services required to support children/youth improve their functioning. Skilled nursing services must be ordered by a physician.
2. **Prevocational Services –** Designed to prepare youth to obtain paid work, volunteer work or learn about various careers.
3. **Supported Employment –** Services designed to support children/youth to be able to continue work.
4. **Caregiver/Family Supports and Services – combined service comprised of two existed HCBS services merged under 1 name:**
   a. **Caregiver/Family Supports and Services** - Improve the child/ youth's ability to remain with their family and improve the caregiver's ability to care for them in the home/community.
   b. **Community Self-Advocacy Training & Support** - Assists child and family/caregiver in understanding and addressing the child's needs related to their disability in order to assist the child's ability to participate with peers in age-appropriate activities.
5. **Community Self-Advocacy Training & Support –** Assists child and family/caregiver in understanding and addressing the child's needs related to their disability in order to assist the child's ability to participate with peers in age-appropriate activities.
6. **Habilitation (including Day and Community Habilitation) –** Assistance with obtaining, retaining or improving member's ability to help themselves, develop social skills and perform daily living skills to take care of themselves.
7. **Adaptive and Assistive Equipment –** Technological aids and devices that enable a child to obtain daily living skills that are necessary to support their health, safety and well-being.
8. **Environmental Modifications –** Provides internal and external physical changes to the home or other residence to support the health, safety, independent functioning and well-being of the child.
9. **Vehicle Modifications –** Provides physical changes to the primary vehicle of the child which are necessary to support the health, safety, or greater independent functioning of the child.
10. **Palliative Care (Pain & Symptom Management, Bereavement Service, Massage Therapy, Expressive Therapy) –** Specialized medical care focused on providing relief for the symptoms and stress of chronic or life-threatening illness.
11. **Non-medical transportation –** Non-medical transportation will be paid by Medicaid for eligible children/youth, whether the child/youth is enrolled in Medicaid Managed Care or not.

For Medically Fragile Children and foster children, MetroPlusHealth will apply medical necessity criteria and authorize services in accordance with established time frames in the:

- Medicaid Managed Care Model Contract
- OHIP Principles for Medically Fragile Children

Under EPSDT, HCBS, and CFCO rules; and with consideration for extended discharge planning, MetroPlusHealth will execute Single Case Agreements (SCAs) with non-participating providers to meet the clinical needs of children when in-network services are not available.

Effective January 1, 2023, Applied Behavior Analysis Services will be covered for eligible Medicaid members under age 21 years of age who are diagnosed with Autism Spectrum

Disorder. MetroPlusHealth will cover Applied Behavior Analysis (ABA) therapy provided by:
- Licensed Behavior Analyst (LBA), or
- Certified Behavior Analyst Assistant (CBAA) under the supervision of an lBA

Eligibility Requirements for ABA therapy:
- Must have an autism or Rett's diagnosis, made by a NYS qualified healthcare provider (including psychiatrists and developmental/behavioral pediatricians, clinical psychologists)
- Must provide a diagnostic comprehensive autism evaluation that preceded the diagnosis, performed by a NYS licensed clinician. The evaluation should be conducted as outlined in the New York State Department of Health, Clinical Practice Guideline on Assessment, and Intervention Services for Young Children with Autism Spectrum Disorders (ASD) 2017 Update. https://www.health.ny.gov/publications/20152.pdf
- Obtain a Medicaid referral from PCP (updated every 2 years)

How to obtain services:
- Find a Licensed Behavior Analyst provider on the M+ directory
- Call MetroPlusHealth 1-800-303-9629

For additional guidance, please access this link for more information from New York State: https://www.emedny.org/ProviderManuals/ABA/index.aspx

7.10 Clinical Criteria for Utilization Review Decisions

The Medical Utilization/Care Management clinical staff uses InterQual® criteria for making inpatient utilization review decisions to evaluate medical necessity and appropriate level of care. The member's individual circumstances and the local health care delivery system are also considered. InterQual® criteria are based on scientific evidence and the consensus of national experts. Hayes and UpToDate guidelines are also evidence-based guidelines licensed by MetroPlusHealth and utilized to support clinical decisions.

When criteria, as applied by the Utilization/Care Management clinical staff, are not met, a Physician Advisor or a clinical peer reviewer will review the clinical information and render a determination. The Behavioral Health Utilization Management Clinical staff uses Medical Necessity Criteria sets for New York State Child Health Plus, Commercial, Essential Plan, and Medicaid Manage Care members. MetroPlus BH is only using InterQual Concurrent criteria for all clinical reviews. In addition, there are BH services which the staff apply the following:

- New York State Office of Mental Health (OMH) Criteria
- New York State Office of Addiction Services and Supports (OASAS) LOCADTR Criteria is applied to all substance use treatment services and levels of care for members receiving treatment from providers located in New York State.
- American Society of Addiction Medicine (ASAM) Criteria for out of state SUD admissions.

One of the above criteria is then applied based on coverage type, type of service (MH vs. SUD), level of care, and if necessary, servicing location of the provider.

OMH Criteria is applied to the following treatment services and levels of care for Medicaid Managed Care members:
- Assertive Community Treatment (ACT)
- Continuing Day Treatment (CDT)Adult Home and Community Based Services
- Children's Home and Community Based Services
- Intermediate Care Unit

- Adult and Child Crisis Residence
- Adult Home and Community Based Services
- Community Oriented Recovery and Empowerment Services

Age-specific InterQual criteria is applied to the following mental health treatment services and levels of care for concurrent review.

7.10.1 Behavior Health Notice of Admission (BHNOA)
MetroPlusHealth has also developed prior-authorization for a mental health notification of admission program (MHNOA) as per the regulatory guidance for all providers except H+H facilities where a NOA is not required.

The Provider notifies MetroPlusHealth of a member's admission telephonically, fax or via the provider portal within 2 business days with an initial treatment plan for the following services. A Notice of Admission process is utilized for most for the following services:

- Admissions for Mental Health
- Inpatient Mental Health
- Partial Hospital Program
- Mental Health Intensive Outpatient Program
- Day Treatment Program
- Outpatient Programs/Treatment: Applied Behavioral Analysis (ABA,) Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS), Psychological/Neuropsychological Testing

Required information for a MHNOA:

- Diagnosis for which the member is being treated
- Prescribed medications (if any / known at the time of admission)
- Special population indicators that may be relevant to the member
- Enrollment with Assisted Outpatient Treatment (AOT)
- Eligibility and/or enrollment with a Health Home
- Involved supports and services (if any)

Note: The number of NOA days is to be adjusted to account for weekends and holidays so that the last covered day falls on a business day. The number listed above is the minimum number of days under an NOA. During this registration period, the utilization review does not occur. A UM Clinician is assigned for care coordination activities during the initial NOA registration period and conducts outreach to the provider based upon high risk and quality-related triggers including, but not limited to:

- High risk for an extended length of stay
- History of readmissions
- Identification of first-episode psychosis (FEP)
- Complex co-morbidities (i.e. substance use, medically fragile, developmentally disabled, etc.)

On or before the end of the NOA registration period, the provider notifies the UM Clinician of the discharge plan (within 24 of discharge). If the discharge does not occur by the close of the NOA registration period, the provider requests a continued stay review with the UM Clinician which follows a standard process.

NY In-network providers who do not complete the notification within two business days of the

member admitting as well as Out- of -Network providers will be subject to the standard review process. Failing to provide notification of admission may lead to claim denial

MetroPlusHealth's NOA process will not remove the UM/CM touch on cases, rather focus clinicians on a transactional approach during the admission. Working closely with providers and outside support to connect the member to the most appropriate social, behavioral and medical care. Providers are expected to notify MetroPlusHealth within two business days of the admission.

Information sources used to determine member's course of treatment are based on benefit coverage, medical necessity criteria, and clinical appropriateness received from the provider through telephone, Web-based, or fax. The comprehensive continuum of services ranges from inpatient acute treatment to community-based diversionary programs and traditional outpatient services.

MetroPlusHealth does not require a PCP referral to obtain authorization for Behavioral Health services. A member may initiate outpatient BH services for a predetermined number of visits, without prior authorization from MetroPlusHealth, as determined by his/her benefits package. For authorization of ongoing visits beyond the initial number of visits allowed by their health plan, providers are required to submit documentation of medical necessity prior to the exhaustion of initial visits.

MetroPlusHealth does not require prior authorization for emergency services rendered in hospital ED and does not deny hospital emergency room claims.

OASAS LOCADTR criteria is applied to all substance use treatment services and levels of care for Child Health Plus, Commercial, Essential Plan, and Medicaid Managed Care members receiving treatment from providers located in New York State. OASAS Guidelines are followed for admission to SUD treatment in New York State.

ASAM Criteria is applied to all substance use treatment services and levels of care for members receiving treatment from providers located outside of New York State. Admissions to a SUD facility follow the OASAS guidelines for NOA.

7.10.2 Physician/Peer Advisor for Behavioral Health

When the Utilization/Care Management staff apply the criteria and the level of care is not met, a Physician Advisor/Peer Advisor will review the clinical information and render a determination. MetroPlusHealth ensures that the Behavioral Health Utilization Department utilizes physician advisors who are board-certified in General Psychiatry. A physician advisor certified in addiction treatment reviews all denials, grievances and appeals for inpatient SUD treatment. A physician board-certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of 21. Any appeal of a denied BH medication for a child should be reviewed by a board-certified child psychiatrist. A physician must review all denials for services for a medically fragile child and such determinations must take into consideration the needs of the family/caregiver. MetroPlusHealth ensures that adverse determinations are made by clinicians with the appropriate training, experience, and stratified by age as required by the New York Public Health Law

Utilization review clinicians and Peer Advisors may deviate from all the above-listed medical necessity guidelines when there are access and/or safety issues that require authorization of

a higher level of care. Examples include, but are not limited to:

1. The recommended and most appropriate level of care is not available in the member's geographic area
2. The recommended and most appropriate level of care is at capacity and does not have the ability to treat the member within a reasonable timeframe
3. There is no safe discharge residence in place for the member to return to

For utilization review of services for children with complex needs, MetroPlusHealth will use MNC guidelines approved by the State to determine appropriateness of new and ongoing services related to the child's transition. New York State supports a family-driven, youth-guided, person-centered approach to care in which each enrollee's needs, preferences, and strengths are considered in the development of a treatment plan. MetroPlusHealth will view each request for authorization for a specific service level within the larger context of the child's needs. When a child no longer meets MNC for a specific service, MetroPlusHealth will work with providers to ensure that an appropriate new service is identified (if needed), necessary referrals are made, and the enrollee successfully transitions without disruption in care.

7.11 Requirements for Utilization Review Decisions

The following sub-sections contain the information needed to make a medical necessity and level of care determination for each of the services requiring authorization. Providers will be informed within the indicated timeframes if incomplete information has been submitted or if additional information is required to make an authorization determination. Failure to submit the requested information within these timeframes will be reviewed based on the information received and may result in an adverse determination. (also see *Section 7.14*).

Providers must phone, fax, mail or access the portal for all the required information requests to the Utilization Management Department. Providers may use their own forms to submit this information if all necessary member behavioral and medical information is captured, or they may contact the Utilization Management Department for a copy of the MetroPlusHealth Authorization Request Form found here https://www.metroplus.org/provider/forms. For Behavioral Health, the BHNOAS's are located on the MetroPlus website: metroplus.org

Providers will be encouraged to utilize the MetroPlusHealth Portal for all Notices of Admissions for Behavioral Health. Medically necessary emergency services and medical care for stabilizing or evaluating an emergency condition are not subject to prior authorization. If a member believes that a medical emergency exists, they should be directed to go to the nearest emergency room or call 911 for assistance.

7.11.1 Services Provided by a Non-Participating Provider

Authorization for payment for services provided by a Non-Participating Provider may be given only when the service is deemed medically necessary and is not available from a Participating Provider, or for continuity of care as appropriate. The Participating Provider referring the member to a Non-Participating Provider must request prior authorization. The following information must be submitted:

Member's name, date of birth, and identification number
Referring Participating Provider name and phone number.
Type of care being requested
Proposed tests, treatment and care to be rendered by the Non-Participating Provider
Member's medical and treatment history
Current medications

Non-Participating Provider's name and phone number	Diagnostic test and lab results to date
A Rationale for proposing the use of a Non-Participating Provider	Number of visits requested and frequency of visits
Diagnosis including co-morbidities	

The Utilization Management Department will notify the member, the Participating Provider, and the Non-Participating Provider of the authorization decision. If additional services of an approved authorization is needed, the referring Participating Provider or the Non-Participating Provider treating the member must contact the Utilization Management Department with clinical justification for the continuation of treatment. The information required is:

Member's name, date of birth, and identification number	Current signs and symptoms
Non-Participating Provider's name and phone number	Proposed future tests, treatment and care to be rendered
Tests, treatment and care rendered to date	Diagnostic test and lab results to date
Outcome of treatment to date	Number of visits requested and frequency of visits

7.11.2 Behavioral Health and Substance Use Services

Members may self-refer to a Participating Provider for an initial behavioral health or substance use visit. Members can make unlimited self-referrals for mental health and Substance Use Disorder assessments from Participating Providers without requiring preauthorization or referral from the Members Primary Care Provider. This provision does not apply to ACT, inpatient psychiatric hospitalization, partial hospitalization, or Behavioral Health Home and Community Based Services, for which no self-referrals for assessments are permitted. Please see *Appendix XE* for benefits information and authorization requirements.

7.11.3 Inpatient Admissions (except maternity)

Inpatient care is defined as any 24-hour level of acute, sub-acute or skilled care. This includes medical, surgical, antepartum, rehabilitation, mental health, and substance use services. An authorization for elective admissions must be requested at least ten business days before the scheduled admission date. MetroPlusHealth requires notification about an emergency admission within one business day after the admission. The following information must be submitted:

Member name, date of birth, and identification number	Signs and symptoms necessitating admission (severity of illness)
Referring Participating Provide name and phone number	Estimated length of stay
Admitting Physician's name and phone number	Proposed procedure(s) and treatment(s)
Admitting facility name	Member's medical and treatment history (including failed attempts at conservative outpatient medical treatment, if applicable)
Utilization review contact name, phone and fax numbers	Diagnostic test and lab results to date
Admission date	Co-morbidities
Diagnosis	Current medications including proposed or actual medication changes during the admission
Level of care (medical, surgical, rehabilitation, mental health, and substance use services)	Proposed discharge plan

For admissions reimbursed under DRG payment methodology review is conducted to facilitate discharge planning. The facility must submit ongoing clinical information if the inpatient stay is expected to go beyond the 30-day DRG stay. Concurrent review is conducted for admissions to Per Diem units approximately every seven to fourteen days following the initial review, or as deemed necessary by the Utilization Management clinical staff. The following information is required for concurrent review:

Member name, date of birth, and identification number	Procedures, treatments and consults completed and scheduled
Member medical record number	Diagnostic test and lab results to date
Diagnosis including co-morbidities	
Diagnosis and ICD-10 code(s), including co-morbidities	Medication changes since the last review
Signs and symptoms necessitating continued stay (severity of illness)	Estimated discharge date
Current condition/medical status	Proposed discharge plan
Treatment Plan (intensity of services needed)	Utilization review contact name and phone number

Maternity admissions (excluding antepartum admissions prior to delivery) do not require prior authorization.

If the newborn is admitted to the Neonatal Intensive Care Unit, the Utilization/Care Management Department must be notified. Concurrent review for the newborn will be conducted as outlined above.

7.11.4 Home Health Care

The Participating Provider ordering home health care for a member is responsible for contacting the Utilization Management Department for prior-authorization and for arranging the service with a Participating Home Health Care Provider. The Participating Provider must verify that the Participating Home Health Care Provider will take responsibility, and has the capacity, to provide the specific services needed within the required timeframes. The Utilization Management Department can assist with the selection of an appropriate Participating Home Health Care Provider.

To authorize services, a faxed copy of the initial referral with the services requested and physician orders must be sent to the Utilization Management Department within 48 hours of the request. In the case of a discharge from an inpatient facility on a weekend or holiday, the Participating Provider may arrange for the Participating Home Health Care Provider to begin services without prior authorization. In this case and the case of any urgent home care visit, at minimum one initial visit will be authorized for assessment purposes. The Participating Home Health Care Provider must call Utilization Management the next business day to request authorization for continued services.

The following information is required for authorization:

Member name, date of birth, and identification number	Member's medical and treatment history
Diagnosis including co-morbidities	Treatment plan, including short and long-term goals, number, type and frequency of visits requested
Referring Participating Provider name and phone number	Signs and symptoms
Participating Home Health Care Provider's name and phone number	Current medications

Proposed date of initiation of services	Diagnostic test and lab result to date
Type of service(s) to be rendered	Discharge plan

If additional services of the initial approved services authorized is needed, the Participating Home Health Care Provider must submit a clinical justification for the continuation of treatment. The following information is required:

Member name, date of birth, and identification number	Current signs and symptoms
Diagnosis including co-morbidities	Proposed treatment plan including changes to goals and the number, type and frequency of visits requested
Participating Home Health Care Provider's name and phone number	Medication changes since the last review
Tests, treatment and care rendered to date	Diagnostic test and lab results to date
Outcome of treatment plan to date including achievement of goals and progress with member and family teaching when applicable	Discharge plan

If additional services beyond the initial authorization are not required, the Participating Home Health Care Provider must contact the Utilization Management Department with a detailed discharge summary within two business days of discharge. The information required is as follows:

Member name, date of birth, and identification number	Member's progress towards meeting goals
Diagnosis including co-morbidities	Proposed discharge date
Outcome of treatment	Plan for follow up with the PCP

For short term cases, updates of member status and ongoing needs must be faxed to the Utilization Management Department if additional services will be requested for long term cases, updates of member status and ongoing needs must be faxed to the Utilization Management Department weekly, or as requested by the Utilization Care Management Department. When applicable, a Court Appointed Special Advocates (CASA) application must be submitted as soon as the need is identified. The Utilization Management Department must be contacted immediately if a Participating Home Health Care Provider cannot accept a member, a member cannot be located or if there is a change in member status.

7.11.5 Personal Care and Consumer Directed Personal Care Services

Effective December 23, 2015, MetroPlusHealth provides the Personal Care/Home Attendant benefit for members who are eligible for this benefit (See *Appendices XA-XJ* for benefits information). Personal Care/ Home Attendant Benefit must be provided by an agency that has a contract with MetroPlusHealth.

Personal Care Services (PCS) provide assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). Such services must be essential to the maintenance of the member's health and safety in his or her own home. The service must be ordered by a physician or nurse practitioner, and there must be a medical need for the service. Licensed home care services agencies, as opposed to certified home health agencies, are the primary Providers of PCS. Members receiving PCS must have a stable medical condition and are generally expected to receive such services for an extended period of time.

Personal care services are authorized as Level I (environmental and nutritional functions) or Level II (personal care, environmental and nutritional functions) with the specific number of hours per day and days per week the PCS are to be provided. Authorizations solely for Level I PCS services may not exceed eight (8) hours per week.

7.11.6 Personal Emergency Response System (PERS)
Personal Emergency Response System (PERS) is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. Such systems are usually connected to a patient's phone and signal a response center when a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center.

Assessment of need for PERS services must be made in accordance with and in coordination with authorization procedures for home care services, including personal care services. Authorization for PERS services is based on a physician or nurse practitioner's order and a comprehensive assessment which must include an evaluation of the client's physical disability status, the degree that they would be at risk of an emergency due to medical or functional impairments or disability and the degree of their social isolation.

7.11.7 Durable Medical Equipment (DME), Orthotics and Prosthetics and Enteral Formula/Supplies
The following information is required for authorization (applies to MLTC and UltraCare. See *Section 7.4. Benefits Management Services for the other MetroPlusHeatlh lines of business*):

Member name, date of birth, and identification number	Type and specifications of DME requested
Member address and phone number	Medical need for the DME
Participating DME Provider's name and phone number	Purchase or rental (include the projected duration of need for rentals)
Diagnosis including co-morbidities	Number of units required

The MetroPlusHealth DME benefits manager must be contacted immediately if a Participating DME Provider cannot accept a member or a member cannot be located. DME must be dispensed within 24 hours of authorization unless there are special circumstances. Requests for authorization of payment for services must be submitted directly to the DME benefits manager.

For some MetroPlusHealth plans, enteral formula must be obtained through CVS Caremark. See *Section 7.4.2: Pharmacy Services* and *Appendices XA-XJ*.

7.11.8 Erectile Dysfunction Treatments
The following information is required for authorization:
- Member name, date of birth, procedure(s) and identification number
- Referring Participating Provider name and phone number
- Admitting facility name
- Proposed date of service
- Diagnosis requested
- Level of care (inpatient or outpatient)
- Estimated length of stay
- Utilization review contact name, phone and fax numbers

ED treatment is not covered by Medicaid for beneficiaries who are listed on the New York State Sex Offender Registry.

7.11.9 Restricted Breast Cancer Surgery Facilities for Medicaid Recipients
MetroPlusHealth complies with the New York State Department of Health (NYSDOH) that Medicaid recipients receive breast cancer surgery at high volume facilities. A high-volume facility is one that performs 30 or more mastectomy and lumpectomy procedures in a three-year period. This policy will not affect a facility's ability to provide diagnostic or excisional biopsy and post-surgical care (chemotherapy, radiation, reconstruction, etc.) for Medicaid patients.
For more information and a list of restricted low-volume facilities, please see:
http://www.health.ny.gov/health_care/mediacid/quality/surgery/cancer/breast/

In accordance with Chapter 645 of the Laws of 2005, the New York State (NYS) Medicaid program does not cover prescription or physician administered drugs used for the treatment of sexual dysfunction (SD) or erectile dysfunction (ED). Additionally, Medicaid does not reimburse any supplies or procedures used to treat SD/ED for persons requires to register as sex offenders. Providers must verify that Medicaid members receiving any procedures or supplies which may be used for these indications are not listed as registered sex offenders. There may be limited exceptions where some of these services are covered for members on the sex offender list, if their conditions are not related to SD/ED. These situations will require medical review by MetroPlusHealth.

7.12. Types of Service Authorization Determinations and Timeframes for Review (See Section 7.19 for Medicare)
When a service authorization is requested, the process to review the request depends on the clinical urgency of the member's situation, the level of care requested, and whether the request is for prior authorization, concurrent review, or retrospective review. When a determination is not made within the timeframes described below, it is considered an Adverse Determination or Action and a notice of denial is sent on the date the timeframe expired.

A member or a member's representative may request an expedited or fast track determination verbally or in writing. A request for an expedited review will be granted if applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. If the request does not meet the criteria for an expedited determination, the request will be processed under standard timeframes, and the member will be notified verbally and in writing. If a Provider requests or supports the member's request for an expedited determination or appeal, indicating that the standard timeframe would seriously jeopardize the life or health of the member or the member's ability to regain maximum function, MetroPlusHealth will automatically expedite the review.

Punitive action will not be taken against a provider who requests an expedited resolution or supports a member's service authorization request or appeal.

7.12.1 Prior Authorization Request
A prior authorization request is a request for approval for coverage of a service or treatment before the service or treatment is performed. Upon receipt of the request, the Utilization Management Department staff will review it under either a standard or fast track process. The fast track process is used if it is requested by the Provider or if it is believed that a delay in the review of the request will cause serious harm to the member's life, health or ability to regain maximum function health. In either case, the Utilization Management staff will review the request and notify the Provider and the member by phone and in writing as fast as the member's medical condition requires but no later than the timeframes outlined below. MetroPlusHealth delegates member phone notification to the Provider, when the authorization

is requested by the Provider.

Standard review –
Medicaid, HARP, CHP, Medicaid HIV/SNP, UltraCare & MLTC:
A decision is made within three (3) business days of the receipt of all necessary information, but no later than fourteen (14) days after the request is received.

- Home care after an inpatient stay if next day is a working day, 1 business day of receipt of the necessary information, but no more than 72 hours from the date request received.
- Inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility: 1 business day of receipt of the necessary information.
- Mental Health/Substance Use Disorder (MH/SUD) Court Ordered Services: a decision will be made within 72 hours from the date that the request is received.
- Inpatient Substance Use Disorder (SUD) treatment following inpatient admission when request received before an inpatient discharge: a decision will be made within 24 hours from the date/time that the request is received.

Marketplace,Essential, MetroPlus Gold & MetroPlus GoldCare:
A decision is made within three (3) business days of the receipt of all necessary information, but no later than forty-five (45) days from the date that the request is received.

- Home care after an inpatient stay if next day is a working day: 1 business day of receipt of the necessary information, but no more than 72 hours from the date request received.
- Home care after an inpatient stay if next day is a weekend/holiday: 72 hours of receipt of the necessary information.
- Inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility: 1 business day of receipt of the necessary information.
- Mental Health/Substance Use Disorder (MH/SUD) Court Ordered Services: a decision will be made within 72 hours from the date that the request is received.
- Inpatient SUD treatment following inpatient admission when request received before an inpatient: a decision will be made within 24 hours from the date/time that the request is received.

Fast track review-
Medicaid, HARP, CHP, Medicaid HIV/SNP, UltraCare & MLTC:
A decision is made, and notification occurs within seventy-two (72) hours from the date that the request is received.

Marketplace, Essential, MetroPlusHealth Gold & MetroPlusHealth GoldCare:
A decision is made, and notification occurs within 72 hours of receipt of the necessary information. Additional information must be requested within 24 hours from the date the request is received. A determination must be made within 48 hours after the request for additional information.

7.12.2 Concurrent Review Request
A concurrent review request is a request for the continuation or addition of a service that was previously authorized, or a request for authorization of payment for services that the member is currently receiving. Upon receipt of the request, the Utilization Management Department staff will review the authorization request under either a standard or fast track process. The fast-track process is used if it is requested by the Provider and if it is believed that a delay will cause serious harm to the member's life, health or ability to regain maximum function health. In either case, the Utilization Management staff will review the request and notify the Provider

and the member by phone and in writing as fast as the member's medical condition requires but no later than the timeframes outlined below. MetroPlusHealth delegates member phone notification to the Provider, when the authorization is requested by the Provider.

Standard review –
Medicaid, HARP, CHP, Medicaid HIV/SNP, UltraCare & MLTC:
A decision is made within one (1) business day of the receipt of all necessary information, but no later than fourteen (14) days from the date that the request is received.
Marketplace & Essential, MetroPlus Gold & MetroPlus GoldCare:
A decision is made within one (1) business day of the receipt of all necessary information, but no later than forty-five (45) days from the date that the request is received.

Fast track review –
Medicaid, HARP, CHP, Medicaid HIV/SNP, UltraCare & MLTC:
A decision will be made within one (1) business day of the receipt of all necessary info, but no later than 72 hours from the date that the request is received.
Marketplace & Essential, MetroPlus Gold & MetroPlus GoldCare:
If the request is received at least 24 hours prior to the expiration of the previously approved service, a determination is made within 24 hours of receipt of the request. If the request is not received at least 24 hours prior to the expiration of a previously approved service, determination made within the earlier of 72 hours or 1 business day of receipt of the request.
7.12.3 Service Authorization Determination Extensions
Timeframes for the service authorization determinations noted above may be extended if:

- The member, the member's designee or the Provider requests an extension orally or in writing.
- The Utilization Management staff demonstrates or substantiates that there is a need for additional information and the extension is in the member's best interest. In this case, the notification of the extension will be sent to the member.

Extension Timeframe –
Medicaid, HARP, CHP, Medicaid HIV/SNP, UltraCare & MLTC:
The timeframes for the service authorization determinations may be extended fourteen (14) calendar days when:
(1) The enrollee, designee or provider requests an extension; or
(2) The Plan demonstrates there is a need for more information and the extension is in the enrollee's interest.

When an extension is applied to an authorization requests, we will notify you and the enrollee/designee in writing.

7.12.4 Retrospective Review Request
A retrospective review request is an initial review of a service for which the request for payment or authorization is received after the service or treatment has been provided to the member. If the request is denied, a notice is sent to the provider and member. MetroPlusHealth reserves the right to deny a request for retrospective review when the service has been deemed non-urgent and preauthorization requirements were not met.

Retrospective Review –
Medicaid, HARP, CHP, Medicaid HIV/SNP, MetroPlusHealth Gold, MetroPlusHealth GoldCare, MLTC, Marketplace & Essential:
Retrospective review decisions are made within 30 business days of the receipt of all

necessary information.

MetroPlusHealth reserves the right to reverse a pre-authorized treatment, service or procedure on retrospective review in the following cases:

- Relevant medical information presented to MetroPlusHealth upon retrospective review is materially different from the information that was presented during the pre-authorization review.
- The information existed at the time of the pre-authorization review but was withheld or not made available.
- MetroPlusHealth was not aware of the existence of the information at the time of the pre-authorization review; and had MetroPlusHealth been aware of the information, the treatment, service or procedure being requested would not have been authorized.

7.12.5 Timeframes for Notices of Other Actions

If there is a reduction, suspension or termination of a previously authorized service within a previously authorized period, notification will be provided to the member and Provider at least ten days prior to the Action except in cases of confirmed member fraud. In this case, the period of advance notice is shortened to five days prior to the Action. Notification to the member and Provider will be made in writing no later than the date of the reduction, suspension or termination of a previously authorized service in the following cases:

- The death of the member.
- A signed written statement from the member requesting service termination or giving information requiring termination or reduction of services where the member understands that this must be the result of supplying the information.
- The member's admission to an institution where the member is ineligible for further services.
- The member's address is unknown, and mail directed to the member is returned stating that there is no forwarding address.
- The member has been accepted for Medicaid services by another jurisdiction.
- The Provider prescribes a change in the level of medical care.

7.13 Service Authorization Request Denials

Any decision to deny a service authorization request or to approve for an amount that is less than requested is called an action or initial adverse determination. MetroPlusHealth will not deny coverage of an ongoing course of care unless an appropriate provider of alternate level of care is approved for such care. An action or initial adverse determination of a service authorization request is an activity that results in:

- The denial or limited authorization of a Service Authorization Request including the type or level of service.
- The reduction, suspension or termination of a previously authorized service.
- The denial in whole or part of payment for a service.
- Failure to provide services in a timely manner as defined by applicable law and regulation.

Service authorization request denials may be administrative or clinical (not medically necessary, experimental/investigational or rare disease treatment). Authorization requests that meet any of the following criteria will be denied on an administrative basis:

- The member is ineligible on the date of service.
- Authorization procedures were not followed including failure to request authorization within the required timelines and failure to obtain prior approval for services that are

retrospectively deemed to have been non-emergent.
- The service is not a covered service under the benefit plan.
- The benefit limit for the requested service has been met.
- The treatment being requested is a result of a motor vehicle accident and the primary insurer is no-fault coverage.
- The treatment being requested is a result of a work-related injury and the primary insurer is workers' compensation.
- The proposed Provider does not participate with MetroPlusHealth and the service(s) could be performed by a Participating Provider, or the out-of-network health service is not materially different than the health service available in-network But if the following information is provided upon appeal, the out-of-network appeal will: be reviewed for medical necessity:

Out-of-Network Service:
(a) a written statement from the member's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health service sought, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat the insured's health care needs; and

(b) two documents from the available medical and scientific evidence that the out-of-network health service is likely to be more clinically beneficial to the member than the alternate recommended in- network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.

Out-of-Network Referral:
A written statement from the member's attending physician, who must be a licensed, board-certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat the member for the health service sought, provided that:

(a) the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the member for the health service; and
(b) recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the enrollee, and who is able to provide the requested health service.

Behavioral Health:
- MetroPlusHealth will not deny coverage of an ongoing course of care unless an appropriate provider of alternate level of care is approved for such care.

7.13.1 Notice of Denial of Request for Authorization
When a request for authorization is denied, the Utilization/Care Management Department will call the Provider and mail a notice to the Provider and member. MetroPlusHealth delegates member phone notification to the Provider, when the authorization is requested by the Provider.

At a minimum, the notice of utilization review (UR) clinical denials include:
- The reasons for the adverse determination or action including the clinical rationale, if any. The clinical rationale will identify:
  - The nature of the member's medical condition

  - The medical service, treatment or procedure in question, and
  - The basis for determining that the service, treatment or procedure is or was not medically necessary or experimental/investigational, which demonstrates that the member-specific information was considered when making the determination.
- The process and timeframe for filing/reviewing appeals, including member's right to request expedited review.
- Instructions on how to initiate internal standard and expedited appeals
- A statement that the Plan will not retaliate or take discriminatory action if an appeal is filed.
- Description of any additional information required to render a decision on the Appeal
- Notice of the availability, of the clinical review criteria relied upon to make the determination, when applicable.
- For denials based on medical necessity or experimental/investigational, eligibility for an external appeal
- Definition of an External Appeal
- The member must file for an external appeal with four (4) months of receiving the final adverse determination or agreement to waive the internal appeal process. A Provider who is filing an external appeal on his/her own behalf will have 60 days from the date of the final adverse determination to file an external appeal.
- Statement that if the member files an expedited internal appeal, the member may request an expedited external appeal at the same time. The member may contact MetroPlusHealth or the NY State Dept of Financial Services for an external appeal application and instructions.
- The member's right to contact DOH, with 1-800 number, regarding their complaint.
- A statement that the notice is available in other languages and formats for special needs and how to access these formats.

For the MetroPlusHealth Medicaid, Enhanced (HARP), HIV/SNP and MLTC Plans, the notice will include:

- An explanation of the aid continuing rights, if applicable
- Fair Hearing rights, if the enrollee/designee submits an appeal that is upheld by the Plan
- A statement that the notice is available in other languages and formats for special needs and how to access these formats.

7.13.2 Reconsideration of Clinical Denials

A Provider may request reconsideration when notified about a clinical denial or when an adverse determination is rendered without discussing the matter with the member's health care provider. The provider must call the Utilization Management Department upon receipt of the clinical denial and ask to speak to the Physician Advisor who made the initial determination. The reconsideration will occur within one business day of receipt of the request and will be conducted by the member's health care provider and the clinical peer reviewer who made the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer is not available. A copy of the review criteria used to make the decision may be requested.

Reconsiderations are part of the initial clinical review process and is not considered an appeal.

7.13.3 Request for Reconsideration of Adverse Determination

If a plan member or member's provider disagrees with an expedited or urgent utilization review decision issued by MetroPlusHealth, the member, his/her authorized representative, or the provider may request a reconsideration. Please call Behavioral Health Appeals and Grievances Clinician upon receiving notice of the denial for which reconsideration is requested

When a reconsideration is requested, a PA, who has not been party to the initial adverse determination, will review the case based on the information available and will make a determination within one business day. If the member, member representative, or provider is not satisfied with the outcome of the reconsideration, he or she may file an appeal.

7.13.4 Behavioral Health Appeals and Grievances Process
A plan member and/or the member's appeal representative or provider (acting on behalf of the member) may appeal an adverse action/adverse determination. Both clinical and administrative denials may be appealed. Appeals may be filed either verbally, in person, or in writing. The HARP grievance/appeals procedures will follow the same grievance/appeals process for mainstream Medicaid Managed Care.

When a member assigns appeal rights in writing to a participating provider, the participating provider may appeal on behalf of the member adverse determinations (denials) made by MetroPlusHealth. Participating providers must inform the member of adverse determinations and any appeal rights of which the participating provider is made aware.

Member appeal rights are limited to those available under the member's benefit plan, and may involve one or more levels of appeal.

While the number of appeals available is determined by the member's benefit plan, the type of appeal, "administrative" or "clinical," is based on the nature of the adverse determination. The member's care circumstances at the time of the request for appeal determine the category of appeal as urgent, non- urgent, or retrospective. The member benefit plan and applicable state and/or federal laws and regulations determine the timing of the appeal as expedited, standard, or retrospective. For example, if a provider/participating provider files a Level I appeal on behalf of a member in urgent care, the appeal is processed as an expedited appeal, even if the member is discharged prior to the resolution of the appeal.

Unless otherwise provided for in the member benefit plan, government-sponsored health benefit program, or applicable state or federal law or regulation, the provider/participating provider and/or the member (or the member's authorized representative), has the right to file or request an appeal of an adverse determination up to 60 business days from the date of the initial adverse action notice. An appeal may be made verbally, in writing, or via fax transmission.

Appeal policies are made available to members and/or their appeal representatives upon request. Appeal rights are included in all action/adverse determination notifications. Every appeal receives fair consideration and timely determination by a MetroPlusHealth employee who is a qualified professional. MetroPlusHealth conducts a thorough investigation of the circumstances and determination being appealed, including fair consideration of all available documents, records, and other information without regard to whether such information was submitted or considered in the initial determination. The member, member's authorized representative, and/or the provider/participating provider may submit any information they feel is pertinent to the appeal request and all such information is considered in the appeal review. Punitive action is never taken against a provider who requests an appeal or who supports a member's request for an appeal.

The date of the request for an appeal of the adverse action is considered the date and time the appeal request is received by MetroPlusHealth.

When a provider/participating provider, member (or the member's authorized representative) requests an appeal of an adverse action, the provider/participating provider may not bill or charge the member until all appeals available to the member have been exhausted by the member, and the member agrees in writing to pay for non-certified services.

7.13.5 Peer Review

A peer review conversation may be requested at any time by the treating provider and may occur prior to or after an adverse action/adverse determination. MetroPlusHealth UR clinicians and Pas are available daily to discuss denial cases by phone.

7.13.6 Urgency of Appeal Processing

Appeals can be processed on a standard or an expedited basis, depending on the urgency of the need for a resolution. All initial appeal requests are processed as standard level appeals unless the definition of urgent care is met, in which case the appeal would be processed as an expedited internal appeal. If the member, provider, or other member representative is not satisfied with the outcome of an appeal, he or she may proceed to the next level of appeal, if applicable, as determined by the member's benefit plan.

7.13.7 Appeals Processing Detail

This section contains detailed information about the appeal process for members.
This table illustrates:

- How to initiate an appeal
- Resolution and notification time frames for expedited and standard clinical appeals, at the first, second (if applicable), and external review levels.

Expedited Appeals	
Plan Appeal	Fair Hearing & External Appeal
MEDICAID/HARP/HIVSNP/CHP/MLTC/ULTRACARE Members, their legal guardians, or their authorized representatives have up to 60 calendar days from the date of the adverse action notice to file an appeal. MARKETPLACE/ESSENTIAL/GOLD/GOLDCARE Members, their legal guardians, or their authorized representatives have up to 180 calendar days from the date of the adverse action notice to file an appeal. If the member designates an authorized representative to act on his or her behalf, MetroplusHealth will attempt to obtain a signed and dated Authorization of Representative Form. Both verbal and written communication can take place with a provider who initiated the expedited appeal or with the individual who the member verbally designated as his or her representative. A MetroPlusHealth PA, who has not been involved in the initial decision, reviews all available information and attempts to speak with the member's attending physician. MEDICAID/HARP/HIVSNP/CHP/MLTC/ULTRACARE An expedited appeal determination is made within 72 hours after the appeal is received. EXCHANGE/OFF-EXCHANGE/ESSENTIAL/GOLD/GOLDCARE 72 hours of receipt of the Appeal or 2 business days of receipt of the information necessary to conduct the Appeal, whichever is sooner. MEDICAID/HARP/HIVSNP/CHP/EXCHANGE/OFF-EXCHANGE/ESSENTIAL/GOLD/GOLDCARE/MLTC/ULTRACARE An appeal determination for inpatient substance use disorder treatment is made within 24 hours if the request is received at least 24 hours before the member leaves the hospital. A decision is made within three business days of receipt of the request. Verbal notification to requesting provider occurs	MEDICAID/HARP/HIVSNP/MLTC Medicaid Members or their representatives may request an expedited State Fair Hearing with the state office associated with the member's Medicaid plan. Please refer to the health plan-specific contact information at the end of this manual for the address and phone number of the State Fair Hearing office. For assistance in filing a request for a State Fair Hearing with the state office associated with the member's Medicaid plan, members or their representatives may contact the MetroPlusHealth Member Services Department through the plan's dedicated phone line Please note: members may represent themselves or appoint someone to represent them at the fair hearing. Independent External Reviews with a state-appointed agency are available only in cases where the health care services were: Not medically necessary Experimental/ investigational

7.13.8 Appeals of Complaint/Grievance Resolutions

- If the member or member representative is not satisfied or does not agree with MetroPlusHealth's complaint/grievance resolution, he/she has the option of requesting an appeal with MetroPlusHealth
- The member or member representative has 30-60 calendar days [depending on state regulation] after receipt of notice of the resolution to file a written or verbal appeal.
- Appeals of complaint/grievance resolutions are reviewed by the MetroPlusHealth Peer Review Committee. This determination will be made in a time frame that accommodates the urgency of the situation but no more than 10 business days. Notification of the appeal resolution will be by telephone on the same day of the resolution for urgent complaints/grievances. Written notification will be made within one to two business days of the appeal decision (time frames according to state regulation).

7.14 Non-Covered Benefits

If the Provider recommends a course of treatment or service that is a non-covered benefit, the provider must inform the member, in writing, that the service or item may not be covered by MetroPlusHealth and that the member will be responsible for payment of those services. If the Provider is willing to waive payment, the member should be informed that he or she will be held harmless for payment if MetroPlusHealth determines that the treatment or service is not covered.

If the Provider is uncertain as to whether a service is covered, the Provider should contact MetroPlusHealth prior to advising a member about coverage and liability for payment and before providing the service.

MetroPlusHealth excludes coverage of cosmetic surgery that is not medically necessary, but generally provides coverage when the surgery is needed to improve the functioning of a body part or otherwise medically necessary, even if the surgery also improves or changes the appearance of a portion of the body. Examples of potentially cosmetic procedures include but are not limited to the following:

- Excision of excessive skin of thigh (thigh lift, thighplasty), leg, hip, buttock, arm (arm lift, brachioplasty), forearm or hand, submental fat pad, or other areas
- Salabrasion
- Grafts, fat
- Electrolysis or laser hair removal
- Suction assisted lipectomy
- Correction of diastasis recti abdominis
- Removal of spider angiomata
- Vaginal rejuvenation procedures (designer vaginoplasty, revirgination, G-spot amplification, reduction of labia minora, labia majora surgery)
- Gynecomastia surgery
- Chin implant (genioplasty, mentoplasty)
- Cheek implant (malar implants)

7.15 Request for Reconsideration of Adverse Determination (Behavioral)

If a plan member or member's provider disagrees with an expedited or urgent utilization review decision issued by MetroPlus, the member, his/her authorized representative, or the provider may request a reconsideration. Please call Behavioral Health Appeals and a Grievances Clinician upon receiving notice of the denial for which reconsideration is requested When reconsideration is requested, a PA, who has not been party to the initial adverse determination, will review the case based on the information available and will determine within one business day. If the member, member representative, or provider is not satisfied with the outcome of the reconsideration, he or she may file an appeal.

7.16 Authorization Denial Appeals (See Section 7.19 for Medicare Plans)

7.16.1 Internal Appeals

Internal appeals are also known as **action appeals**. There are two types of internal appeals that correspond to the two types of authorization denials. When members wish to file any action appeal:

- MetroPlusHealth will assist members with the completion of forms and procedural steps for filing an action appeal.
- The member may designate a representative to file on their behalf.
  - Providers cannot request aid to continue on behalf of the member without the written consent from the member.
- Members in the Medicaid/HARP/HIV SNP/MLTC/UltraCare lines of business have the right

to Aid Continuing in the following circumstances:
- The plan decides to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or
- For a member in receipt of long-term services and support or nursing home services (short- or long-term), the plan decides to partially approve, terminate, suspend, or reduce the level or quantity of long-term services and support or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.

- A member does not generally have a right to Aid Continuing for concurrent review determinations for extended services beyond the original authorization period unless the above circumstances exist. The plan must still provide Aid Continuing if so directed by the Office of Administrative Hearings.
- Member will automatically be provided with aid continuing without interruption if they submit an appeal within 10 days of the date of the Initial Adverse Determination, Notice, or prior to the effective date of the determination, whichever is later.
- The member may file an action appeal orally or in writing.
- The member may present the action appeal in person
- MEDICAID/HARP/HIVSNP/CHP/MLTC - The case file and any medical records related to the action appeal will be sent to members. For other lines of business, the case file will be sent to the member upon request.
- An action appeal resulting from a concurrent review determination will be handled as an expedited appeal.
- The member may request an expedited appeal, and if the request is denied the member will be notified orally and in writing within two days of the denial.
- Punitive action will not be taken against a provider who requests an expedited resolution or supports a member's service authorization request, appeal or grievance.
- Action appeal notices are available in several languages and alternate formats are available for members who are visually impaired. Oral interpretation and alternate formats can be requested through the Member Services Department.

The member and MetroPlusHealth may agree to waive the internal appeal process. If this occurs, a notice containing the appeal application and instructions for filing an external appeal will be sent to the member within 24 hours of the agreement to waive the internal appeal process.

Appeals should be sent to:
Metro Plus Health Plan
Appeals Coordinator
50 Water St, 7th Floor
New York, NY 10004
Tel: 212.908.8532
Fax: 212.908.8824

For Behavioral Health
Metro Plus Health Plan
Appeals Coordinator
50 Water St, 10th Floor
New York, NY 10004
Tel: 800.303.9626
Fax: 212.908.5209

7.16.2 Administrative Appeals

Members and Providers may file an administrative appeal. An administrative denial is defined as a denied request for authorization of services that is not based on medical necessity, as well as a claim payment denial. Medicaid Managed Care, HIV SNP, HARP and MLTC plan members must complete this process before filing a request for a Fair Hearing. Providers may appeal administrative denials by submitting documentation to the Utilization Review Appeals Coordinator by mail or fax. The documentation must contain the rationale for requesting the reversal of the administrative denial. If an administrative denial is issued due to the Provider's failure to obtain prior approval for an elective service, the Provider must either submit a cogent rationale for not complying with the prior approval requirements or submit evidence that the procedure was emergent and not elective. The following steps and timeliness will be followed:

- The Provider submits the appeal which must be received:
  - *Medicaid, HARP, HIV/SNP, MLTC, Medicare, CHP, UltraCare:*
  - within 60 calendar days from the date of the denial notice.
  - *MarketPlus and Essential, MetroPlus Gold, MetroPlus GoldCare:*
  - Within 180 calendar days from the date of the denial notice.
- An appeal acknowledgment notice is sent to the Provider within 15 calendar days of the receipt of the appeal.
- A decision on a standard appeal is made within 30 calendar days from the date that the appeal was received.
- Medicaid, HARP. HIV/SNP, MLTC, CHP, UltraCare, *MarketPlus and Essential, MetroPlus Gold, MetroPlus GoldCare*: Inpatient Substance Use Disorder – treatment following an inpatient admission when request is received before the inpatient discharge, a decision is made, and the notice is sent within 24 hours from date/time the request was received.
- For MEDICAID/HARP/HIVSNP/CHP/MLTC/ULTRACARE, notice of appeal decision is mailed to the Provider within two business days of the determination, but no later than 30 calendar days after receipt of the appeal request.
- For MEDICAID/HARP/HIVSNP/CHP/MLTC/ULTRACARE when the member is eligible for aid-continuing, the notice is sent at least 10 days before the effective date of the denial.
- If the denial decision is upheld, the notification will include the rationale for the decision and instructions for filing a Fair Hearing request. (MEDICAID/HARP/HIVSNP/MLTC).

If there is any reason to believe that a related delay in the provision of a service may result in an increased risk to the member's health, the Provider should request an expedited appeal.

7.16.3 Clinical Appeals

A member, their designee, or a Provider on behalf of the member may appeal clinical authorization denials, also known as adverse determinations. A provider appealing on behalf of a member must have a signed consent from the member. A provider may file a utilization review appeal for a retrospective denial of payment on their own behalf. Adverse determinations are made by a clinical peer reviewer at MetroPlusHealth. There are two types of clinical appeals, standard and expedited.

7.16.3.1 First Level Standard Appeals

The following steps and timeliness will be followed:

- The member, the member's designee or the Provider submits the appeal to the Utilization Review Appeals Coordinator by phone, fax or mail. Medicaid members who submit an oral appeal must follow up with a signed, written appeal. The appeal must be received within
  - 60 calendar days of the date on the denial notice for Medicaid, HARP, MLTC, HIV SNP, CHP & UltraCare Plans.

- 180 days for Marketplace Essential Plans. MetroPlus Gold, MetroPlus GoldCare

- An appeal acknowledgment notice will be mailed to the appealing party within 15 calendar days of receipt of a standard appeal.
- If additional information is required to make a determination, the request for information will be in writing within 15 business days of receipt of the appeal.
- If only a portion of the additional information requested is received, the request for the additional information needed will be sent in writing within five business days of receipt of the partial information.
- A Clinical Reviewer other than the Clinical Reviewer who issued the initial denial will review the medical information.
- A decision will be made within the following timeframes:
  - 30 calendar days of the date that the appeal was received. For Medicaid/HARP/HIV SNP/CHP/MLTC/Medicare/UltraCare, this time may be extended for up to 14 days if requested by the member or provider, or if MetroPlusHealth demonstrates that more information is needed, and delay is in the best interest of the member. If the timeframe is extended, a notice will be sent to the member and provider.
- If a decision is not made within this timeframe, the clinical denial is reversed, and the service is authorized.
- MEDICAID/HARP/HIVSNP/CHP/MLTC/ULTRACARE: A written notice is mailed within two business days of the decision but no later than 30 calendar days from the date that the standard appeal was received.
- EXCHANGE/OFF-EXCHANGE/ESSENTIAL/GOLD/GOLDCARE – A written notice is mailed within 24 hours of determination but no later than 30 days of receipt of the standard appeal.
- If the initial clinical denial decision is upheld, the appeal determination notice, called a Final Adverse Determination, will include the rationale for upholding the original determination and instructions for an External Appeal, when the denial is based on medical necessity or experimental/investigational services. Medicaid Managed Care, HARP, MLTC and HIV SNP members also received a notice of the right to a Fair Hearing, including an application and filing instructions with the final adverse determination (Action) notice. The Final Adverse Determination will also include the member's coverage type, a description of the denied service and contact information for the MetroPlusHealth Appeals department.
- The member or designee may see their case file at any time before or during the appeal review and may present evidence to support their appeal in person or in writing. Members in the Medicaid/HARP/HIV SNP/MLTC/UltraCare lines of business will be sent the case file when the appeal is received.
- A member or designee may also ask for an External Appeal within four (4) months after the date of the final adverse determination notice when the denial is based on medical necessity or for services determined to be experimental/investigational. Providers filing an External Appeal on their own behalf must submit an external appeal within 60 days of the final adverse determination. Providers should also enclose a fifty-dollar ($50.00) check or money order made out to MetroPlusHealth with the External Appeal application. Members have 4 months to request an external appeal from the date of the Final Adverse Determination and are not required to submit a check or money order.

7.16.3.2 Expedited Appeals

Appeal may be expedited when:

- The Plan determines that a delay would seriously jeopardize the Enrollee's life, physical or

mental health or ability to attain, maintain, or regain maximum function.

- The health care provider believes an immediate appeal is warranted. This does not include a retrospective determination.
- The request is for continued or extended health care services, procedures or treatments or additional services for an enrollee undergoing course of continued treatment prescribed by a health care provider.
- The request is for home health care services following discharge from an inpatient hospital admission.
- For proposed mental health or substance use disorder service, where the Enrollee, or the Enrollee's designee, has certified that the proposed services are for an individual who will be appearing, or has appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services.

The Enrollee may request an expedited review of an appeal. If the Plan denies the Enrollee's request for an expedited review, the Plan will notify the Enrollee and process the request under standard appeal resolution timeframes.

The following steps and timeliness will be followed:

- Expedited appeal requests should be phoned or faxed to the Utilization Review Appeals Coordinator.
- If additional information is required to make a determination, the member and the Provider will be notified immediately by phone or fax followed by a written notice for additional information by mail.
- A Clinical Reviewer other than the clinical reviewer who issued the initial denial will review all necessary medical information. The Clinical Reviewer will be available to talk to the treating Provider within one business day of receipt of the expedited appeal.
- A decision regarding the appeal will be made and notification will be provided within the following timeframes:
  - *Medicaid, HARP, HIV SNP, MLTC, CHP, UltraCare: Oral notice within* 72 hours after the receipt of the appeal, and written notice within 24 hours of decision. This time may be extended for up to 14 days if requested by the member or provider, or if MetroPlusHealth demonstrates more information is needed and delay is in the best interest of the member. If the timeframe is extended, a notice will be sent to the member and provider.
  - *Marketplace, Essential, MetroPlusHealth Gold and MetroPlusHealth GoldCare Plans:* as fast as the member's condition requires but no more than 72 hours of receipt of the Appeal or 2 business days of receipt of the information necessary to conduct the Appeal, whichever is sooner. Notice will be provided within 24 hours of determination but no later than 72 hours from the date that the appeal was received.

  If the decision is not made within these timeframes, the clinical denial is deemed to be reversed and the service requested is authorized.
- Upon making a decision, MetroPlusHealth will attempt to notify the member and the Provider of the decision within the following timeframes:
  - *Medicaid, HARP, HIV SNP, MLTC, CHP, UltraCare:* Verbal notice upon determination within 72 hours of receipt of the appeal. Written notice within 24 hours of the decision.
  - *MarketPlus, Essential, MetroPlusHealth Gold, MetroPlusHealth GoldCare:* 24 hours of determination but no later than 72 hours from receipt of appeal
- Expedited appeals based on medical necessity or experimental/investigational reasons that are not resolved to the satisfaction of the appealing party may be appealed again through the external appeal process.

7.16.4 Final Adverse Determination Notice

Each notice of final adverse determination will be in writing, dated, and include:

- The basis and clinical rationale for the determination.
- The words "final adverse determination".
- MetroPlusHealth contact person and phone number.
- The member's coverage type.
- The name and address of Plan, contact person and phone number.
- A description of the health service that was denied, including facility/provider and developer/ manufacturer of the service, as available.
- A description of the external appeals process, with the application and instructions attached for denials based on medical necessity or experimental/investigational services.
- For *Medicaid, HARP, HIV SNP & MLTC* the notice will also include:
- A summary of the appeal and date filed.
- The date that the appeal process was completed.
- A description of the member's fair hearing rights, including the Fair Hearing form.
- The right of the member to complain to the Department of Health at any time including the toll-free number: **1.800.206.8125**, or for MLTC: **1.866.712.7197**.
- A statement that the notice available in other languages and formats for special needs and how to access these formats.

7.16.5 External Appeals

New York State law allows members to request an external appeal of a prospective, concurrent or retrospective Final Adverse Determination. An external appeal may be filed:

- when the member has had coverage of health care service, which would otherwise be a covered benefit, denied on appeal in whole or in part, on the grounds that such health care services are not medically necessary, **and**
- the Plan has rendered a final adverse determination with respect to such health care service, **or**
- both the Plan and the member have jointly agreed to waive any internal appeal.

  An external appeal may also be filed:
- when the member has had coverage of a health care service denied on that basis that such service is experimental or investigational, **and**
- the denial has been upheld on appeal or both the Plan and the member have jointly agreed to waive any internal appeal,
- **and** the member's attending physician has certified that the member has a life-threatening or disabling or disease
  (a) for which standard health services or procedures have been ineffective or would be medically inappropriate,
  (b) for which there does not exist a more beneficial standard health service or procedure covered by the Plan, or
  (c) for which there exists a clinical trial,
- **and** the member's attending physician, who must be board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's life-threatening or disabling condition or disease, must have recommended either
  (a) a health service or procedure including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B), that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or
  (b) a clinical trial for which the member is eligible.

A physician certification under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation,

- **and** the specific health service or procedure recommended by the attending would otherwise be covered under the policy except for the plan's determination that the health service or procedure is experimental or investigational.

Providers may request an external appeal on their own behalf to obtain payment from a health plan when there has been a retrospective Adverse Determination that a service is not medically necessary or is considered experimental or investigational.

The notice of Final Adverse Determination includes the following information about external appeals:

- The member may be eligible for external appeal and timeframes for appeal.
- The member has 4 months from the final adverse determination to request an external appeal. Providers appealing on their own behalf have 60 days. Providers appealing on their own behalf must also enclose a fifty-dollar ($50.00) check or money order made out to MetroPlusHealth with the External Appeal application.

A copy of the External Appeal Application is contained in *Appendix XV* or can be obtained from the New York State website at www.ins.state.ny.us/extapp/extappqa.htm. A Provider may be required to complete certain sections of the member's application to provide the information needed for clinical review. Additionally, an attestation is required for a member's request for an external appeal on an expedited basis or when the treatment is considered potentially experimental or investigational. In these cases, the Provider must complete a form attesting that:

- The member has a life-threatening or disabling condition or disease and delay of the proposed service poses an imminent or serious threat to the member's health.
- The member is eligible for a clinical trial and has been or will likely be accepted into the clinical trial.
- For experimental/investigational treatments, the Provider must submit copies of documents used to establish medical and scientific evidence that the recommended service is likely to be more beneficial than any standard health care service or procedure.

Applications lacking physician attestations and supporting documentation will not be reviewed.

MetroPlusHealth will waive application fees for all Medicaid, HARP, HIV SNP, MLTC and CHP members. Other members must pay the fee or prove financial hardship in order to receive a fee waiver. A waiver form is included with the application materials. Providers are responsible for the full cost of an appeal for a concurrent adverse determination upheld in the favor of MetroPlusHealth. MetroPlusHealth is responsible for the full cost of an appeal that is overturned. The Provider and MetroPlusHealth must evenly divide the cost of a concurrent adverse determination that is partially overturned. The fee requirements do not apply to Providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of MetroPlusHealth.

Completed External Appeal Applications should be submitted directly to the NY State Department of Financial Services (DFS). If the application satisfies the criteria for an external appeal, DFS will forward the request to the External Appeal Agent (EAA).

7.16.6 Standard External Appeals

For standard External Appeals, MetroPlusHealth will provide the EAA with any requested clinical information within three business days of receipt of the request. The EAA must make a decision within 30 calendar days of the receipt of the completed application. If additional information is requested, the EAA has five additional business days from receipt of the

information to make a decision. Once the determination has been made, the EAA must notify the member, Provider and MetroPlusHealth within two business days. If MetroPlusHealth receives no communication from the Provider, member or EAA within 55 days of the date on the Final Adverse Determination notice, the Final Adverse Determination will be deemed upheld.

7.16.7 Expedited External Appeals
Expedited External Appeals may be requested by a member, their designee or a Provider on behalf of a member when there is reason to believe that a delay in the provision of services may result in an increased risk to the member's life, health, or ability to regain maximum function. In such cases, a decision will be rendered within 72 hours of the request. If additional information is required, DFS will contact the member, their designee or Provider and MetroPlusHealth by phone or fax, followed by a written notice. MetroPlusHealth will provide the DFS and/or the EEA with any requested clinical information within 24 hours.

If the EAA determines that the documentation submitted represents a material change from what was previously submitted and reviewed by MetroPlusHealth, the EAA will allow MetroPlusHealth to reconsider the earlier determination. MetroPlusHealth has up to three business days to amend, reverse or uphold an earlier determination. If the EAA overturns the original decision, MetroPlusHealth will be responsible for the cost of treatment. However, if the member is no longer eligible at the time of the reversal, MetroPlusHealth is not obligated to cover the cost of services.

7.16.8 Fair Hearing
Medicaid Managed Care, Medicaid HIV SNP, HARP and MLTC members have the right to apply for a Fair Hearing in cases where a Final Adverse Determination has been rendered. A Final Adverse Determination is any decision to uphold or deny a service authorization request or to approve for an amount that is less than requested. A member, or a member's designee, may file a request for a Fair Hearing within 120 calendar days of receipt of the Final Adverse Determination Notice. A Fair Hearing form is sent to the member with the Final Adverse Determination letter. Members may also obtain a copy of the Fair Hearing forms by calling the Member Services Department at **1.800.303.9626**.

MetroPlusHealth will also provide assistance to the member in filing complaint appeals and action appeals. The following cases also qualify for the Fair Hearing process:

- There is a reduction, suspension or termination in payment for treatments or benefits that were previously authorized for payment.
- Authorization for payment is denied or a Provider refuses to approve care.
- Payment is authorized for a lesser level of care than the Provider or member requested.

For denials involving the reduction, suspension or termination of Long-Term Social Service (LTSS) or Residential Health Care Facility Treatment (short term or long term), a determination letter will be sent at least ten days prior to the effective date. If the member would like to keep their services the same after an initial adverse determination (aid continuing), they must ask the plan for a Plan Appeal with in 10 calendar days of the initial adverse determination or by the date the decision takes effect, whichever is later. The member's services will stay the same until the plan makes a final adverse determination.

The final adverse determination letter will be sent at least ten days prior to the effective date. If the member would like to keep their services the same after a final adverse determination, they must ask for a Fair Hearing request within 10 days of the Final Adverse Determination.

Aid continuing applies in such cases and services must continue during the Fair Hearing process until a decision is issued or the period of care initially ordered by the Provider ends, whichever occurs first.
A member may apply for an External Appeal simultaneously with a Fair Hearing. If an External Appeal is decided first, the member may still continue with the Fair Hearing. The determination made at the Fair Hearing supersedes all other determinations.

UltraCare
If MetroPlus upholds the first level appeal, the case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Office of Administrative Hearings (OAH) reviews our decision of the first appeal. The OAH is an independent New York State agency. It is not connected with MetroPlus.
If the first level appeal was expedited, the OAH Level 2 may also be expedited, if using the standard timeframes could seriously jeopardize the member's life, health, or ability to regain maximum function. An expedited determination will be made by the OAH within 72 hours of when it receives the appeal.
Standard appeals will be decided with 60 calendar days of the date that the appeal is received by the OAH, receives your appeal.

7.17 Discharge Planning
Discharge planning begins whenever an inpatient, home health care or behavioral health outpatient service is initiated. Initial discharge planning includes consideration of the member's aftercare needs and arrangements for the provision of those services. The discharge planning assessment should be comprehensive evaluations of the needs of the member, considering the member's medical, behavioral and psychosocial history, family or other means of support, home and housing conditions, prior level of functioning and public assistance. The final discharge plan should include dates, times and locations for all follow-up appointments and aftercare services. It should also describe self-management instructions that are given to the member or their caregiver. Providers may call the MetroPlusHealth Utilization/ Care Management Department for assistance in making aftercare arrangements. The initial discharge plan and periodic plan updates are part of the medical information required in the inpatient utilization review process. A copy of the final discharge plan should be given to the member.

7.18. Member Transition to Other Care
If a member's coverage ends under the benefits package and the member is still in need of care or the member needs to transition to another level of care not covered within the benefits package, or it is determined that the current level of care is not medically necessary, the Utilization Management Department is available to review alternatives for care with the treating Provider and the member. This includes providing education about existing resources available to the member such as those funded by local and state agencies. If needed, the Utilization Management Department can participate in the development of a transition plan.

7.19 Timeframes and Notice Requirements For MetroPlusHealth Medicare Plans
MetroPlusHealth follows a standard procedure for making organization determinations, and an expedited procedure for situations in which applying the standard procedure could seriously jeopardize the member's life, health, or ability to regain maximum function. An organization determination is a decision by MetroPlusHealth to provide or pay for a service to a MetroPlusHealth Medicare member.

An organization determination may be requested by the member (including his or her authorized representative), a Provider that furnishes, or intends to furnish, services to the member or the legal representative of a deceased member's estate.

An expedited organization determination is provided if a physician indicates, either orally or in writing, or a member (his/her authorized representative) believes that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If MetroPlusHealth does not provide the member with timely notice of an organization determination, this constitutes an adverse organization determination and may be appealed. MetroPlusHealth is required to provide timely notice to members whose services in a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) are ending.

7.19.1 Standard Timeframes and Notice Requirements for MetroPlusHealth Medicare Plans
When a request for a service is received, MetroPlusHealth provides notification of the determination as expeditiously as the member's health condition requires, but no later than fourteen (14) calendar days after the date MetroPlusHealth receives the request for a standard organization determination.

The timeframe may be extended by up to fourteen (14) calendar days if the member requests the extension or if MetroPlusHealth justifies a need for additional information and how the delay is in the interest of the member. When the timeframe is extended, the member is notified in writing of the reasons for the delay and informed of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

Medicare Part B Drugs Only
When a request for a Part B Drug is received, MetroPlusHealth provides notification of the determination as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.
NOTE: Part B drug timeframes cannot be extended
Written Notice for MetroPlusHealth Denials:
If a decision is made to deny service or payment, in whole or in part, or if the member disagrees with the decision to discontinue or reduce the level of care for an ongoing course of treatment, a written notice of the determination is provided.

If a member requests an explanation of a Provider's denial of an item or service, in whole or in part, the member will be provided with a written notice. The notice of the denial:

- Uses approved notice language in a readable and understandable form.
- States the specific reasons for the denial.
- Informs the member of his or her right to reconsideration.
- For service denials, describes both the standard and expedited reconsideration processes (level 1 appeal), including the member's right to, and conditions for, obtaining an expedited reconsideration
- Complies with all other notice requirements specified by CMS.

7.19.2 Timeframes and Notice Requirements for Expedited Organization Determinations for MetroPlusHealth Medicare Plans
Upon receipt of the request for an expedited or fast track determination, the decision to

expedite a determination is based on whether applying the standard timeframe for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. An expedited organization determination is always provided if a physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

When a request for expedited determination is approved, a determination is made and the member (and the physician involved, as appropriate) is notified of the decision, whether adverse or favorable, as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.

When a member's request for an expedited determination is denied, the request is automatically transferred to the standard timeframe and a determination is made within 14 calendar days (the 14- day period starts when the request for an expedited determination is received). The member is given prompt oral notice of the denial of the expedited request. In addition, MetroPlusHealth will provide written notice within 3 calendar days of the oral notification that includes:

- An explanation that MetroPlusHealth will automatically transfer and process the request using the 14- day timeframe for standard determinations.
- The right and instructions on how to file an expedited grievance if he or she disagrees with the organization's decision not to expedite the determination.
- The right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the request will be expedited automatically.

The 72-hour deadline may be extended by up to 14 calendar days if the member requests the extension or if MetroPlusHealth justifies a need for additional information and shows how the delay is in the interest of the member. When the deadline is extended, the member is notified in writing of the reasons for the delay and informed of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

Medicare Part B Drugs Only

When a request for expedited determination is approved, a determination is made and the member (and the physician/prescriber involved, as appropriate) is notified of the decision, whether adverse or favorable, as expeditiously as the member's health condition requires, but no later than 24 hours after receiving the request.

When a member's request for an expedited determination is denied, the request is automatically transferred to the standard timeframe and a determination is made within 72 hours (the 72 hours begins when the request for an expedited determination is received). The member is given a prompt oral notice of the denial for the expedited request. In addition, MetroPlusHealth will provide a written notice within 3 calendar days of the oral notification that includes:

- An explanation that MetroPlusHealth will automatically transfer and process the request using the 72-hour timeframe for standard determinations for Medicare Part B Drugs.
- The right and instructions on how to file an expedited grievance if he or she disagrees with the organization's decision not to expedite the determination.
- The right to resubmit a request for an expedited determination and that if the member gets any physician's or prescriber's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the request will be expedited automatically.

NOTE: *Part B drug timeframes cannot be extended*
Verbal notice to member occurs no later than 24 hours from receipt of the expedited Part B authorization request. Written notice will be sent within 3 calendar days of the verbal notice.

7.19.3 Adverse Organization Determinations for MetroPlusHealth Medicare Plans
If the determination is not completely favorable, MetroPlusHealth provides a written notice using the standardized denial notice is the Notice of Denial of Medical Coverage or Payment that includes:

- A Specific and detailed explanation of why the medical services, items or Part B drugs were denied, including a description of the applicable coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage, if applicable.
- Information regarding the member's right to appeal and the right to appoint a representative to file an appeal on the member's behalf.
- For service denials, a description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process.
- For payment denials, a description of the standard reconsideration process and timeframes, and other elements of the appeals process.
- The member's right to submit additional evidence in writing or in person.

If a timely notice of an expedited organization determination is not provided to the member, this is considered an adverse organization determination and may be appealed.

7.19.4 Timeframes and Notice Requirements for Termination of Coverage in a SNF, HHA, or CORF for MetroPlusHealth Medicare Plans
When MetroPlusHealth has approved coverage of a member's admission to a SNF (Skilled Nursing Facility), or coverage of HHA (Home Health Agency) or CORF (Comprehensive Outpatient Rehabilitation Facility) services, the member must receive a Notice of Medicare Non-Coverage (NOMNC) at least 2 days in advance of the services ending.

The NOMNC will be faxed to the Provider along with every preauthorization letter issued on behalf of MetroPlusHealth members. The Provider should deliver it to the members 2 days prior to discharge or within the last two sessions of home health services. MetroPlusHealth will not be responsible for any charges that extend past the authorized amount due to the failure of a provider/facility to deliver the notice and receive a patient signature.

7.19.4.1 Quality Improvement Organization (QIO) review of ending services at SNF, HHA or CORF
If a member disagrees with the decision to end services, they may file an expedited appeal with Livanta – the Quality Improvement Organization (QIO) in New York State. Once the QIO notifies MetroPlusHealth and Provider of an appeal, MetroPlusHealth is responsible for providing a Detailed Explanation of Non-Coverage (DENC) to the Provider, who in turn must deliver the DENC to the member. MetroPlusHealth and the Provider will furnish all the necessary documentation to the QIO upon request. The QIO is responsible for making a decision on the case by no later than close of business the day after the QIO receives the needed information.

SNFs, HHAs, and CORFs (or their agent) are responsible for delivering the NOMNC and DENC to members and assuring a valid delivery. Valid delivery means that the member

signed the NOMNC to acknowledge that they received and understood the notice. If the member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the member's legally authorized representative. If no authorized representative has been appointed, then the Provider should seek the requested signature from the caregiver on record (i.e. the family member involved in the plan of treatment). Although the caregiver is not a legally authorized representative, he/she has assumed responsibility for the member's medical treatment. If the member has no legally authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the member.

The NOMNC is not used when the member's services end based on the exhaustion of benefits (such as the 100-day SNF limit), or when an admission to a SNF, or HHA or CORF services are not covered. In this case, an Integrated Denial Notice is sent to the member.

7.19.5 Timeframes and Notice Requirements for Inpatient Hospital Stays for MetroPlusHealth Medicare Plans

With every Medicare inpatient stay, hospitals are required to issue a revised version of the Important Message from Medicare (IM), CMS-R-193 to all Medicare beneficiaries, including MetroPlusHealth members. This notice explains the discharge appeal rights. Hospitals must issue the IM within 2 calendar days of the day of admission and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each MetroPlusHealth member within 2 calendar days of the day of discharge. Thus, in cases where the delivery of the initial IM occurs more than 2 days before discharge, hospitals will deliver a follow-up copy of the signed notice to the beneficiary as soon as possible prior to discharge, but no more than 2 days before. Only one notice is required for inpatient stays that are 5 days or less in length. Hospitals must retain a copy of the signed IM and may do so wherever it makes sense given their record retention system. Scanning and electronic storage of notices is acceptable. Hospitals also must be able to demonstrate compliance with the requirement for delivery of the follow-up copy of the notice. However, as noted above, hospitals have some flexibility in terms of methods for documenting delivery of the follow-up copy, such as obtaining the beneficiary's initials on an "Additional Information" area of the notice.
The template notice can be located online at:
www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

QIO Review of Inpatient Hospital Care

If a member disagrees with the discharge decision, they may file an appeal with the QIO no later than the day of discharge. A hospital cannot discharge a member who disputes the discharge with the QIO. Once the QIO notifies MetroPlusHealth and the hospital of an appeal, the hospital is responsible for delivering a Detailed Notice of Discharge (DNOD) to the member. The hospital must furnish all the necessary documentation to the QIO and deliver the DNOD no later than noon of the day after the QIO notifies the hospital. The QIO is responsible for deciding on the case by no later than one calendar day after the QIO receives the necessary information.

7.20 Liability for Hospital Costs for MetroPlusHealth Medicare Plans

The presence of a timely appeal for an immediate QIO review as filed by the member in accordance with this section entitles the member to automatic financial protection by MetroPlusHealth. This means that if MetroPlusHealth authorizes coverage of the inpatient hospital admission, or this admission constitutes emergency or urgently needed care, MetroPlusHealth continues to be financially responsible for the costs of the hospital stay until

noon of the day after the QIO notifies the member of its decision, or more if the QIO agrees with the member.
If a member fails to request an immediate QIO review in accordance with the CMS requirements, they may file a request for an expedited reconsideration with MetroPlusHealth. Members also retain the right to file an appeal with the QIO for 30 days after the discharge. QIO and/or MetroPlusHealth will determine the member's liability in these situations upon appeal.

7.21 Reconsiderations for Medicare Members-Medical Benefits (Level 1 Appeals)
When MetroPlusHealth receives a request for payment or to provide services to a member, it must make an organization determination to decide whether or not coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member has the right to request a reconsideration (hereinafter referred to as a level 1 appeal). A member that disagrees with a Provider's decision about a request for a service or a course of treatment has a right to request an organization determination from MetroPlusHealth. This member should be told to consult their Evidence of Coverage (EOC) or contact MetroPlusHealth Member Services for additional information.
MetroPlusHealth is required to make determination about level 1 appeals as expeditiously as the member's health status requires but no later than as follows:

- **Standard (Pre-Service Related):** Not to exceed 30 calendar days. (The 30-day deadline may be extended by an additional 14 calendar days if the member requests the extension or MetroPlusHealth justifies the need for additional information and how the delay is in the best interest of the member)
- **Expedited (Pre-Service Related):** Not to exceed 72 hours days from the date that the level 1 appeal was received. (The 72-hour deadline may be extended by an additional 14 calendar days if the member requires the extension or MetroPlusHealth justifies the need for additional information and how the delay is in the best interest of the member)
- **Standard Only (Payment/Claims Related):** Not to exceed 60 calendar days from the date that the level 1 appeal was received.

Medicare Part B Drugs Only
MetroPlusHealth is required to process level 1 appeals as expeditiously as the member's health status requires but no later than as follows:

- **Standard (Pre-Service Related):** Not to exceed seven (7) calendar days from the date that the level 1 appeal was received.
- **Expedited (Pre-Service Related):** Not to exceed 72 hours days from the date that the level 1 appeal was received.
- **Standard Only (Post-Service/Retrospective Related):** Not to exceed 60 calendar days from the date that the level 1 appeal was received.

NOTE: *Part B drug timeframes cannot be extended.*

A member has a right to level 1 appeal if a member believes that:

- MetroPlusHealth has not paid for emergency or urgently needed services.
- MetroPlusHealth has not paid a bill in full.
- Health services have been furnished by a non-contracted medical provider or facility or supplier that the member believes should have been provided, arranged for, or reimbursed by MetroPlusHealth.
- Services that the member feels are the responsibility of MetroPlusHealth to pay for or provide have not been received or paid.
- Health services that have been discontinued or reduced, but the member still believes the

services are medically necessary.
- An organization determination has not been made within the appropriate timeframes.
- Services that should be provided by, arranged for, or reimbursed have not been provided, arranged or reimbursed.

All level 1 appeal requests must be received by MetroPlusHealth within 60 calendar days from the date of the notice of organization determination. MetroPlusHealth may extend the period for filing a request for reconsideration for good cause. A member or a member's representative or a Provider must request a standard level 1 appeal request of an adverse organization determination in writing. A member can name a relative, friend, advocate, attorney, doctor, or someone else to act on his/her behalf or others authorized under State law. Participating Providers acting on behalf of a member must complete an Appointment of Representative Statement – but not if the participating provider is acting on his/her own behalf. Non-participating providers acting on their own behalf must complete and send the Waiver of Liability Form to MetroPlusHealth before the Plan can act on an level 1 appeal. If further information about the member's level 1 appeal is required to render a decision, providers must submit the additional information in a timely manner.

A member or a member's representative may request an expedited determination or expedited appeal verbally or in writing. A request for an expedited review will be granted if applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. If the request does not meet the criteria for an expedited determination or an expedited appeal, the request will be processed under standard timeframes, and the member will be provided with prompt verbal notice and written notice within 3 calendar days of the verbal notice. If the member disagrees with that decision, the member may submit a grievance. If a physician makes a request or supports a member's request for an expedited appeal and indicates that applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function (the physician does not have to use these exact words). MetroPlusHealth must automatically expedite the review.

A member or a member's representative can request an expedited determination or expedited reconsideration (appeal) regarding a service or a referral under the following circumstances:
- The request is for continued or extended healthcare services or additional services for a member undergoing a continued course of treatment.
- The standard appeal process would lead to a delay that seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

All members may present evidence and allegations of fact or law related to the issue in dispute in person or in writing. If further information regarding the member's appeal is required to render a decision, providers must submit the additional information in a timely manner.

If MetroPlusHealth reverses the adverse organization determination, then services will be provided as expeditiously as the member's health condition requires, but no later than 30 calendar days after the date the request for appeal was received. For payment related requests, payment will be made no later than 60 days after the appeal request was received.

If MetroPlusHealth upholds the initial adverse organization determination, then the appeal will be sent to Independent Review Entity (IRE) contracted by CMS' to conduct an independent review.
If the IRE upholds the MetroPlusHealth adverse organization determination, the contractor will

notify the member in writing and explain further appeal options that may be available to the member.
If MetroPlusHealth does not complete an expedited appeal process within 72 hours or the standard appeals process within 30 days, the case will be automatically sent to the IRE for an independent review.

Members who wish to submit a verbal request for an Expedited Appeal should be directed to call **1.866.986.0356**.

7.22 Coverage Determinations and Appeals (Reconsiderations) Medicare-Prescription Drug Benefits
When MetroPlusHealth receives a request to pay for or provide a Part D drug it must make a coverage determination. Coverage determinations include exception requests. An exception is a request to cover a drug that is not on our formulary, requires utilization management or to reduce cost-sharing for that drug. To request a coverage determination or exception, members or providers should visit www.metroplus.org to submit an electronic request or call our pharmacy vendor CVS Caremark at **1.866.693.4615** (TTY: 711) or fax the request to **1.855.633.7673**.

MetroPlusHealth is required to make Medicare Part D coverage determinations as quickly as the member's health status requires but no later than 72 hours from receipt of the request for standard requests and no later than 24 hours from receipt of the request for expedited requests. Payment requests must be processed no later than 14 days from receipt of the request.

Members who disagree with a coverage determination and want MetroPlusHealth to reconsider and change its decision about a Part D prescription drug benefit, may file a redetermination (appeal). MetroPlusHealth will decide an appeal as expeditiously as the member's health status requires. MetroPlusHealth will decide on an expedited appeal no later than 72 hours after receiving the request for expedited cases, or no later than seven (7) calendar days after receiving the request for standard cases. For payment reconsiderations, the plan must make the determination no later than 14 days from receipt of the request.
If MetroPlusHealth fails to meet the appeal timeframes, it must automatically forward member's request to the Independent Review Entity (IRE) contracted by CMS. If the IRE upholds the adverse coverage determination, the IRE will notify the member in writing and explain further appeal options that may be available to the member.

8. Care Management Services

8.1 Disease/Care Management Programs

8.1.1 MetroPlusHealth Integrated Care Management Program
MetroPlusHealth Integrated Care Management (ICM) program is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the services and options available to meet the health and human service needs of members with complex care needs and are at risk for increased hospital admissions and emergency room visits.
The ICM program is delivered telephonically and aims to foster member engagement, member-centered care planning and goal attainment.

ICM has two components:

- **Transitions of Care** (TOC) for members admitted to the hospital and are at risk for admission.
- **Comprehensive Care Management** (CCM) for members identified as having complexity and morbidity factors. We identify high-risk members using our proprietary stratification algorithm that factors in risk, cost of care, complexity (i.e. number of chronic conditions, medications and providers) and other indicators that suggest uncoordinated care practices (members utilizing multiple pharmacies).

Services provided by our nurses and social workers include, but are not limited to:

- Assisting members in the least restrictive, medically appropriate environment.
- Fostering social, behavioral and physical well-being of members.
- Promoting good health outcomes.
- Identifying and resolving any barriers to care.
- Coordinating needed services (i.e. transportation, provider visits, financial support, safety).
- Developing relationships with primary care providers, specialists and community service agencies by providing assistance in attaining needed services for the complex and/or at-risk member.

The goal of the ICM program is to:

- Provide high quality, integrated, culturally competent care management services to members with high medical and/or non-medical care management needs to improve health outcomes, prevent avoidable admissions and emergency room visits.
- Facilitate member/provider engagement.
- Promote member/caregiver satisfaction.
- Meet regulatory requirements.

Behavioral/Medical Integrated Care Management:
Members with Behavioral Health needs are referred to MetroPlusHealth's Behavioral Health vendor for care coordination.

The goal of ICM Case Management is to provide holisitic care management but in the event the member has significant co-occurring behavioral health or HIV needs, the ICM care manager may co-manage the member with a BH or HIV care manager.

Integrated care management conferences are conducted as needed to assist members in receiving comprehensive integrated services.

High-Risk OB Program:
The MetroPlusHealth High-Risk OB Program focuses on attaining positive health outcomes for both mother & newborn. The Care Management Program partners with Obstetrical providers to promote early entry into prenatal care for members identified with a High-Risk diagnosis.

A Care Manager (CM) ensures that the pregnant member's needs are met through a complete initial assessment, planning, implementation and evaluation once they have been stratified a High-Risk pregnancy.

Education is provided to the member to increase understanding about pregnancy risks and necessary interventions allowing the member to develop a realistic pregnancy and delivery plan.

The goal is a healthy delivery for mother and newborn> 39 weeks gestation, decrease NICU

and low birth weight deliveries, increase postpartum examinations compliance prior to 56 days post-delivery, and complete newborn Pediatric follow-up within 1 week of birth.

If your member is pregnant and is high-risk, please notify the Case Management department using our confidential **fax number: 212.908.5190, Attn: High-Risk OB Care Manager.** Our clinical staff will contact the member to facilitate services like:

- OB provider selection.
- Screening for the high-risk OB program.
- Assistance with scheduling appointments.
- Transportation
- Identifying a pediatrician for the member's newborn.
- WIC and other community referrals.

Children with Special Care Needs:
Our stratification algorithm is applied to all members, this facilitates the identification of children with special health care needs (chronic debilitating conditions; disabilities; behavioral, developmental or emotional conditions) that may require health and related services to maintain or improve their health status and to prevent deterioration of their health.
In addition to providing the care coordination activities outlined in this document, care managers where applicable interact with school districts, pre-school services, early intervention officials, behavioral health and developmental disabilities service organizations to coordinate and assure appropriate delivery of needed services.

Children receiving Blood Clotting Factor receive care management which includes, but is not limited to:

- Providing care coordination.
- Interacting with providers, schools, members/caregivers.
- Developing a person-centered care plan.
- Ensuring continuity of care and access to needed services.

Members, their caregivers, Providers, and others as appropriate may access these services by calling MetroPlusHealth Member Services at **1.800.303.9626**.

Health Risk Assessment (HRA):
The Quality Department conducts Health Risk Assessment (HRA) for all new Medicare DSNP members. This information is populated into MetroPlusHealth's care management system, Disease Case Management System (DCMS). The care management staff has access to all completed HRAs and reviews this information as part of care plan development. For Managed Medicaid members, the HRA is available on the member portal, and the Case Management Department is made aware of any urgent issues Interdisciplinary teams reviews the HRA and plan of care as needed or required by regulation.

8.1.2 Behavioral Health Care Management and Outreach Program

Behavioral health services are provided by MetroPlusHealth. Upon discharge from inpatient psychiatric or chemical dependence care, members receive post-discharge outreach from a behavioral health Care Manager. This outreach is intended to facilitate aftercare appointment attendance and offer support and education regarding treatment compliance with the goal of improving health outcomes. Behavioral Health Care managers conduct telephonic outreach and are also available to meet members at facilities and/or in the field. Peers can also be engaged to deliver these services.

By design HARP (Health and Recovery Plan) and other eligible members are encouraged to join Health Homes to receive enhanced care coordination services.

The HARP program is a recovery model of care which emphasizes and supports a person's potential for recovery by providing the utmost support to fragile members with significant behavioral and medical health conditions.
The HARP program is designed to optimize the quality of life and reduce symptoms of mental illness and substance disorders through empowerment, personal choice, treatment, educational, vocational, housing, and health and wellness goals. The HARP benefit offers a broad range of services that support recovery journeys such as Home and Community Based Services (HCBS) and Community Oriented Recovery Empowerment Services (CORE) that can be delivered at a member's home and or social setting.

Effective February 1, 2022, four Adult Behavioral Health Home and Community Based Services (BH HCBS) have transitioned to Community Oriented Recovery Empowerment (CORE) Services. New York State is making this change to improve access to services and use the expertise of clinicians and rehabilitation practitioners to support the eligibility and intake process. CORE Services provide opportunities for Adult (21 years and older) HARP enrollees and Adult HARP eligible in HIV SNP with mental illness and or substance use disorders to receive services in their own home or community.

The four CORE services are:

- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation (PSR)
- Family Support and Training (FST)
- Empowerment Services – Peer Support

The two Adult BH HCBS Short-term and Intensive Crisis Respite services have transitioned to Crisis Intervention Benefit Crisis Residence services covered in the benefits package for Adult Medicaid Managed Care enrollees, aged 21 years and older.
The following Adult BH HCBS remain unchanged:

- Habilitation
- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Non-Medical Transportation

CORE Services require a written recommendation of a Licensed Practitioner of the Healing Arts (LPHA). Providers are not required to send the LPHA form to MetroPlus Health. Providers must send a Provider Service Initiation Notification form to MetroPlus Health within three (3) business days after the member's first Intake & Evaluation for CORE service(s)

This enhanced set of benefits encourages hope and a return to a healthier lifestyle for members who may have previously failed in routine psychiatric settings. Using the guiding principles related to our Company's Core Values, the Behavioral Health and HARP leadership team will aim to empower their staff to build trust and practice transparent communication to positively impact both member and provider relationships.

Members with a serious behavioral health disorder as well as a complex or chronic co-morbid medical condition are also eligible to receive care management services. Care management

services are particularly encouraged for members with a history of treatment and/or medication non-compliance as well as members who are dually diagnosed with a serious mental illness and substance use disorder.
Members in the Behavioral Health Care Management and Outreach Program receive regularly scheduled outreach calls and/or visits to support a greater level of treatment compliance. The care manager also maintains contact with both participating medical and behavioral care providers to ensure proper treatment.

8.2 Health Education Classes

Many of the larger MetroPlusHealth Participating Provider sites offer a range of health education classes that our members may attend free of charge. Topics covered in these classes include:

- Health maintenance and wellness.
- Diet and nutrition.
- Maternal health and childbirth.
- Diabetes.
- Asthma education.
- Childhood weight management.
- Parenting.
- Smoking/vaping cessation.
- Living with HIV/AIDS.

If a provider or member is interested in additional information, they should contact the facility for specific information on health education classes.

9. Medicaid HIV Special Needs Plan, Partnership in Care

9.1 HIV Specialist Primary Care Providers

An **HIV Specialist PCP** is an HIV-experienced provider who meets the MetroPlusHealth PCP credentialing criteria for Family Practice, Pediatrics, Internal Medicine, Adolescent Medicine or Infectious Disease, and is available a minimum of 16 hours per week over at least two days at each primary care site where they will provide care. Nurse practitioners and physicians may be credentialed as an HIV Specialist PCP. Physician Assistants who provide HIV primary care under the supervision of an HIV Specialist Physician may be considered physician extenders, subject to their scope of practice limitation under New York State Law.

9.1.1 Waiver of Minimum Hours for Primary Care Providers in the Special Needs Plans

An HIV-experienced provider who practices fewer than 16 hours per week but is available 8 or more hours per week at the same facility may request a Waiver of Minimum Hours. HIV Services will submit a request on behalf of the provider to the NYSDOH/AIDS Institute, subject to the guidelines established by and approval of the NYSDOH/AIDS Institute.

Providers requesting a Waiver of Minimum Hours must demonstrate to the Plan:

a) a designated practitioner is named for backup.
b) patients are cared for by a well-defined care team.
c) There are systems in place to guarantee continuity of care and to meet all SNP access and availability standards; and
d) members will be educated about how the primary care model operates in the facility and how their care will be coordinated, including the name of the primary care provider and the system for backup.

HIV Specialist PCP assigned member ratios are based on a 40-hour workweek full-time

equivalent (FTE). HIV Specialist PCP physicians and nurse practitioners may have no more than 350 SNP members per FTE. A physician HIV Specialist PCP practicing with a physician extender may have no more than 500 SNP members per FTE. Assigned member ratios are prorated for HIV Specialist PCPs with fewer than 40 hours per week.

9.1.2. Credentialing and Re-credentialing of HIV Specialist PCPs

An HIV Specialist Primary Care Provider is an HIV-experienced PCP who meets any one of the following nationally-recognized definitions of an HIV-experienced provider.

9.1.2.1 HIV Medicine Association (HIVMA) definition of an HIV-experienced provider

Providers must meet one of the following criteria:

- Completed board certification or recertification in Infectius Diseases by the American Board of Medical Specialties or the American Osteopathic Association in the preceding 36 months; OR
- Completed fellowship training in Infectious Diseases accredited by the ACGME or AOIA in the preceding 36 months; OR
- Meet criteria for all three categories identified below:
  - Patient management – Management of at least 25 patients with HIV longitudinally in the preceding 36 months; AND
  - Continuing Medical Education – At least 45 hours of HIV-related continuing medical education in the preceding 36 months, earning a minimum of 15 hours per year; AND
  - Board Certification or Significant Clinical Experience – Board certification or equivalent in one or more specialties or subspecialties recognized by the American Board of Medical Specialties or the American Osteopathic Association is preferred; OR significant clinical and professional experience in HIV medicine, defined as a minimum of at least five years

9.1.2.2 American Academy of HIV Medicine (AAHIVM) certification as an HIV Specialist

American Academy of HIV Medicine (AAHIVM) certification as an HIV Specialist is available, through AAHIVM, to MD, DO, and NP practitioners with a current valid license, patient care experience and evidence of completion of 45 credits or hours of HIV and/or HCV-related continuing education. Providers seeking AAHIVM certification or recertification may contact AAHIVM directly (https://aahivm.org) for further details.

Providers with limited patient experience may register for the AAHIVM Clinical Consult Program. This program, administered by AAHIVM, is designed to pair the “lower volume” applicant with the more experienced provider for the duration of the credentialing period, offering an ongoing, personal one-on-one relationship. The relationship is intended to be a professionally supportive connection to assist the lower volume provider with particular clinical questions or other matters related to his or her HIV patient panel.

9.1.2.3 HIV/AIDS Nursing Certification Board (HANCB) certification as an Advanced AIDS Certified Registered Nurse (AACRN)

Certification is available to Nurse Practitioners and is valid for 4 years. Recertification may be granted by re-Examination or by Continuing Education Points (CEPs). Nurse Practitioners seeking AACRN certification or recertification should contact the HIV/AIDS Nursing Certification Board (www.hancb.org).

9.1.3. HIV Continuing Medical Education

All HIV experienced providers should be knowledgeable in or attend CME programs addressing:

- Antiretroviral therapy in the ambulatory care setting.
- Latest information about HIV disease and treatments.
- State-of-the-art diagnostic techniques including resistance testing.
- Immune system monitoring.
- Strategies to promote treatment adherence.
- Management of opportunistic infections and diseases.
- Management of HIV infected patients with commonly associated co-morbid conditions.
- Access and referral to clinical trials.
- Pre-exposure prophylaxis for high-risk individuals.
- Post-exposure prophylaxis protocols and infection control issues.
- Care coordination with other Providers for specialty care.
- Patient education including risk reduction/harm reduction counseling.

9.1.3.1. Obstetric CME

In addition to the topics outlined in 9.1.3, above, an HIV experienced provider also credentialed in Obstetrics should be knowledgeable in, or attend CME programs that address:

- Factors associated with perinatal HIV transmission including appropriate use of antiretrovirals for prevention of perinatal HIV transmission consisting of antepartum, intrapartum and newborn regimens as well as the risks, benefits and indications for cesarean delivery versus vaginal delivery for reduction of perinatal transmission.
- Importance of immune system/viral load monitoring during pregnancy.
- Use of antiretrovirals for maternal health including risks and benefits to the fetus and mother.
- Importance of prenatal HIV counseling and testing for pregnant women.
- Collaboration with an HIV Specialist for long-term care of the mother.
- NYSDOH regulations regarding counseling and testing, newborn testing and expedited newborn testing.

9.1.3.2. Pediatric CME

In addition to the topics outlined in *Section 9.1.3* above, a Pediatric HIV Specialist should be knowledgeable in, or attend CME programs addressing:

- Factors associated with perinatal HIV transmission including transmission from breastfeeding.
- Preventive therapy for the newborn to prevent perinatal HIV transmission.
- Diagnostic testing schedule for the HIV-exposed infant including interpretation of HIV tests in the newborn, other appropriate diagnostic tests, and recommended testing schedules.
- Prophylaxis guidelines for HIV-exposed and infected infants.
- Immune system monitoring including the normal range of CD4 counts in children at different ages.
- Antiretroviral treatment of an HIV-infected infant or child including the timing of initiation, pharmacokinetics of antiretrovirals in infancy and childhood, appropriate antiretroviral combinations and their side effects, and special adherence issues.
- Regulations regarding newborn testing and expedited testing.
- Immunization schedule for infected infants and non-infected infants in homes with HIV infected person(s).
- Issues related to disclosure of HIV status to children within affected families and management of HIV-infected children in school and daycare settings.

9.2. Co-Management with HIV and Non-HIV PCPS
Members with a life-threatening or degenerative and disabling disease or condition, which requires prolonged specialized medical care, may receive a referral to a Specialty Care Provider (SCP) who will function as the coordinator of primary and specialty care for that member. If the SCP does not meet the qualifications of an HIV PCP, a co-management model must be employed in which an HIV PCP assists the SCP in an ongoing consultative relationship as part of routine care. In such cases, the HIV PCP continues with primary responsibility for decisions related to HIV-specific clinical management in coordinating with the SCP. Co-management is evidenced by the documentation of ongoing written communication between the HIV PCP and the designated SCP in the member's medical record.

In the event that an HIV SNP member does not have a Participating Provider with the appropriate training and expertise to meet the particular health needs of a member, MetroPlusHealth will make a referral to an appropriate Non-Participating Provider upon approval of a treatment plan by the HIV SNP in consultation with the PCP, the Non-Participating Provider and the member or member's designee.

9.3. HIV-Negative Special Populations
Members identified as homeless or transgender may enroll with the Partnership in Care program. Children (up to age 21) of Partnership in Care members may also qualify, even if they are HIV-negative.

MetroPlusHealth expects that designated providers will make every effort to identify homeless and transgender persons at the point of care. Providers are expected to screen identified individuals for co- morbidities, including, but not limited to psychoactive substance use, mental illness, tuberculosis, hepatitis, and sexually transmitted infections. Providers, also ensure linkages to treatment and interventions that are culturally, developmentally and linguistically appropriate, assess for potential barriers in adhering to therapy, under a comprehensive plan of care.

9.4. SNP Access to Care Guidelines

9.4.1 24 Hour Access
All PCPs must provide a way to reach a clinician, either directly or through a covering Participating Provider, to medical services for members on a 24 hours a day, 7 days a week basis. All PCPs and OB/ GYNs must also ensure that pregnant members have the same access to OB/GYN services.

9.4.2 Walk-ins
PCPs must have policies and procedures addressing members presenting for unscheduled walk-in visits, particularly for adolescents and substance users

9.4.3 PCP Appointment Availability Standards
Members in need of an adult baseline assessment or routine physical exam must be seen within 4 weeks of enrollment.
Initial appointments for PCP office visits for newborns must occur within 48 hours of hospital discharge. For non-urgent matters, the member must be scheduled for an appointment within 48 to 72 hours as clinically indicated. For urgent medical or behavioral problems, the member must be scheduled for an appointment within 24 hours of the request.

9.4.4 Missed Appointments

To facilitate continuity of care, prevention of illness and maintenance of health, PCPs are held to additional standards for the follow-up of missed appointments. PCPs must take the following actions after a missed appointment:

- Canceled appointments must be rescheduled within one week.
- Members without telephones must be mailed a letter.
- Members requiring "urgent" review should be contacted by telephone and, if unsuccessful, by telegram.
- All follow-up attempts must be documented in the member's chart.
- Members with four or more missed appointments should be referred to a care manager to ascertain any psychosocial problems that may be affecting adherence.
- Notify the member's designated care manager if a problem arises with the member's care so they can facilitate problem-solving.

9.5 New Member Outreach

MetroPlusHealth conducts new member outreach within 30 days of the effective date of enrollment. Contact attempts are made by phone, mail and text message; Upon successful contact, a member is provided with:

- Plan policies with respect to obtaining Benefits Package services, including services for which the member may self-refer, procedures for obtaining standing referrals, the use of specialty care centers, the use of a specialist as a primary care provider, and what to do in an emergency.
- A brief health screening to assess the enrollee's need for any special health care (for example, prenatal or behavioral health services) or language/communication needs. When a special need is identified, the Plan assists the member in arranging an appointment with their PCP or another appropriate provider on a timely basis.
- Information regarding basic primary and preventive services specific to the care, treatment, and prevention of HIV infection, as well as the advantages of new treatment regimens and therapies and information on different primary care options, if available, such as those that provide co- located primary care and substance use services.
- Assistance in arranging an initial visit to the Enrollee's PCP for a baseline physical and other preventive services, including a comprehensive risk assessment.

9.6 Verification of HIV SNP Enrollment Eligibility

9.6.1 Verification for HIV-Positive Special Populations

HIV positive SNP members may be enrolled in the Plan, subject to verification of HIV infection within ninety (90) days of the effective date of enrollment. Acceptable verification of HIV infection shall include one of the following laboratory test results or other diagnostic tests approved by the AIDS Institute:

(a) HIV antibody screen assay.
(b) Viral Identification Assay (e.g., p24 antigen assay, viral culture, nucleic acid [RNA or DNA] detection assay); or
(c) CD4 Level Measurement of less than 200. For patients currently under treatment without diagnosis- confirming laboratory results and with undetectable viral load, a physician's statement verifying HIV status will be accepted when other verifying tests are not available.

9.6.2 Verification for HIV-Negative Special Populations

Members identified on the Human Resources Administration (HRA) homeless roster likewise qualify for the Partnership in Care program and may remain enrolled in the Special Needs

Plan until the member has achieved an extended period of housing stability. Homeless members enrolled in the SNP will be considered HIV-unverified until confirmation of HIV-positive status has been obtained by the Plan.

Members identified as homeless qualify for the Partnership in Care plan and can remain enrolled for an indefinite period until the member has achieved permanent housing. To be verified as homeless, the member must have evidence of having accessed services in DHS shelters or drop-in centers. If the member is not connected to DHS, then an attestation by a certified organization providing homeless services to the member can suffice.

Members identified as transgender also qualify for the Partnership in Care plan. Acceptable verification of transgender status include a signed and dated statement from a physician, nurse practitioner or physician assistant who has treated, or reviewed and evaluated the gender related medical history of the member including language that the member has undergone appropriate clinical treatment as someone diagnosed with gender dysphoria. In lieu of the provider statement, the member can provide a copy of a Certified Amended Birth Certificate; a passport; a New York State Driver's License; a Non-Driver ID card; or a statement from the Social Security Administration reflecting the change in gender designation.

9.7 Care Management Services

The HIV SNP provides member-centered case management services that link the member to timely, coordinated access to medically appropriate levels of care and services that support adherence to care and wellness. The Partnership in Care Program provides a range of care and benefits coordination to enrolled members:

- Medical case management/care coordination services in consultation with the PCP;
- Assessment and service plan development that identifies and addresses the enrollee's medical and psychosocial support needs;
- Service utilization monitoring and care advocacy services that promote enrollee access to needed care and services, including treatment adherence services and education; primary and secondary prevention education; health promotion assistance and partner/spousal notification assistance;
- Case manager provider participation in quality assurance and quality improvement activities.

9.7.1 Medical Case Management

Every SNP member will be assigned to a medical case manager within 30 days of the effective date of enrollment. Medical Case Management is provided to the member, in consultation with the primary care provider (PCP) at the primary care site, and/or, with appropriate member consent, by a Health Home and/or other community-based case management service. The Medical Case Manager coordinates any medical and psychosocial support services needed by the member. The maximum caseload for an FTE medical case manager is 150 active SNP members.

Activities of the medical case manager include, but are not limited to:

- Screening for eligibility, assistance in completing applications for entitlements, referral to special benefit programs.
- Advocating and negotiating on behalf of a member/family.
- Documenting changes that may have an impact on a member's functioning and making appropriate referrals.
- Arranging for services that support a member's ability to remain at home.

- Maintaining a system for tracking members to ensure that they are not lost to follow-up.
- Contacting members to ensure that services are received.
- Case conferencing with service providers and other involved case managers.
- Crisis intervention, including assessment and intensive short-term treatment of acute medical, social, or emotional distress.

The member should be evaluated for case management needs, including psychosocial support service's needs, within 30 days of enrollment and once every trimester thereafter, but not less than once every 180 days thereafter. If the member elects not to receive psychosocial case management, this should be documented in the member record and reviewed with the member at least every 180 days, or if changes in condition warrant or if the member requests psychosocial support services.

All enrolled members of a household will be assigned to the same Medical Case Manager, absent special circumstances warranting an alternate case manager assignment.

When indicated, a referral to a Health Home Case Management program can substitute for a medical case management assignment. Such referral will be documented in the PCP medical record.

When indicated, a referral to a psychosocial support services provider or community-based organization is made to address the member's psychosocial support needs. Such referrals will be documented in the PCP medical record.
In certain circumstances where the PCP site does not provide on-site case management and prior arrangement has not been made by the PCP to refer the member to case management services, the Plan may offer medical case management services on an interim basis until a referral is made. The Plan will notify the member and the provider regarding the availability of case management services at an alternate facility.

9.7.2 Psychosocial Support Services
Psychosocial/Non-Intensive Case Management includes HIV/AIDS social support service providers, including those funded through the Ryan White CARE Act, and other community-based providers offering case management services and non-intensive psychosocial case management:

Individual or group HIV prevention and risk reduction services, education, and counseling services;	Community education;
Treatment education to support and promote adherence to treatment regimens;	Housing and supportive services for the homeless;
Substance use treatment readiness;	Shelters and other providers of services or victims of domestic violence;
Harm reduction and needle exchange;	Services to migrants;
Counseling and assistance with partner/spousal notification;	Nutritional services;
Permanency planning and transitional service providers;	Transportation services to supportive services;
	Legal services

9.7.3 Health Home Case Management
Health Home Case Management is offered to those members requiring intensive medical case management coordination and/or coordination of psychosocial support service needs.

Participating Providers are expected to refer members who need intensive case management services to a certified Health Home program. The services may be provided at the Participating Provider site or at a designated community-based organization. The Health Home Case Manager is responsible for the coordination of services between the different case managers providing services to the member.

9.7.4 Service Utilization Monitoring and Care Advocacy

After receiving a New Member Orientation and Health Assessment within 30 days of enrollment, MetroPlusHealth assigns every member to a SNP Health and Wellness Advisor who implements a member- centered Plan of Care within 60 days of enrollment. The member-centered plan of care focuses on:

Treatment adherence;
Mental health;
Substance use
Safer sex/family planning;
Coordination and access to specialty medical care

With the appropriate consent of the member, the SNP Health and Wellness Advisor communicates significant findings and coordinates information exchange between the Plan, the member, the member's PCP, and other Case Management and psychosocial support service providers, including, as necessary, multidisciplinary case conferencing.
The SNP Health and Wellness Advisement Team conducts subsequent reviews of the member's service utilization and care advocacy needs at regular intervals, approximately every 180 days, including hospitalizations and ER visits, provider referrals and care advocacy efforts provided on behalf of the member.

9.7.5 Linkage Agreements

MetroPlusHealth has an established linkage agreement for community-based psychosocial support services, including case management, treatment adherence, and harm reduction services through its contracted Health Home network. Referral information is available in the MetroPlusHealth *Provider Directory* and online at www.metroplus.org.

9.7.6 Quality Monitoring

The PCP's member medical record will reflect evidence of ongoing case management through communication and coordination with the Medical Case Manager and other case management providers and case conference activities involving all service providers engaged in the care of the member. The PCP or the HIV Medical Director and/or Administrator of each facility will ensure the quality of case management programs by monitoring, at a minimum, the following:

- Completeness and timeliness of initial needs assessment.
- Appropriateness of case management services.
- Adequacy of care plans and care plan reassessments.
- Service utilization.
- Allocation of an adequate number of case management staff to meet identified capacity.

MetroPlusHealth monitors case management services provided to members through:

Member telephonic outreach;
Chart review;
Utilization review;
Claims monitoring;
Quality improvement studies;
Member satisfaction surveys

Information on case management programs is available from the Partnership in Care Program office.

9.8 Clinical Guidelines for the Treatment of HIV
MetroPlusHealth adopts guidelines for the medical management of HIV, namely Adult and Adolescent guidelines, Pediatric guidelines, Perinatal guidelines, including interventions to reduce perinatal HIV transmission, prevention and treatment of opportunistic infections, health-care worker exposure guidelines and non-occupational exposure considerations. These guidelines are updated periodically due to the addition of new medications and technologies used in the care of individuals living with and affected by HIV. Providers are advised to refer to these websites at least annually. The websites that MetroPlusHealth recommends most often can be accessed at www.AIDSinfo.nih.gov and www.hivguidelines.org.

9.8.1 Adult Member Management Guidelines
The HIV PCP, in collaboration with the member's health care team and support network, creates customized treatment plans which address the complex medical, psychosocial, economic and environmental issues surrounding adherence to the prescribed treatment plan. MetroPlusHealth HIV SNP will support HIV PCPs to ensure best care practices. MetroPlusHealth also recommends guidelines published by the NYSDOH AIDS Institute that can be accessed at www.hivguidelines.org.

In alignment with these guidelines, a baseline (and subsequently annual) examination should include:

- A complete gender- and age-appropriate medical history (including substance use history, smoking/vaping and sexual history, if appropriate) conducted in vocabulary or language that members can understand without regard to education level.
- A full physical examination.
- Screening for cervical cancer screening and STI screening (including for Gonorrhea and Chlamydia).
- Screening for colorectal cancer (preferably by colonoscopy), breast cancer, and prostate cancer, as appropriate.
- A mental health screening that includes but is not limited to assessments of cognitive function, appetite, behavior, depression, sleep, anxiety, and post-traumatic stress disorder, as well as a screening for domestic violence.
- An alcohol and substance use screening using selected brief screening instruments; at-risk drug and alcohol users should be screened more frequently to identify escalation of present levels of use or harmful consequences from use.
- Immunizations when clinically indicated (see www.hivguidelines.org for more details).
- Appropriate laboratory tests (such as CD4 count and HIV-1 viral load tests), health maintenance screening tests (e.g. annual syphilis screening and tuberculosis skin testing) and appropriate use of opportunistic infection prophylaxis, quantification of antiretroviral adherence, subspecialty referrals as needed (e.g., Gynecologist, Ophthalmologist, Dentist, Endocrinologist, Psychiatrist, Smoking/Vaping Cessation services and Podiatrist).
- Access and referral to approved needle exchange programs, if indicated.

Before initiating antiretroviral therapy (ART), HIV PCPs should consider the following:

- Assess a member's willingness, readiness to start and ability to adhere to treatment.
- Weigh start decisions against clinical factors such as CD4 count, viral load, and HIV related symptoms as well as social factors such as living environment, mental health, HIV disclosure to others, pregnancy, substance use and health beliefs.

- Ensure that the member is an active, engaged partner in the decision-making process and is educated about how ARVs work and their potential adverse effects of therapy as well as on the development of drug resistance with non-adherence to the medication regimen.
- Make an assessment of treatment adherence, proper dosing, side effects and toxicity of medications at each visit including quantification of ART adherence over a specified period of time.

Clinicians should monitor HIV RNA levels and CD4 counts according to the intervals recommended by HIVguidelines.org. Follow-up visits should be scheduled more frequently as clinically necessary to address non-HIV-related conditions, secondary prevention, and issues that may affect adherence to ART or retention in care, such as substance use, mental health disorders, unstable housing, or need for supportive services.

As emphasized in the NYSDOH U=U Policy Statement and detailed in HIVguidelines.org, the U=U concept is a "driving force to accelerate the achievement of New York State's Ending the Epidemic goals." Specifically, U=U aligns with numerous efforts to dismantle HIV-related stigma and improve the health, well-being, and self-esteem of all people living with HIV, particularly by removing fear from their sexual and romantic relationships and combating the isolation they may experience. The statement further elaborates that "Endorsing U=U opens a new and hopeful chapter in New York State's HIV epidemic, creating unprecedented opportunities for New Yorkers living with HIV and the institutions that serve them."
Treatment Adherence / ART Adherence Strategies:

- Develop open lines of communication with the member to facilitate frank discussions regarding barriers to adherence.
- All medications, both prescribed and non-prescribed, should be evaluated at each visit to minimize the risk of drug interactions.
- Perform quantitative assessments of ART adherence at each visit. The results of this discussion should be correlated to lab results to determine if the member is appropriately virologically suppressed and if resistance testing is warranted. If deficiencies are noted, then an assessment of barriers to adherence is necessary and a plan should be formulated to address identified barriers.
- Provide medication counseling (including side effects, long-term and short-term toxicities) as well as consider offering adherence supports such as pre-packed pill boxes or blister packs to the patient to address medication storage, confidentiality or housing issues.
- Coordinate with pharmacists to determine patient refill habits as pertaining to prescribed medication.
- Consider the provision of reminder tools to ensure adherence with ART such as beepers, watches or a written daily schedule of medications.
- Instruct how to proceed if medication dosages are missed.
- Provide support to address food insecurity and poor nutrition
- Assess adherence with medical appointments/tests at every visit.
- Coordinate with social work or mental health workers or care managers as necessary to ensure patient adherence to an annual mental health and substance use screening to identify underlying behavioral health issues and to ensure that they have fully accessed available social benefits and supports depending on their needs.
- Referral to a psychiatrist for evaluation, if there is evidence that behavioral health issues are contributing to member non-adherence with ART
- Provide access to transportation (such as MetroCards, as outlined in *Section 2.1*) and/or health-related incentives for members to reduce barriers to medical care.

- Provide referral to support groups as necessary.
- Provide non-judgmental ongoing substance use assessments for those members that are actively using or have used substances. HIV PCPs should provide routine HIV risk-reduction counseling and behavioral health counseling for HIV-infected patients.
- Consider referral to alternative/adjunctive therapy such as massage, acupuncture, acupressure, aromatherapy, biofeedback as necessary.
- Provide referral to intensive care management services such as Health Home if the patient needs multi-disciplinary support beyond the scope of the care management at the HIV PCP's office.

9.9 HIV Prevention/Risk Reduction Services

Sexual history taking can be an onerous and awkward task that does not always provide accurate or useful information for patient care. Standard risk assessment questions (e.g., How many partners have you had sex within the last 6 months? How many times did you have receptive anal sex with a man when he did not use a condom?) may be alienating to patients, discourage honest disclosure, and communicate that the number of partners or acts is the only component of sexual risk and health.

In contrast, the GOALS framework is designed to streamline sexual history conversations and elicit information most useful for identifying an appropriate clinical course of action.

The GOALS framework was developed in response to 4 key findings from the sexual health research literature:

- Universal HIV/STI screening and biomedical prevention education is more beneficial and cost- effective than risk-based screening.
- Emphasizing benefits—rather than risks—is more successful in motivating patients toward prevention and care behavior.
- Positive interactions with healthcare providers promote engagement in prevention and care.
- Patients want their healthcare providers to talk with them about sexual health.
  HIV PCPs must ensure that the following prevention/risk reduction services are available and provided, or accessed via referral, to members when appropriate:
- HIV risk screening.
- Information and health education on HIV risk.
- HIV testing.
- Partner notification services including risk screening for family violence.
- Information on harm reduction and needle exchange programs.
- Information on safer sex, sexually transmitted infection (STI) treatment and prevention and condom use.
- Information about Undetectable = Untransmittable as a key HIV prevention strategy. People with HIV should be on ART immediately after an individual's HIV positive status is known. ART treatment is lifelong.
- Education and counseling on the opportunity to effectively eliminate perinatal transmission through HIV treatment.
- Baseline history and physical examination and laboratory evaluation.
- Social work evaluation to anticipate financial needs, eligibility for entitlements, need for counseling and long-range planning such as childcare, power of attorney, health care proxy, etc.
- Individualized care plan based on clinical presentation, laboratory data, psychosocial issues and stage of illness.

- Teaching health-promoting behaviors to enhance immunocompetence such as nutrition, exercise, stress management, etc.
- Arranging for medical follow up at scheduled intervals.
- Monitoring lab data to ensure that antiretroviral therapy and prophylaxis protocols are followed appropriately.
- Monitoring of clinical status at least quarterly.
- Evaluating adherence to therapy with an emphasis on lifetime suppressive ART.
- Identifying development of drug resistance to prescribed therapies.
- Teaching symptom management to members and care partners.
- Arranging for hospitalization on an as-needed basis.
- Arranging and coordinating support services such as physical therapy, home care, hospice care, etc.
- Providing education and referrals to clinical trial and experimental treatments, as appropriate.

9.10 Maternal, Pediatric and Adolescent Healthcare

HIV PCPs are responsible for making appropriate referrals and documenting the timely exchange of clinical information among gynecological, prenatal, delivery, pediatric and adolescent settings. For care identification, HIV PCPs should:

- Counsel all adolescents and members of childbearing age who present with risk factors.
- Identify pregnant members and members with infants to ensure early entry and access to care and to diagnose or rule out HIV infection.
- Assess risk issues at the annual physical evaluation, including sexual activity and substance use, as well as issues regarding home environment, history of violence, family history and school.
- Use sensitivity when asking questions about a history of physical and sexual abuse, sexual assault, and suicidal ideation, gestures or attempts.
- Know that the right to consent to or refuse HIV testing in New York State is based on a person's capacity to understand, without regard to chronological age, what an HIV antibody test detects, the implications and consequences of being HIV infected, and why they are at risk for HIV. However, there is no requirement to obtain written or oral consent for the HIV test.
- Test HIV-exposed newborns/infants to establish HIV infection status and follow NYSDOH recommended diagnostic schedules for HIV RNA or DNA PCR testing, that is, within 48 hours of birth, and at two weeks, four to six weeks, six to twelve weeks and four to six months of age.

A baseline physical examination should include:

- A complete gender and age-appropriate medical history.
- A full physical examination.
- A pelvic examination including STI screening as indicated for persons with a vagina or cervix who have had sexual intercourse or have an unexplained gynecological problem.
- A mental status examination that includes, but is not limited to, assessment of general mood, depression, suicidal ideation and attempts and an abbreviated examination for cognitive function.
- Immunizations when clinically indicated.
- Laboratory tests that are necessary to get a composite picture of the member's health.

Clinicians should recommend ART to all patients with HIV infection. Clinicians should evaluate and prepare patients for ART initiation as soon as possible; completion of the following should not delay initiation:

- Discuss benefits and risks of ART with the patient.
- Assess patient readiness

- Identify and ameliorate factors that might interfere with successful adherence to treatment, including inadequate access to medication, inadequate supportive services, psychosocial factors, active substance use, or mental health disorders.

Additionally, clinicians should:

- Involve patients in the decision-making process regarding initiation of ART and which regimen is most likely to result in adherence. The patient should make the final decision of whether and when to initiate ART.
- If the patient understands the benefits of rapid initiation but declines ART, then initiation should be revisited as soon as possible.
- Assess treatment adherence, proper dosing and toxicity at each visit.
- Follow HIV positive members at least once every three months and conduct laboratory evaluations.
- Discuss, on an ongoing basis, issues regarding birth control, safe sex, and partner notification.

When making psychosocial intervention referrals, HIV Provider team members should identify drug treatment programs, community-based organizations and counseling and support programs that are focused to address and support members' presenting needs (see the MetroPlusHealth Community Based Organization Resource Directory). Adolescent-focused services need to be age- and developmentally- appropriate and be familiar with New York State laws pertaining to adolescents' rights to consent to certain forms of health care.
The MetroPlusHealth Partnership in Care staff helps to facilitate access for adolescent members to HIV PCPs who are knowledgeable about adolescent development, HIV treatment, methods of reducing the risk of transmission and methods of effective communication with teens. HIV PCPs treating adolescents should be aware of the diverse populations of HIV infected youths that may include perinatally infected, gay, transgender, pregnant, substance-using and homeless adolescents. Interventions and referrals should be individualized and address issues with sensitivity and skill and include, but not be limited to:

- Comprehensive developmental assessments.
- Early intervention services including physical, speech and occupational therapies.
- Child, teen and women-specific services.
- Oral health services.
- Linkages to clinical trials.

9.11 Homeless Healthcare

PCPs should routinely assess patients for ongoing homelessness and evaluate for co-morbidities, including substance use, mental illness, hepatitis, tuberculosis, and sexually transmitted infections. Linkages to treatment interventions that are culturally, developmentally and linguistically appropriate are necessary to develop a comprehensive plan of assessment and treatment to address potential barriers to adherence to antiretroviral therapy.

PCPs are responsible to identify new and existing members who are homeless by completing a comprehensive assessment at the member's first office visit, including inquiries about the member's housing status and documenting the housing status in the member's medical record; reassessment should occur at least annually.

To facilitate access for a member who is identified as homeless, HIV PCPs must:

- Ensure that members are seen within one hour of their appointment time or within two hours of presenting without an appointment, and
- Assign a designated case manager who will assist the member with:
  - Obtaining needed support services.

  - Scheduling and keeping appointments.
  - Arranging transportation.
  - Obtaining, safely storing, and taking all medications as directed.
  - Accessing all entitlements.
  - Creating an individualized multi-disciplinary comprehensive care plan that is updated at least every 180 days.
- Ensure that a physician is responsible for the medical management of the member if in the hospital and, in consultation with the member's case manager, that they will:
  - Assess the member's post-discharge medical, mental health, substance use and housing needs; and
  - Develop a discharge plan for the member that identifies appropriate interventions, including safe placement in the community or a recuperative facility and specifying the first post- discharge appointment.

Once engaged in care, MetroPlusHealth expects that designated providers refer to clinical guidelines adapted for homeless individuals such as those issued by the National Health Care for the Homeless Council; these resources were developed with consideration the unique challenges presented by homelessness that may limit an individual's access to needed services or ability to adhere to a plan of care.

If a member does not present for an appointment with the Provider within six consecutive months of the effective date of enrollment, the Provider must notify MetroPlusHealth Partnership in Care staff who will conduct targeted outreach efforts.

9.12 Transgender Healthcare

PCPs should strive to establish a safe, welcoming and culturally appropriate clinic environment to facilitate having transgender individuals seek and stay engaged in care. This means, at minimum, incorporating an affirming, non-judgmental approach to the patient-provider relationship. Attention to the physical aspects of the clinical environment is also important, such as ensuring that at least one gender-neutral bathroom be made available and, ideally, that the waiting area features transgender- themed media and art.
A gender-affirming approach to the history and physical exam is indicated, both to determine the patient's preferred terminology and to focus on the anatomy that is present, regardless of gender presentation, and without assumptions as to anatomy or identity.

MetroPlusHealth expects that designated providers follow existing guidelines and standards of care for the provision of culturally and linguistically competent care to transgender individuals such as those issued by the World Professional Association for Transgender Health (WPATH) and/or the University of California San Francisco (UCSF) Center of Excellence for Transgender Health Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.

9.13 Mental Health and Alcohol/Substance Use

Formal assessment instruments such as those designated by the NYSDOH AIDS Institute are used by HIV PCPs during initial and subsequent patient assessments to:

- Identify members who require mental health and alcohol/substance use services.
- Determine the types of mental health and alcohol/substance use services that should be furnished.

MetroPlusHealth supports Participating Providers in accessing formal training and in the use

of the above-mentioned assessment tools and in techniques for identifying individuals with unmet behavioral health care needs. With a member's consent, any Partnership in Care care manager or Behavioral Health Provider may contact a member they believe to need mental health or alcohol/substance use services and attempt to arrange for an evaluation of their needs.

9.14 Clinical Trials

HIV PCPs must be knowledgeable about the availability of clinical trials to facilitate access to information and early entry into trials for members who express interest or who could benefit from selective new research modalities. Before referring a member to a clinical trial, HIV PCPs should verify that:

- The member has a life-threatening or disabling condition or disease.
- Standard health services or procedures have been ineffective or would be medically inappropriate.
- A more beneficial health service or procedure is not available in current practice.
- The clinical trial, as documented from available medical and/or scientific evidence, is believed to be more beneficial to the member than any standard health service or procedure.
- An appropriate Institutional Review Board (IRB) has given approval for the investigational/ experimental treatment.

The interdisciplinary team, including the Partnership in Care Program Office and the member's care manager, will be in ongoing contact to ensure coordination of the treatment continuum. Information on the availability of clinical trials can be found at www.acria.org.

9.15 Disenrollment from the Partnership in Care HIV Special Needs Plan

9.15.1 Voluntary Disenrollment from the Partnership in Care Special Needs Plan

Members can enroll in a SNP plan at any time. When they enroll in the SNP, they can change to a different Plan in the first 3 months. After 3 months, they must stay in the Plan for a total of 12 months before they can change Plans again, unless they have a good reason. Some examples of good reasons include:

- The Plan cannot provide a suitable primary care provider for the member within acceptable travel times (providers are routinely within 30 minutes or 30 miles from where the member lives).
- The Plan does not meet New York State requirements and members are harmed because of it.
- The member moves out of the Plan service area.
- The member, the Plan, and New York City Human Resources Administration (LDSS) all agree that disenrollment is in the best interest of the member.
- The member is or becomes exempt or excluded from managed care.
- The Plan does not offer a Medicaid managed care service that the member can get from another health plan in the member's service area.
- The member needs a service that is related to a benefit the Plan has chosen not to cover and getting the service separately would put the member's health at risk.
- The Plan is not able to provide services to the member as required under the contract with the State.

An Enrollee may disenroll from the Contractor's plan at any time, for any reason. The Member calls NY Medicaid Choice at **1.800.505.5678** or New York State of Health **1.855.355.5777** for assistance.

9.15.2 Member Becomes Ineligible for Medicaid Managed Care and Special Needs Plans:
A member (and/or her/his child) may have to leave the Partnership in Care SNP if the member (or the child):

- Moves out of the County, the service area, or New York City.
- Changes to another managed care plan.
- Joins an HMO or other insurance plan through work.
- Joins a long-term Home Health Care Program.
- Is incarcerated for one or more months.
- becomes a permanent resident of a nursing home. A child may have to leave the SNP if she/he.
- Joins a Physically Handicapped Children's Program, or

In some cases, a member may be guaranteed 6 months of coverage by the SNP. The Plan will not disenroll the member if they are no longer eligible for Medicaid and their Medicaid case is closed. The reasons for losing eligibility must not be related to death, moving out of state, or incarceration. During this time the member can get the services that the Plan covers. The member can also get pharmacy and family planning care using her/his Medicaid card. Guaranteed coverage does not apply if the member chooses to disenroll from the Plan, or if the Plan must disenroll the member because she/he does not keep appointments.

9.15.3 Disenrollment
The Plan can ask the Human Resources Administration that a member be disenrolled from the Plan if the member:

- Refuses to work with her/his PCP regarding care.
- Does not keep appointments.
- Goes to the emergency room for non-emergency care.
- Does not follow Plan rules.
- Does not fill out forms honestly or does not give true information (commits fraud).
- Acts in ways that make it hard for the Plan to provide care to the member and other members even after the Plan has tried to fix the problem.
- Causes abuse or harm to Plan members, providers or staff.

9.16 Discharge Plan
Each member disenrolled from the Plan will receive a written discharge plan to assist the member to obtain needed services and ensure continuity of care.
9.16.1 HIV Uninsured Care Programs
If a member loses Medicaid coverage, they may be eligible for the New York State Department of Health, HIV Uninsured Care Programs (also known as ADAP). The programs provide limited coverage for the care and treatment of HIV. If the member has private health insurance, they also may be able to get help paying for insurance premiums. The member can call **1.800.542.AIDS (2437)** for more information.

9.17 Quality Management and Improvement Program
All PCPs must participate in our Quality Management and Improvement Program. Adherence to access, clinical and service standards for Participating Providers and cooperation with the exchange of information between HIV SNP Providers and MetroPlusHealth is required. Medical record review for a sample of HIV SNP adult and pediatric members every six months for evidence of initial needs assessment and coordination of care and annually for NYSDOH/CMS QARR data collection. Specific reviews may also be conducted to assess Participating Provider adherence to the HIV/AIDS Clinical and Preventive Health Guidelines established by MetroPlusHealth and the NYSDOH AIDS Institute.

Additional details of the Partnership in Care Special Needs Plan Quality Management program are outlined in *Section 10*.

10. Quality Management

10.1 Quality Management Program, Improvement Plan and Evaluation

10.1.1 Quality Management Program

The goals and objectives of the Quality Management Program (QMP) are to support MetroPlusHealth in realizing its mission. The QMP provides a framework and processes that will facilitate the continuous improvement in medical (including pharmacy and dental) and behavioral health care and service provided to MetroPlusHealth's complex, culturally and linguistically diverse membership. Activities and Program content are derived largely from the New York State Department of Health (NYSDOH) Article 44, New York State AIDS Institute, OASAS, CMS MAPD and SNP and IPRO requirements and the National Committee for Quality Assurance (NCQA) performance standards.

The MetroPlusHealth Quality Assurance Performance Improvement Committee (QAPI) acts on behalf of the Board of Directors to oversee MetroPlusHealth' Quality Management Program. The Quality Management Program is the vehicle through which MetroPlus Health Plan measures, analyzes and responds to collected data and program measurement processes. The QAPI oversees the organization's performance improvement activities and monitors and manages progresses toward annual quality improvement goals. The QAPI includes Participating Provider representatives active in making decisions regarding all aspects of MetroPlusHealth's Quality Management Program.

10.1.2 Quality Management Program Description

Each year, MetroPlusHealth develops a Quality Management Program Description which sets forth the work or content of the Quality Management Program for the year. The annual program description includes the goals and measures for the year aimed at continuously improving access, quality of care and services. Annual goals and measures, at minimum, encompass the following:

- Member Satisfaction
- Provider Satisfaction
- Customer Service
- Access and Availability
- Member and Provider Complaints
- Utilization Management
- Case Management
- Behavioral Health
- Managed Long-Term Service and Support
- Pharmacy
- Network Management
- Credentialing and Re-credentialing
- Compliance with Clinical Treatment, Preventive Health and Public Health Guidelines
- Clinical Focus/Quality Improvement Studies
- The NYSDOH Quality Assurance Reporting Requirements (QARR) and HEDIS
- CMS Reporting Requirements

The annual program description is submitted to the QAPI Committee for approval. Participating Providers are required, as requested, to participate in the quality measurement and improvement projects outlined in the annual program description. A copy of the annual program description is available to participating Providers and members upon request.

10.1.3 Quality Management Program Evaluation

The annual Quality Management Program Evaluation provides a mechanism for determining the extent to which the annual quality improvement activities have contributed to the quality of care and service provided to our members. A summary of this evaluation is available to participating Providers and members upon request.

10.2 Participating Providers and Improvement Plans

Providers should be compliant with all MetroPlusHealth performance standards established contractually, documented in this Manual or disseminated in writing during the year including compliance with appointment access and availability standards and continuity and coordination of care standards:

- Compliance with MetroPlusHealth's approved clinical treatment and preventive health guidelines and Public Health Guidelines
- Incident reporting
- Monitoring adherence to MetroPlusHealth performance standards for areas in which functions have been delegated to a Participating Provider or other entity by MetroPlusHealth

Participating Providers should measure, monitor and manage compliance in these areas to ensure ongoing contractual compliance and continuous improvement in all areas of operation. MetroPlusHealth will periodically collect data in these areas to monitor contractual compliance.

10.3 Investigation and Reporting of Quality of Care Complaints

Quality of Care (QOC) issues can be identified during Care Management, Utilization Review, Behavioral Health, Provider Relations, Regulatory Affairs or through Customer Services, or any other MetroPlusHealth business unit. Additionally, providers and/or members can report quality of care complaints/grievances directly to MetroPlus. Upon receipt of a QOC complaint/grievance, the Quality Risk Reviewer will conduct an initial investigation. The purpose of the initial investigation is to review the care that was rendered and to ascertain the provider's policies and procedures or medical protocols regarding the situation and whether the provider appears to have followed nationally recognized clinical guidelines/protocols in the case of the given incident/concern.

The Quality Risk Reviewer will also collect race/ethnicity and language data to help monitor health care disparities and identify differences in care delivered to specific population groups. The Quality Risk Reviewer will summarize the QOC complaint for review by the appropriate Medical Director for review. Complaints about clinical matters shall be reviewed by one or more licensed, certified or registered health care professionals. From time-to-time additional information may be requested and may also include expert opinion. Final determination on QOC complaints are made by the appropriate Medical Director who provides sign-off on all cases.

The Provider will be asked to submit a corrective action plan for all Quality of Care complaints that are substantiated.

10.4 Corrective Action Plans

When a provider's performance does not adhere to established clinical practice guidelines, or if the provider fails to meet any obligation provided for within this manual or their contractual obligations with MetroPlusHealth, the Plan reserves the right to issue a corrective action plan (CAP) from the Provider. The purpose of requesting the corrective action plan is to ensure that the Provider takes steps to address the issues underlying poor performance to attain performance compliance/improvement going forward. When a Provider does not make sufficient progress on a corrective action plan, continues to be non-compliant with performance standards, or has required corrective action plans in multiple areas over the

course of time the Medical Director will review the Provider's performance and determines next steps.

On a quarterly basis, the Quality Assurance Performance Improvement Committee (QAPI) will review provider performance related to Corrective Action Plans. If the QAPI finds that the Provider has failed to complete the CAP within the agreed timeframe and/or has repeatedly failed to meet the established performance standard, then the QAPI Chairperson will refer the case to the Credentialing Committee. The Credentialing Committee will further review the Provider's performance and will determine the next steps, which may include enacting provider disciplinary action and/or termination.

10.5 Provider Performance Profile
MetroPlusHealth publishes monthly Provider performance profiles based on administrative (claim) and supplemental data. PCPs are compared statistically on a range of indicators including but not limited to the MetroPlusHealth Pay-for-Performance Program and the HEDIS/QARR Reportable dataset. Participating Provider sites are also given their results on the final reported HEDIS/QARR indicators on an annual basis. It is anticipated that this data will be applied to each site's quality management programs to improve performance over time. Each time the Provider is presented with this data, MetroPlusHealth will give Participating Providers the opportunity to discuss the unique nature of their patient population, which may account for variation in the statistics, and to work collaboratively with MetroPlusHealth to improve performance.

10.6 Quality Measurement Results and Continued Provider Participation
Quality measurement results for individual Participating Providers consisting of, at minimum, member complaints incidents, and quality of care concerns will be placed in Participating Provider files for consideration during re-credentialing. During the re-credentialing decision-making process, MetroPlusHealth or its delegate will look for trends over time in the occurrence of incidents or quality of care issues or in performance standard compliance. Participating Providers are expected to have successfully improved their level of care and services and/or completed corrective action plans.

MetroPlusHealth strongly encourages and supports providers in the use of outcome measurement tools for all members. Outcome data is used to identify potentially high-risk members who may need intensive behavioral health, medical, and/or social care management interventions.

MetroPlusHealth' BH Operations team would report provider performance deficiencies and corrective actions related to performance issues to Provider Contracting and Network Relations. Network Relations would monitor these performance issues and report their findings to Provider Contracting Performance could be measured by failing appointment availability surveys over time, member complaints, questionable billing practice, etc. An essential aspect of MetroPlusHealth's contracts with the State of New York OMH and OASAS is to report at least quarterly regarding provider performance deficiencies and corrective actions related to performance issues. In addition, MetroPlusHealth will report any serious or significant health and safety concerns to OMH and OASAS immediately upon discovery.

10.7 Clinical Focus Studies, Improvement Programs and HEDIS/QARR
Each year, MetroPlusHealth, alone or in conjunction with the NYSDOH or other entities, conducts clinical focus studies. These studies target a specific aspect of care or a specific

clinical population and often address Participating Providers' adherence to clinical treatment or preventive health guidelines. The study results are used to establish a baseline for future quality improvement initiatives or to assess the success of implemented improvement interventions.

MetroPlusHealth also works on various quality improvement activities (QIAs) and targeted, focused studies throughout the year to improve the care and service members receive. These include quality improvement projects that focus on improving various aspects of behavioral health. Preventive health, chronic care and member experience. QIA's are conducted for all QARR/HEDIS measures and follow a PDSA process.

For its Medicare product lines, MetroPlusHealth maintains a Chronic Care Improvement Program (CCIP). The CCIPs focus is on promoting effective management of chronic disease. MetroPlus uses various sources of data to identify members for this study and is required to submit reports to CMS on progress throughout the study initiative.

Additionally, MetroPlusHealth participates annually in collecting and analyzing data for HEDIS for Medicare, UltraCare, QHP and QARR for the CHPlus, Medicaid, HIV SNP, HARP and Essential Plan product lines. Medical record and administrative claim data is reviewed for a series of quality indicators encompassed in the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) standardized measurement methodologies. HEDIS plus state- specific indicators comprise the New York State Department of Health Quality Assurance Reporting Requirements (QARR). Participating Providers are required to assist with collecting data for these studies and for HEDIS/QARR as needed. This includes ensuring access to member medical records for quality review when needed. MetroPlusHealth will disseminate the results of HEDIS/QARR performance to Participating Providers when they become available. Participating Providers are expected to review the results within their own quality management programs and improvement plans and/or complete quality improvement goals or corrective action plans based on the results, if requested by MetroPlusHealth.

10.8 Medical Records

10.8.1 Medical Record Availability and Record-Keeping Systems

Upon request, Participating Providers are required to submit medical records for review by MetroPlusHealth or government oversight agencies as required for quality and utilization management, complaint investigation and program oversight. At minimum, Participating Providers will be given two business days to submit requested records. Depending on the nature of the request, maximum timeframe to comply is thirty days. Failure to provide records as requested by MetroPlus could lead to denial of payment, recoupment or offset of previously paid claims, contract termination, and/or reporting to applicable federal or state reporting agencies.

Medical records of members shall be confidential and shall be disclosed to and by other persons within MetroPlusHealth, including Participating Providers, only as necessary to provide medical care, to conduct quality functions and peer review functions, or as necessary to respond to a complaint and appeals.

Participating Providers are required to maintain organized medical record-keeping systems. Such systems should ensure that records can be retrieved using more than a one-member identifier. Participating Provider medical record-keeping systems should ensure that member records can be retrieved immediately for both individual Provider review in caring for members

and, as needed, for health plan review. The actual content of medical records should be organized to ensure that critical medical information could be gleaned quickly by Providers in the event of a medical emergency. Records should contain sections appropriate to the practice type and information within those sections should be filed in chronological order. Medical records should include the following:

- Maintain a separate medical record for each member
- Verification that the PCP coordinates and manages care
- The medical record is required to be retained for a period of six years after the date of service rendered to members and for a minor, six (6) years after majority
- For prenatal care, a centralized medical record is required for the provision of prenatal care and all other services
- Access to medical records is required by MCO, NYS DOH, CMS LDSS and/or IPA for UR and QA.

10.9 Preventive Health Guidelines

MetroPlusHealth has adopted preventive health guidelines for the prevention and early detection of illness and disease. MetroPlusHealth has adopted guidelines for Participating Providers' use in the following categories:

- Children's Health 0-18 years old
- Preventive care for adults 19-21 years old
- Women's Health
- Pregnant Women's Health

Each of these guidelines describes the prevention or early detection interventions and the recommended frequency and conditions under which the interventions are required. The scientific sources or authorities upon which these guidelines are based are cited on each guideline summary. These guideline summaries are contained in *Appendix IIA* and *Appendix IIB*.

MetroPlusHealth suggests that all members be screened for drug use, mental health disorders (including depression and anxiety) and social determinants of health. We have included two useful screening tools for drug use and depression that providers may wish to adopt (see *Appendix XVI*).

10.10 Clinical Practice Guidelines

MetroPlusHealth adopts and disseminates Evidence-Based Guidelines for the provision of acute and chronic care services that are relevant to our population in all lines of business. Clinical Practice Guidelines serve as a decision support tool for our contracted providers and members. Medical Directors and care management leadership regularly review clinical practice guidelines to determine how they should be incorporated into the care planning process. These guidelines aid in establishing practices consistent with national standards of care and with standardization of these practices network-wide, thereby reducing unnecessary variation in care. Adopted guidelines are regularly reviewed and updated whenever national guidelines change, but no less than every two years. When the guidelines change, they are updated for the providers. Updated CPGs are communicated to the providers through provider newsletters, provider portal and the MetroPlusHealth provider website. They are also available in print form upon request. MetroPlusHealth measures performance against several important aspects of the guidelines annually. The plan monitors compliance with clinical practice and preventative health guidelines through HEDIS' measure medical record review.

Clinical Practice Guidelines are not intended as a substitute for the professional assessment of the practitioner but are to be used as a tool to assist in the management of certain types of preventive and clinical care. Individual patient treatment may vary. To access the clinical

practice guidelines please see Appendix V or log onto the MetroPlusHealth Provider Portal.

Because HIV/AIDS treatment guidelines change frequently, HIV providers are directed to specific links, such as www.AIDSinfo.nih.gov and www.hivguidelines.org. HIV/AIDS treatment guidelines are updated at least annually and/or as necessary to maintain compliance with recommended NYS DOH AIDS Institute and federal government clinical standard.

The final guidelines summary and all updates are presented and reviewed in the Medical Policy Subcommittee (MPS) meeting for approval. The MPS will establish and adopt, as necessary, publishable Medical and Behavioral Health Guidelines through consultation with actively practicing specialty matched clinical peer reviewers and through research of professional and regulatory source. The Guidelines will then be moved to the Quality Management Committee (QMC) for final approval.

The Quality Management Department will monitor medical publications and City and State Department of Health communications for announcements of changes in national and local guidelines. When national guidelines change, or every two years (whichever occurs first) the guideline summary will be updated.

10.11 Communicable Diseases and Public Health Guidelines

MetroPlusHealth shall make reasonable efforts to assure timely and accurate compliance by participating providers with public health reporting requirements relating to communicable diseases and conditions mandated in Article 21 of the NYS Public Health Law and for Contractors operating in New York City, the New York City Health Code (24 RCNY §§11.03-11.07).

Appendix VII contains a list of resource guides available from MetroPlusHealth regarding communicable diseases and Public Health Guidelines. Changes in practice guidelines are regularly communicated to Participating Providers through the *MetroPlusHealth Provider Newsletter* and/or through City and State Medicaid and Health Department updates.

MetroPlusHealth shall make reasonable efforts to assure timely and accurate compliance by Participating Providers with other mandated reporting requirements, including the following:

- Infants and toddlers suspected of having developmental delay or disability. Providers may contact 311 and ask for Early Intervention to refer members to early intervention programs. The provider will be asked to complete an Early Intervention Program referral form and fax the form to the regional office in the child's borough of residence. The Early Intervention Program is available to all eligible New York City babies, young children, and their families, regardless of race, ethnicity, income, disability or immigration status. Please visit the Early Intervention provider information website at https://www1.nyc.gov/site/doh/providers/resources/early-intervention-information-for-providers.page to learn more about the early intervention program.
- Suspected instances of child abuse.
- All Participating Providers have the responsibility to report tuberculosis (TB) cases to the local Public Health Agency.
- Participating Providers will screen and treat members for STIs and report cases of STIs to the LPHA and cooperate in contact investigation, in accordance with existing state and local laws and regulations.
- Participating Providers will comply with lead poisoning screening and follow-up as specified in 10 NYCRR Subpart 67-1. Participating Providers will coordinate with the LPHA

to assure appropriate follow-up in terms of environmental investigation, risk management and reporting requirements.

- **Immunizations** – Providers are required to report all immunizations given to members to the New York City Immunization Registry. Additionally, Participating Providers may obtain member immunization histories from the Registry.
- **Lead poisoning prevention** – Providers are required to report all lead test results to the New York City Lead Registry.

Public Health Guidelines encompass communications regarding the following:

- **Maternal health**
- **Adolescent preventive health services**
- **Foster child health care**
- **Smoking/Vaping cessation** – NYC DOHMH has protocols for referring members to the State's Smokers Quitline and for assessing and referring members for smoking/vaping cessation services. Most members are also eligible for smoking/vaping cessation related medications and aids through their pharmacy benefit.
- **Family violence prevention** – Providers should screen all new patients, at annual exams and when family violence is suspected
- **Injury prevention** – providers are expected to implement recommendations from the American Academy of Pediatrics for injury and violence prevention among children.
- **Informed consent for hysterectomy and sterilization** – Providers must have a signed consent form on file which indicates the member understands the sterilization must be considered permanent and not reversible. Participating Providers will comply with the informed consent procedures for Hysterectomy and sterilization specified in 42 CFR Part 441, subpart F, and 18 NYCRR § 505.13
- **Severe Acute Respiratory Syndrome (SARS)** – Providers are expected to report any suspected cases immediately to the Bureau of Communicable Diseases, as per Section 2.1 of the New York State Sanitary Code.

10.12 Communicable Disease Protocols and Regulations

HIV/AIDS

In New York City in 2019, there were more than 1,396 people newly diagnosed with HIV, 268 of whom also had a concurrent diagnosis of AIDS, an advanced stage of HIV disease. It takes an average of 10 years from the time someone is infected with HIV before she or he develops AIDS. People infected with HIV who are not aware of their diagnosis cannot benefit from medications that could keep them healthy and prevent death or serious illness associated with AIDS. Another benefit of earlier diagnosis of HIV infection is the potential of improved immune recovery once treatment is started, especially for those individuals over the age of 50 years.

Someone with HIV who is not diagnosed may spread the infection to others without their knowledge. Per the CDC, people who have HIV but are in care, taking HIV medicines, and have a consistently undetectable viral load have effectively no risk of transmitting HIV (https://www.cdc.gov/hiv/risk/art/index.html).
Delayed diagnosis of HIV is harmful to both the person living with HIV and the community.

The number of new HIV diagnoses per year has declined modestly in the last several years in the United States. Currently, there are more people living with HIV in the US than ever before, and there is concern that we are falling behind in our efforts to contain the spread of HIV. The only way to get ahead of the epidemic is to identify the estimated 1 in 7 of all infected people who are unaware of their HIV diagnosis. The CDC, NYSDOH and NYC DOHMH agree that the promotion of HIV testing in health care settings is a critical component of the fight against

HIV and AIDS.

HIV/AIDS Testing, Reporting and Confidentiality of HIV-Related Information (Effective Date: May 17, 2017)

SUMMARY
Effective April 1, 2014, amendments contained in the 2014-15 enacted New York State budget authorized certain changes to HIV testing in New York State. These amendments simplified HIV testing as part of routine medical care, improved linkage to care, and made New York State law consistent with Centers for Disease Control and Prevention (CDC) recommendations for routine HIV screening in healthcare settings.
Effective April 1, 2015, amendments contained in the 2015-16 enacted New York State budget authorized the elimination of the requirement of written consent for HIV testing in New York State correctional facilities.

Effective November 28, 2016, amendments contained in Chapter 502 of the Laws of 2016 require that, at a minimum, the individual be advised that an HIV-related test is going to be performed, that no such test be performed if the individual objects, and that any objection by the individual be noted in the individual's medical record. Chapter 502 also expands the requirement to offer HIV testing to individuals over the age of 64.

Effective March 28, 2017, Chapter 461 of the Laws of 2016 allows disclosure of confidential HIV- related information to qualified researchers for medical research purposes upon the approval of a research protocol under applicable State or federal law.

Key provisions of these regulation amendments implementing the legislation include:

- Removing the requirement for informed consent prior to ordering an HIV-related test, including the elimination of written consent for HIV testing in New York State correctional facilities, and removing references to consent forms.
- Adding a provision stating that performing an HIV test as part of routine medical care requires at minimum advising that an HIV-related test is being performed, prior to ordering an HIV-related test.
- Removing the reference to the expiration of an individual's informed consent.
- Adding a provision authorizing local and state health departments to share HIV surveillance information with health care providers, including entities engaged in care coordination, for purposes of patient linkage and retention in care.
- Clarifying language pertaining to reporting by blood and tissue banks.
- Inserting updates to the list of reportable HIV-related test results that need to be reported. These updates are consistent with the CDC and the Association of Public Health Laboratories guidance related to the diagnosis of HIV infection. Additionally, reporting of results for NYS residents and NYS-located clinicians is explicitly required. This change was designed to address known gaps in reporting.
- Including language specifically stating that reports must include the requesting provider and facility. The requirement is expected to improve the quality of provider data and lead to more complete data. This should improve the accuracy of the Department's surveillance data and, consequently, the National HIV/AIDS Strategy retention and care measures.
- Removing the requirement that the information on HIV provider reporting forms associated with newly diagnosed cases of HIV infection be reported within 60 days.
- Adding individuals who were previously diagnosed as HIV positive, and who are at elevated risk of transmitting HIV to others, to the contact notification prioritization process.

- Removing the requirement that data on the partners of HIV cases be destroyed after three years and stating that the Department will establish a policy for "record retention and schedule for disposition."

All pregnant women should be tested for HIV infection as early in pregnancy as possible. Retesting in the third trimester (i.e., preferably before 36 weeks' gestation) is recommended for women at high risk for acquiring HIV infection (i.e., women who use illicit drugs, have STIs during pregnancy, have multiple sex partners during pregnancy, or have HIV-positive partners). Pregnant women found to be HIV positive should be referred to an HIV specialist and subsequent care should be carefully coordinated between the HIV specialist and an obstetrician experienced in the care of HIV and pregnancy.

All patients seeking treatment for STIs, including all patients attending STI clinics, should be screened routinely for HIV during each visit for a new complaint, regardless of whether the patient is known or suspected to have specific behavioral risks for HIV infection.

Free Confidential or Anonymous HIV Rapid HIV Testing/Counseling is also available at the NYC Department of Health Sexual Health Clinics in all five boroughs for persons seeking these routes for testing. Providers and members can call NYC 311, the New York City government information and non-emergency services line, for days and hours of operation.

For additional information about HIV counseling and testing and the changes to the law, please visit the New York State Department of Health website (https://www.health.ny.gov/diseases/aids/providers/testing/) or the New York City Health Department website (https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv.page). Questions not addressed here or on the websites may be sent to hivtestlaw@health.state.ny.us.

STIs

Providers must educate members about the risk and prevention of STIs. Providers are required to screen and treat members for STIs and report cases of STIs to the Local Public Health Agency (LPHA) and cooperate in contact investigation in accordance with existing state and local regulations. A comprehensive guide to STI screening can be accessed at https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm.

Subpopulations requiring more frequent screening for syphilis, gonorrhea, and Chlamydia include pregnant women under 25 years of age, sexually active women under 25 years of age, men who have sex with men at least annually and every 3 to 6 months if at increased risk (i.e, MSM on PrEP, with HIV infection, or if they or their sex partners have multiple partners, and people with HIV. Additional risk factors for gonorrhea include inconsistent condom use among persons who are not in mutually monogamous relationships; previous or coexisting sexually transmitted infections; and exchanging sex for money or drugs.

A comprehensive guide to STI treatment can be accessed at: www.cdc.gov/std/treatment

Tuberculosis

Participating providers must educate members about the risk and prevention of Tuberculosis (TB) and report cases of TB to the Local Public Health Agency (LPHA).

Participating Providers are responsible for reporting communicable and conditions mandated in Article 21 of the NYS Public Health Law and, for Contractors operating in New York City,

the New York City Health Code (24 RCNY §§ 11.03-11.07)
MetroPlusHealth will monitor Participating Provider adherence to communicable disease protocols, regulations and reporting as well as compliance with Public Health Guidelines.

10.13 Sterilization Consent
MetroPlusHealth Medicaid members have family planning coverage that includes sterilization.

In addition to the provision of information at the initial counseling session, the physician who performs the sterilization must review important information with the patient prior to the procedure. Reimbursement is only available if the requirements are met.

Sterilization of a mentally competent individual aged 21 or older:
(a) The individual is at least 21 years old at the time consent is obtained;
(b) The individual must be mentally competent and able to consent to sterilization
(c) The individual must not be institutionalized (involuntarily confined to a correctional, rehabilitation, or mental illness treatment facility or voluntarily confined to a mental illness treatment facility)
(d) The individual has voluntarily given informed consent in accordance with all the requirements described under "Informed Consent" below; and
(e) At least 30 days, but not more than 180 days have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Informed Consent:
(a) Informing the individual. An individual has given informed consent only if:
1. The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have concerning the procedure, provided a copy of the consent form and provided orally all of the following information:
    i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled
    ii. A description of available alternative methods of family planning and birth control
    iii. Advice that the sterilization procedure is considered irreversible
    iv. A thorough explanation of the specific sterilization procedure to be performed
    v. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used
    vi. A full description of the benefits or advantages that may be expected as a result of the sterilization
    vii. Advice that the sterilization will not be performed for at least 30 days, except for premature delivery or emergency abdominal surgery
2. Suitable arrangements were made to ensure that the information specified in paragraph (a)(1) of this section was effectively communicated to any individual who is blind, deaf, or otherwise handicapped
3. An interpreter was provided if the individual to be sterilized did not understand the

language used on the consent form or the language used by the person obtaining consent
4. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained
5. The consent form requirements of § 441.258 were met; and
6. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.
7. In New York City, individuals must sign a reaffirmation statement upon admission, acknowledging an understanding of the consequences of sterilization and reaffirming their desire to have the procedure

(b) When informed consent may not be obtained. Informed consent may not be obtained while the individual to be sterilized is:
1. In labor or childbirth;
2. Seeking to obtain or obtaining an abortion; or
3. Under the influence of alcohol or other substances that affect the individual's state of awareness.

To access the Sterilization Consent Form, visit our website and select "Forms" under the "Provider" tab https://www,metroplus.org/provider/forms

10.14 Early Periodic Screening Diagnosis (EPSDT) Services through the Child Teen Health Program (C/THP) and Adolescent Preventative Services

Child/Teen Health Program/Adolescent Preventive Services (C/THP) is a program of early and periodic screening, including inter- periodic screens and, diagnostic and treatment services (EPSDT) that New York State offers all Medicaid eligible children under twenty-one (21) years of age. Care and services are provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The care includes necessary health care, diagnostic services, treatment and other measures (described in §1905[a] of the Social Security Act) to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The program is designed to help families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance.

Effective 6/1/2022, coverage of Pediatric Vaccine Counseling visits for members under the age of 18 in the Medicaid and PIC (HIVSNP) members. The counseling visits are allowable when the member has not received the ACIP-recommended doses and does not have an appointment to receive the recommended dose. Physicians, Nurse Practitioners, Midwives, Outpatient clinics can be reimbursed for up to 6 Pediatric vaccine counseling visits per year as part of the EPSDT program. Provided per following billing criteria:

- as a stand-alone service when all the criteria specified in this guidance are met and documented.
- in addition to an (E&M) or Well-Child Visit when all the criteria of the vaccine counseling visit specified in this guidance are met and documented.
- in addition to all necessary components of the E&M/Well-Child visit, whether or not a recommended vaccine is administered, or vaccine administration is billed for, during the encounter.

POLICY FOR PROVIDERS

The childhood vaccine counseling session must be documented in the medical or pharmacy record and must include the following:

- confirming with the parent, guardian, caregiver, or patient (if appropriate) that the patient is not currently "up to date" with childhood vaccination doses (according to the ACIP Child and Adolescent Immunization Schedule, recommended for ages 18 years or younger, located at: https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html
- confirming vaccination status in the NYS Immunization Information System (NYSIIS) or City Immunization Registry (CIR), whenever possible;
- confirming the patient does not already have an appointment scheduled to receive the vaccine dose for which they are being counseled;
- reason(s) expressed by the parent or caregiver for vaccine hesitancy;
- recommendation of the vaccine(s);
- counseling the parent, guardian, caregiver, or patient (if appropriate), on the safety and effectiveness of the vaccine(s);
- answering any questions that the parent, guardian, caregiver, or patient (if appropriate) have regarding the recommended vaccine(s);
- counseling to the parent, guardian, caregiver, or patient (if appropriate) for a minimum of eight minutes;
- arranging for vaccination(s) or providing information to the parent, guardian, caregiver, or patient (if appropriate) on how the patient can get vaccinated.

Immunization Schedules for 18 & Younger View and print CDC recommended immunization schedules.

The Plan and its Participating Providers are required to provide C/THP services and comply with applicable Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements specified in 42 CFR Part 441, sub-part B, 18NYCRR Part 508 and the New York State Department of Health C/THP manual. The Plan and its Participating Providers are required to provide C/THP services to members under twenty-one (21) years of age when:

- The care or services are essential to prevent, diagnose, prevent the worsening of, alleviate or ameliorate the effect of an illness, injury, disability, disorder or condition.
- The care or services are essential to the overall physical, cognitive and mental growth and developmental needs of the member.
- The care or service will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for individuals of the same age as the member.

For more information on best practices for Early Hearing Detection and Intervention (EHDI)/Newborn Hearing Screening (NHS) and Early Intervention Program (EIP), please refer to Appendix XXXVII.

11. Children's Special Services Program

11.1 Provider Responsibilities

11.1.1 Children's Special Services Program

NYS is partnering with Medicaid Managed Care Organizations (MMCO) to manage the delivery of the expanded Medicaid-covered services for all Medicaid enrolled children. The goal is to fundamentally restructure and transform the health care delivery system for individuals under 21 that have medically complex conditions and/or behavioral health needs.

The goals of the NYS Medicaid redesign for children are to improve health outcomes, control Medicaid costs and provide care management for all Medicaid members that aligns incentives

for the provision of high quality. A key feature of the model is to create a community-based Medicaid managed care model where there is “no wrong door” for children/youth experiencing complex needs, including children with complex medical and behavioral health needs. NYS envisions a cross-system approach that diminishes silos of care and improves health outcomes for children well into adulthood.

MetroPlusHealth contracts with providers who have expertise in caring for medically fragile children, to ensure that medically fragile children, including children with cooccurring developmental disabilities, receive services from appropriate providers. Participating providers shall refer to appropriate network community and facility providers to meet the needs of the child or seek authorization from the Plan for out-of-network providers when participating providers cannot meet the child’s needs. MetroPlusHealth offers integrated physical health and behavioral health components of these programs.

To support integration and create better health outcomes for children and youth, NYS has taken the following key policy steps to stimulate the transformation:

- NYS has made available, via Medicaid State Plan Amendment (SPA), six new services that were previously not available or were only available to children who met narrow eligibility criteria. See Section 7.9.3 for additional information on transitioned children’s services.
- NYS has established level of care (LOC) and level of need (LON) criteria to identify subpopulations of children who are likely to benefit from an array of home- and community-based services (HCBS). The LON subpopulation will identify children prior to needing institutional care or as a step down from LOC. This population is at risk by virtue of exposure to adverse events or symptoms leading to functional impairments in their home, school or community
- NYS has consolidated six existing children’s 1015(c) waivers into one integrated array of HCBS for an expanded number of Medicaid eligible children allowing them to stay in their home communities to avoid residential and inpatient care.
- MetroPlusHealth complies with all State Medicaid guidance including:
  1. OMH Clinic Standards of Care: (https://omh.ny.gov/omhweb/clinic_restructuring/docs/standards-of-care-anchor-tool-clinic.pdf)
  2. OASAS Clinical Guidance: https://oasas.ny.gov/providers/clinical-support) https://oasas.ny.gov/system/files/documents/2021/10/clinical-standards-for-oasas-certified-programs.pdf
  3. Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care, Version 2, November9 Transition of Children Placed in Foster Care and 29-I Health Facilities into Medicaid Managed Care (ny.gov)
  4. OCFS Working Together: Health Services for Children/Youth in Foster Care Manual (https://ocfs.ny.gov/main/sppd/health-services/manual.php)
  5. OHIP Principles for Medically Fragile Children

11.1.2 Health Home Care Management for Children

Concurrent with managed care carve-in, children eligible for HCBS will be enrolled in Health Homes. The care coordination of service of the children’s HCBS will transition to Health Home unless the child opts-out of the Health Home. For members who opt-out of Health Home, an Independent Entity (IE), Maximus, will coordinate care. Health Homes will administer all assessments through the Uniform Assessment System which will have algorithms (except for

the foster care developmentally disabled (DD) and OPWDD care at home medical fragile developmentally disabled (CAH MF) populations) to determine functional eligibility criteria for HCBS.

MetroPlusHealth has been accepting Plans of Care (POCs):

a. For 1) their enrolled population or 2) a child for whom the Health Home Care Manager or Independent Entity has obtained consent to share the POC with the Plan and the family has indicated that the Plan selection process has been completed;
   i. Each transitioning and newly eligible child must have an updated POC completed every 6 months, or sooner if there is a qualifying event.

b. The transition of children in the care of LDSS/licensed VFCAs to managed care occurred on July 1, 2021, pending federal approval. The Plan will continue to accept POCs for children in receipt of HCBS in advance of the effective date of enrollment when the Plan is notified by another Plan, a Health Home Care Manager or the Independent Entity that there is consent to share the POC with the Plan and the family has demonstrated the Plan selection process has been completed, or for a child in the care of an LDSS-licensed VFCA, Plan selection has been confirmed by the LDSS/VFCA.

Transition of Populations into Medicaid Managed Care

Beginning April 1, 2019 statewide, the State removed the exemptions from Medicaid Managed Care enrollment for children in the following HCBS waivers with a physical, emotional or developmental disabilities diagnosis:

- OMH Serious Emotional Disturbance (SED) 1915(c) waiver (NY.0296)
- Bridges to Health (B2H) SED 1915(c) waiver (NY.0469)
- Bridges to Health (B2H) Medically Fragile 1915(c) waiver (NY.0471)
- Bridges to Health (B2H) DD 1915(c) waiver (NY.0470)
- DOH Care at Home (CAH) I/II 1915(c) waiver (NY.4125)
- Office for People with Developmental Disabilities (OPWDD) Care at Home (CAH) waiver

By October 1, 2019, the following had occurred:

- 1915(c) Children's Consolidated Waiver Services carved-in to Managed Care
- SSI children began receiving State Plan behavioral health services in managed care on July 1, 2019
- Implement Family Peer Support Services as State Plan Services in managed care and fee- for-service
- BH services already in managed care for adults 21 and older are available in managed care for individuals 19-21 (e.g. PROS, ACT, etc.)
- The three-year phase-in of Level of Care (LOC) expansion started on October 1, 2019
- Effective October 1, 2019, Medicaid-eligible children who meet at-risk LOC criteria may receive HCBS
- On October 1, 2019, Medicaid eligibility was expanded to children who meet at-risk LOC criteria and are determined Medicaid eligible through Family of One and receive HCBS

The following transition occurred on July 1, 2021:

- Children residing in a Voluntary Foster Care Agency are being mandatorily enrolled in managed care

Children/youth who continue to be excluded from enrollment in a managed care plan or who are exempt and choose not to enroll will continue to receive benefits via the fee-for-service (FFS) delivery system.

Medicaid enrollees ages 0-21 years of age may be eligible for Health Home services if they have two chronic conditions or one single qualifying condition. New York State has chosen

HIV, Serious Mental Illness (SMI), Sickle Cell Disease and for children Serious Emotional Disturbance (SED) and Complex Trauma as single qualifying conditions.
Individuals may be referred to Health Homes by the MCO, or other entities, including physicians, emergency departments, and community based providers, supportive housing providers, shelters, and family members. MetroPlus contracts with all the Children's Health Homes in its operating area to facilitate the linkage of potentially eligible children for care management.

Participating Providers in the Children's Physical and Behavioral Health program must comply with appointment availability standards by Service Type and Foster Care Initial Health Services listed in the tables below:

11.1.3 Eligibility and Assessment/Health Home, POC and HCBS for Children with Complex Medical, Behavioral, and Developmental Issues
Health Home is a care management service model for individuals enrolled in Medicaid with complex chronic medical and/or BH needs. Health Home care managers provide person-centered, integrated PH and BH care management, transitional care management, and community and social supports to improve health outcomes of high-cost, high need Medicaid members with chronic conditions. The State has tailored the Health Home model to the needs of children and families through the issuance of standards and guidance as well as the designation of Health Homes authorized to serve children. MetroPlus is contracted with the 5 Health Homes serving children and youth in our operating area.

Health Homes Goals:
- Reduce the utilization associated with avoidable inpatient stays
- Reduce the utilization of associated with avoidable ED visits
- Improve outcome for persons with mental illness or substance use disorders
- Improve disease-related care for chronic conditions
- Improve preventive outcomes
- Reporting to be done quarterly to evaluate improvement and effectiveness

Health Home Eligibility Requirements
To qualify for Health Home enrollment, children and youth must have a qualifying condition (Serious Emotional Disturbance, HIV, or trauma) or at have least two chronic conditions. Two qualifying chronic conditions include, but are not limited to, having mental health issues (including substance use), heart disease, diabetes, asthma, or hypertension.

Health Home Engagement and Oversight
MetroPlusHealth uses individualized reports and regular consistent feedback from Health Homes to monitor the efficacy and quality of care delivered to members. This includes monthly meetings to view assignment and status of assignments, challenges faced with enrolling members, billing, and the number of care plans submitted for approval. The Plan will keep a data base with information about the member assessments, assessment results, POCs (plans of care), requested and delivered HCBS. This data base will be used to ensure that members served by the plan will receive appropriate care.
MetroPlusHealth will track, monitor, and work with Health Homes and Home and Community Based Service (HCBS) providers to ensure providers understand and comply with HCBS provisions of the special terms and conditions of New York State 1115 Waiver Amendment, including but not limited to credentialing, how to maintain enrollee health and safety, how to

report financial accountability and enrollee documentation. MetroPlusHealth will make available to providers training and education material that reviews standards on enrollee evaluation, level of care and adequacy of the service plan while also collecting data in MetroPlusHealth's various platforms to ensure visibility into the aforementioned.

Coordinating with Health Home to promote HCBS Services

MetroPlusHealth is notified by New York State of a member's eligibility for HCBS services by Exception Codes assigned to the Medicaid ID. It is the responsibility of the assigned Health Home or CMA worker to complete such assessment which will then determine the level of appropriate need, or eligibility, to have additional services (HCBS) available to them. The Plan or community providers may refer members to Health Homes to be assessed for care management needs and eligibility for HCBS.

Reducing overall Emergency Department and Inpatient Physical and Behavioral Health admissions can be done by ensuring that both case management and utilization management are aligning with the community care managers who are interfacing directly with our members regularly. The goal is for members to experience the benefits of supportive HCBS as they mature and ultimately transition from child serving systems to adult serving systems.

Plan of Care (POC) Development

The HCBS Plan of Care (POC) is developed by the Health Home (HH) based upon the specialized needs of the member, incorporating the member's goals of care as well as his or her individual functional, medical, developmental, and psychosocial needs. The POC should be tailored to meet the individualized needs of the member. The MetroPlus Children's Special Services (CSS) care manager will monitor and evaluate the POC in relation to identified goals and make modifications or suggestions to the assigned health home as needed. The CSS CM will ensure the member receives all approved items and services the member needs including services requested by the member, physician, legal guardian, or other authorized party. The HCBS POC includes preventative services (e.g., annual dental care, physicals) and health education/ promotion services, including nicotine replacement services. Such service requests will be reviewed against plan guidelines and inclusion in the POC.

For those members/families who are hesitant to enroll initially within a Health Home for complete care coordination; they will be given the option to collaborate with an Independent Entity through Maximus called C-YES (Child and Youth Evaluation Services). C-YES may receive referrals directly from the member/family, community providers or Managed Care Organization (MCO). C-YES ensures children with Medicaid or SNP who are not enrolled within a specific Health Home, are still given the opportunity to access Children's HCBS. For children/youth who are not Medicaid eligible, C-YES may also assess eligibility for HCBS services and evaluate a child for Medicaid, Family of One. C-YES completes the initial Plan of Care (POC) and shares it with the MCO; thereafter, the MCO is responsible for care management and updating and maintaining subsequent POCs. The CM will regularly update the care plan, noting progress that has been made towards achieving the goals, conducting the interventions and/or addressing the barriers. If the member does not adhere to the care plan, this will be documented in the care plan and addressed with the interdisciplinary care team, which can include the member, his/her caregivers, and providers as well as various clinical staff and peers on the BH team. While members can refuse care management services, it is the goal of the CSS team to try to engage members as best as possible in their health and wellness.

1. Care and Service Needs

The POC will address all identified care and service needs of HCBS eligible members including the following as needed:

a. All active chronic problems, current non-chronic problems, and problems that were previously controlled and or classified as maintenance care but have been exacerbated by disease progression and/or other intervening conditions
b. All current medications taken by the member
c. For each need identified, the POC will state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated timelines in which to achieve the desired outcomes, and the individual responsible for conducting the interventions and monitoring the outcomes
d. All services authorized and the frequency and duration of the services authorized including any services that were authorized by the Plan since the last POC review was finalized and that needs to be authorized moving forward
e. A schedule of preventive service needs and requirements
f. Member's long and short-term goals; preferences and how they will be addressed, taking into consideration the member's expectations, characteristics, and previous daily routines; and method and frequency of evaluating progress toward goals
g. Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the member's highest feasible level of well-being
h. Known needed physical and behavioral health care and overall services
i. Member requests are taken into consideration during the POC review with the member. Since the MetroPlus CSS CM is a hybrid role of case management and utilization management, the MetroPlus CSS CM will coordinate updates to the POC with the Health Home case manager and create the requested authorizations.

2. Review Process

The Plan's review process for HCBS POC will include review and approval of a POC inclusive of HCBS.

a. HCBS will be managed in compliance with CMS HCBS Final Rule and any applicable New York State guidance.
b. The CSS CM will ensure that the POC was developed in a person-centered manner, compliant with federal regulations and state guidance, and ensuring that it meets the specific individual needs.
c. The person-centered POC development approach includes health education and health promotion services in the HCBS POC. This includes evaluation of chronic medical, behavioral, developmental, and psychosocial conditions. Goals include health promotion and recommendations for preventive care and ongoing care for chronic conditions, keeping in mind the guiding principles of recovery oriented mental health practice.
d. The CSS CM will ensure HCBS is authorized pursuant to a POC.
e. The CSS CM will utilize a data driven approach to identify service utilization patterns that deviate from any approved POC, conduct outreach to review such deviations and request appropriate adjustments to either service delivery or the POC.

3. Effectiveness of Plan Evaluation

On at least a quarterly basis, the MetroPlusHealth CSS CM will review various claims, medical and behavioral utilization, and pharmacy reports to evaluate the effectiveness of the member's POC and the overall care management plan to identify any deviation from services on the

HCBS POC. The primary mechanism for reporting, analyzing, and developing action items of the care management plans is presented to the BH UM subcommittee. The BH UM subcommittee provides oversight of the care management plans to ensure the effectiveness of care plan development and monitoring.

4. Service Delivery Confirmation and Review
Elements from assessments and available claims, utilization and pharmacy data are reviewed for confirmation of service delivery, or deviation, absence of approved POC service authorizations. For example, the MetroPlusHealth CSS CM will review claims data for service delivery or for supplies such as DME that were previously approved. Any deviations will be investigated by the MetroPlus CSS CM to ensure that member's needs are being sufficiently met. During the MetroPlusHealth CSS CM review process any gaps in care identified will result in a recommendation by the CSS CM to update the POC. The POC is tailored to meet the individualized needs of the member. In collaboration with the member's assigned Health Home and the member, the CSS CM will review, monitor, and evaluate the POC and any needed service authorizations in relation to identified goals and make modifications as needed to ensure services are delivered adequately and timely.

5. Frequency of Plan Review
The CM reviews the POC on a quarterly basis or as needed depending on any changes in the health status of the member. The CSS CM will review all aspects of the POC and monitor utilization to identify any change in health status and needs. The CSS CM will closely monitor for inpatient UM (utilization management) activity, alerting the community CMA and AOT workers of such admissions so that POC's can be updated if indicated, post-hospitalization discharge. POCs must be updated every 6 months, or earlier if there is a qualifying event like a hospitalization.

6. Plan of Care Security and Accessibility
The POC is saved and/or documented within the MetroPlusHealth care management system (DCMS), where it is maintained and accessible by the CSS CM. Proper system security measures including unique log-in and password protection, remote backup system is maintained to ensure security and confidentiality of member information

CSS HCBS WORKFLOW

- HH Care Manager conducts CANS (Child and Adolescent Needs and Strengths) Assessment to determine eligibility for Children's HCBS eligibility assessment for Medicaid or SNP enrolled members.
- Capacity Management HCBS eligibility and assigns exception code, K1, to indicate Level of Care (LOC) eligibility as well as additional code to define the diagnostic category:
  - K3 Serious Emotional Disturbance
  - K4 Medically Fragile
  - K5 Developmental Disability and Medically Fragile
  - K6 Developmental Disability and in Foster Care
- HCBS provider(s) assess scope, duration, and frequency of HCBS services and notifies the HH to update the POC for submission to the MetroPlus CSS Department.
- HCBS provider(s) submits the Children's HCBS Authorization Request Form to the CSS Department for approval.

- HCBS Provider remains in contact with Health Home CM and MetroPlusHealth CSS team for on-going monitoring, concurrent reviews, and care coordination.
- MetroPlusHealth will follow the required appointment and availability standards for access per regulatory requirements for health services including HCBS.

Please see Section 11.1.1 for additional information access and availability details for Children's services including Mandated Foster Care Assessments.

11.1.4 Physical and BH Referrals, Assessments & Functional Transition during Case Management

Referrals

In addition to the risk stratified work queue of all newly enrolled and existing HARP, Core, and CSS members, MetroPlusHealth will receive clinical member case management referrals via multiple pathways. Each referral (can be triggered post hospitalization, via new membership, or member/provider referrals) will be assigned to a case manager for necessary follow up. The highest risk members will be outreached in a priority fashion. Internal referrals can originate from any department within MetroPlusHealth though most are received from the UM department who refer members with high utilizations and/or who need more intensive support. Issues that may be assessed for care management include, but are not limited to:

a. Medication management, polypharmacy, and mismanagement
b. Transportation issues getting to provider visits, labs, etc.
c. Financial issues such as paying for food, medication, housing, etc.
d. Utilization of behavioral or medical ED visits and/or acute care due to unmanaged symptoms, not having a PCP/Specialist, etc. to manage the comorbidities.
e. Lack of engagement in care; quality measures
f. Suicidal Ideation, Depression, First Episode Psychosis, substance use,
g. Transitioning Aged Youth: members aged 16-21 transitioning from Child Serving Systems to Adult serving systems to ensure ongoing engagement in care
h. Multi-generational approach: for children/youth, the medical/ behavioral issues of the parent/guardian and negative environmental issues

Once enrolled in care management, the CSS CM completes an assessment and enrolls the member in care management if indicated. When goals/interventions have been developed and discussed with the member, the CM will be responsible for actively managing the member and ensuring robust bidirectional communications initially occur weekly or biweekly (or more depending on the member's needs, goals, and interventions). The CM will also be responsible for coordinating services across different settings. If indicated and with approval, members may be referred to Health Homes, Care Coordination Organizations, or other community supports for ongoing support.

Case Managers are trained on and encouraged to use tools such as NowPow to find appropriate resources for members. CSS CM staff have access to NowPow (via H+H's One City license) and can use it to look up community-based organizations who can provide detailed services for our members.

This type of supportive tool should not only help with engagement, but retention as well. If a member refuses any further, the case management episode will end, and the member will be re-approached only if there is a new hospitalization or at the time the yearly reassessment is to be done.

Functional Transition during Case Management
Members who experience acute Psychiatric or Substance Use Disorder (SUD) events (e.g., hospitalization) while in the MetroPlusHealth case management program will be reevaluated to ensure they have the appropriate services and support to meet the member's current needs. When the case manager is made aware of readmission, the clinician or peer assigned to the member will outreach the facility to assist with discharge planning and care coordination based on the member's current functioning. Assistance around member transition between care settings is an integral part of the CSS Behavioral Health program.

This approach ensures that the member's reintegration into the community following an acute episode of instability is planned and coordinated through the collaboration and transitional planning with the PCP, facility, and community partners. In addition to medication reconciliation and increased monitoring following discharge also support improved outcomes for members, successful reintegration in the outpatient setting, and reduction of avoidable readmissions.

Network Standards: Appointment Availability Standard by Service Type:

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
MH Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request	Within 5 business days of request
IPRT			2-4 weeks	Within 24 hours	
Partial Hospitalization				Within 5 business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hours	Within 1 week or request	Within 5 business days of request	Within 5 business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			

OTP		Within 24 hours	Within 1 week or request	Within 5 business days of request	Within 5 business days of request
Crisis Intervention	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from, justice system placement
CPST		Within 24 hours (for intensive in home and crisis response services under definition)	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Family Peer Support Services		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 busines s days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/Family Supports and Services			Within 5 busines s days of request	Within 5 business days of request	
Crisis Respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned Respite			Within 7 days of request	Within 7 days of request	

Prevocational Services			Within 2 weeks of request		Within 2 weeks of request
Supported Employment			Within 2 weeks of request		Within 2 weeks of request
Community Self-Advocacy Training and Support			Within 5 busines s days of request		Within 5 business days of request
Habilitation			Within 2 weeks of request		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	

Network Standards: Foster Care Initial Health Services and On-going Assessment and Treatment

The table below outlines the timeframes for initial health activities to be completed within 60 days of foster care placement. An "X" in the Mandated Activity and/or Mandated Timeframe column indicates that the activity is required within the indicated timeframe. An "R" in the Mandated Activity and/or Mandated Timeframe column indicated that the activity is required by OCFS.

Initial Health Services Time Frames				
Time Frame	Activity	Mandated Activity	Mandated Time Frame	Who Performs
24 Hours	Initial screening/screening for abuse/neglect	X	X	Health practitioner (preferred) or child welfare caseworker
5 Days	For children under the age of 13, conduct HIV risk assessment	X	X	Child welfare caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	X	X	Child welfare caseworker or health staff
30 Days	Initial medical assessment	X	X	Health practitioner
30 Days	Initial dental assessment	X	X	Health practitioner

30 Days	Initial mental health assessment	X	R	Mental health practitioner
30 Days	Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate)	X	X	Health practitioner
45 Days	Initial developmental assessment	X	R	Health practitioner
45 Days	Initial substance use assessment	R	R	Health practitioner
60 Days	Follow-up health evaluation	R	R	Health practitioner

* OCFS Regulations regarding HIV Counseling and Testing of children and youth in foster care have been revised to reflect the May 2017 updates to Public Health Law. VFCA/ ALDSS are required to conduct and HIV risk assessment on children within 5 days of entering foster care placement and annually thereafter. All patients age 13 or over receiving primary care services must be offered HIV testing at least once as a routine part of health care.

In addition to the above, there are assessments/evaluations that are required to be completed during the course of the foster care placement. These assessments are time sensitive and impact child's health, safety, and well-being. MMCPs are not permitted to require Prior Authorization for these assessments. Examples of on-going assessments include: 1. Following absent without consent (AWOC) 2. For purposes of determining eligibility for residential placements (OPWDD, OMH, OASAS and OCFS placement). 3. Updated/repeated assessments/evaluations are routine and standard. Children/youth in foster care often require multiple assessments/evaluations as they may experience changes in functionality and/or clinical presentation that impact service intensity.

11.2 Covered and Non-Covered Services

Applied Behavioral Analysis (ABA)- as of 1/1/23 Medicaid members under 21 years of age are eligible for these services if eligible	January 2023
Assertive Community Treatment (minimum age is 18 for medical necessity for this adult-oriented service)	July 2019
CFCO State Plan Services for children meeting eligibility criteria	October 2019
Children's Crisis Intervention	January 2020
Children's Crisis Residential Services	December 2020
Comprehensive psychiatric emergency program (CPEP) including Extended Observation Bed	July 2019
Continuing day treatment (minimum age is 18 for medical necessity for this adult-oriented service)	July 2019
Community Psychiatric Treatment and Supports (CPST)	January 2019
Crisis Intervention Demonstration Project	January 2019
Family Peer Support Services	July 2019
Health Home Care Management	October 2019

Inpatient psychiatric services	Current
Intensive Psychiatric Rehabilitation Treatment (IPRT)	Current
Medically Managed Detoxification (hospital-based)	Current
Medically supervised inpatient detoxification	Current
Medically supervised outpatient withdrawal	Current
OASAS Inpatient Rehabilitation Services	Current
OASAS opioid treatment program (OTP) services	July 2019
OASAS Outpatient and Residential Addiction services	Current
OASAS Outpatient Rehabilitation Programs	July 2019
OASAS Outpatient Services	July 2019

Services	MMCO Benefits
Other Licensed Practitioner (OLP)	January 2019
Partial Hospitalization	July 2019
Personalized Recovery Oriented Services (minimum age is 18 for medical necessity for this adult-oriented service)	July 2019
Psychosocial Rehabilitation (PSR)	January 2019
Youth Peer Support and Training	January 2020
Rehabilitation Services for residents of community residences	TBD
Residential Rehabilitation Services for Youth (RRSY)	TBD
Residential Supports and Services (New Early Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)	July 2021
Residential Treatment Facility (RTF)	TBD
Teaching Family Home	TBD

11.3 Access to Specialty Care

Members who are eligible for waiver services are assigned health homes. Once these members enroll in a health home, they receive an HCBS eligibility assessment. The health homes create a Plan of Care (POC) based on the findings of the eligibility assessment. The health homes then submit the POC, the assessment results and request for HCBS services for the Plan's approval. The Plan's Care Managers assess the POC and the request for HCBS services against the eligibility findings. If the request for HCBS services matches the assessment findings, the Plan sends the health homes an initial approval for HCBS and contact information of at least 2 HCBS providers.

If the requested HCBS does not match the assessment findings, the Children's Special Services (CSS) Care Managers will work with the health home Care Coordinators to adjust the POCs.

Members aged 0-21 who refuse enrollment in the Health Homes are managed directly by CSS Care Managers who will refer the members to a contracted State Designated entity called C-YES (Children and Youth Evaluation Services) through Maximus for HCBS eligibility assessment. Based on the assessment findings, CSS care managers will refer the member to an appropriate HCBS provider.

The Health Homes and/or C-YES, the independent NYS designated entity is responsible to conduct the CANS-NY assessment which determines the need for HCBS services. MetroPlusHealth ensures that all members who received waiver services are enrolled in health homes or C-YES and are assessed for HCBS services on a timely basis.

MetroPlusHealth also runs a monthly report identifying members who may need Health Homes and HCBS services. The identified children are referred to Health Homes.

MetroPlusHealth follows up on members receiving services with Health Homes and/or HCBS services by conducting monthly or quarterly follow up assessments as indicated with the Health Home or C-YES care coordinator and members' caretaker or LDSS/VCFA care manager.

If an enrolled child in foster care is placed in another county, and the Plan in which he or she is enrolled operates in the new county, the Plan must allow for the child to transition to a new primary care provider and other healthcare providers without disrupting the care plan that is in place.

If an enrolled child in foster care is placed outside of the Plan's service area, the plan must permit the enrollee to access providers with expertise treating children involved in foster care as necessary to ensure continuity of care and the provision of all medically necessary benefits package services.

The Health Home sends members' Plans of Care (POCs) with the HCBS assessment results to the Plan for HCBS approval

If the Plan has no information about members' HCBS assessment and/or members' POCs, the Plan's Care Managers will call the members' Health Home or Independent Entity to request this information.

The Plan care managers will keep a database with information about the assessments, assessment results, POCs, requested and delivered HCBS. This database will be used to ensure that members served by the Children's Special Services Program receive appropriate care.

11.4 Utilization Review/Actions

Below includes MetroPlusHealth's review process for HCBS review and approval of a POC inclusive of HCBS.

- HCBS will be managed in compliance with CMS HCBS Final Rule and any applicable State guidelines.
- MetroPlusHealth will ensure that the POC is developed in a person-centered manner, compliant with federal regulations and state guidance, and meets individual needs.
- MetroPlusHealth will ensure HCBS is authorized pursuant to a POC.
- MetroPlusHealth has a data-driven approach to identify service utilization patterns that deviate from any approved POC, conducts outreach to review such deviations, and requires appropriate adjustments to either the service delivery or the POC.

MetroPlusHealth authorization process ensures that HCBS services are authorized pursuant to a POC. The Plan follows up on members' progress by monthly and/or quarterly calls as indicated to Health Home care coordinators, member's caretaker or LDSS/VCFA care manager.

11.5 Quality Assurance

The purpose of the Children's Advisory Subcommittee (CAS) is to advise and assist MetroPlusHealth in identifying and resolving issues related to the management of children's health and behavioral health benefits.
Representatives on the CAS include providers who have expertise in children's services and familiarity with children eligible for home and community-based services (HCBS), including medically fragile children, medically fragile developmentally disabled, seriously emotionally disturbed, children in foster care, and children with diagnoses across multiple HCBS categories. The committee representatives include members/ families, voluntary foster care agencies (VFCAs), Health Homes, Care Management Agencies, youth and family peer support specialists, and other providers who are chosen to reflect the entire geographic service area of the Plan.

The CAS reports directly to the MetroPlusHealth Quality Management Committee (QMC). The QMC provides oversight, leadership and direction for quality improvement. When contracting with NYS- designated providers, MetroPlusHealth will not separately credential individual staff members in their capacity as employees of these programs. MetroPlusHealth must still conduct program integrity reviews to ensure that provider staff are not disbarred from Medicaid or any other way excluded from Medicaid reimbursement. MetroPlusHealth shall still collect and accept program integrity-related information from these providers, as required in the Medicaid Managed Care Model Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government or otherwise excluded from participation in the Medicare or Medicaid program.

MetroPlusHealth expanded its current provider training curriculum to reflect the expanded children's benefit and populations. MetroPlusHealth will collaborate with NYS and Regional Planning Consortiums (RPCs) to develop a uniform provider training curriculum that addresses the clinical components necessary to meet the needs of the expanded populations transitioning to managed care.

MetroPlusHealth will educate and train all participating providers on children's benefit and population policies and procedures regarding care and ensure providers are trained in cultural competency when delivering services to members.

MetroPlusHealth requires that all providers meet applicable State minimum training requirements:

- Training is available at alternate times and days of the week and sufficient opportunities are made available to reach all new Plan providers working with the expanded children benefit and populations. Providers may access the training document on the MetroPlusHealth website or contact their respective Provider Services Representative to schedule a training session.
- The training plan reflects member and family involvement in the development and delivery of any new training materials relevant to the expanded children's benefits and populations.
- The Provider Relations Department will distribute and post on the MetroPlusHealth website updated documentation to medical, behavioral, community-based and facility-based providers on the following topics:
  - Billing
  - Coding

- Data interfaces
- Claiming resources/contacts
- Provider profiling programs
- UM requirements for the Medically Fragile population

- This population will be served by MetroPlusHealth's Children's Special Services Department
  - Plan of Care development
  - Child evidence-based/promising practices, including:
    - Trauma-focused cognitive behavioral therapy
    - Trauma-informed child-parent psychotherapy
    - Multi-systemic therapy
    - Functional family therapy
    - Multidimensional treatment foster care
    - Dialectical behavior therapy
    - Multidimensional family therapy
    - Seven challenges
    - Adolescent community reinforcement
    - Assertive continuing care
  - Unique needs of special populations including SED, SUD, TAY, EI, medically fragile and children involved with child welfare
  - Cultural competency
  - HCBS and all its related requirements
  - Family-driven, youth guided, person-centered treatment planning and service provision
  - Recovery and resilience principles
  - Multidisciplinary teams with member/family member/caregiver engagement and meaningful participation and member choice
  - Trauma-informed care
  - Requirements of EPSDT and completion of required foster care initial health assessments
  - Common medical conditions and medical challenges in the medically fragile population
  - For PCPs and Health Homes – children's BH service array and application for children's clinical practice guidelines and EPBs for BH conditions

MetroPlusHealth ensures that its providers have access to rapid consultation from a child and adolescent psychiatrist as well as access to training, referral and support.

For HARP only: Training for BH providers and Health Homes regarding BH Home and Community Based Services (HCBS) requirements, including: (a) medical necessity criteria, (b) BH HCBS settings, (c) person-centered planning process, (d) person-centered plan content, (e) independent evaluation requirements, (f) provider qualifications, (g) critical incident definition and reporting requirements, (h) prior authorization requirements.

11.6 Provider Payment

To facilitate continuity of care for children/youth who are eligible for HCBS services, MetroPlus allows these members to continue with their care providers, including medical, BH and HCBS providers, for a continuous Episode of Care. This requirement was in place for the first 24 months of the transition. It applies only to episodes of care that were ongoing during the transition period from FFS to managed care. To preserve continuity of care, children enrollees will not be required to change Health Homes or their Health Home Care Management Agency

at the time of the transition. MetroPlus will pay on a single case basis for Children enrolled in a Health Home when the Health Home is not under contract with the Plan. MetroPlusHealth shall execute Single Case Agreements (SCAs) with non-participating providers to meet the clinical needs of children when in-network services are not available. The Plan will reimburse at the FFS fee schedule for 24 months for all SCAs.
MetroPlusHealth will reimburse at the Medicaid FFS fee schedule for 24 months or as long as New York State mandates (whichever is longer) for the following services/providers:

1. New EPSDT Child and Family Treatment and Support Services (CFTSS) including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports
2. OASAS clinics (Article 32 certified programs)
3. All OMH Licensed Ambulatory Programs (Article 31 licensed programs)
4. Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

MetroPlusHealth will reimburse transitional rates for Providers who historically delivered Care Management services under one of the 1915(c) waivers being eliminated, and who will provide Care Management services that are being transitioned to Health Home for no more than 24 months. The transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home.

MetroPlusHealth will contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified residential program to ensure access to and continuity of care for patients placed outside of the Plan's service area.

MetroPlusHealth will reimburse on a single case basis for Children enrolled in a Health Home when the Health Home is not under contract with the Plan to ensure continuity of care.

MetroPlusHealth will ensure that all HCBS services costs will be paid according to the NYS fee schedule without risk to the Plan for 24 months from the date of inclusion in the MMCP benefits package or until HCBS services are included in the capitated rates.

11.7 Voluntary Foster Care Agencies

On July 1, 2021, MMCPs are responsible for providing all Benefits Package services to enrolled children/youth placed in foster care, promoting continuity of care, and ensuring health care services are delivered in a trauma-informed manner and consistent with standards of care recommended for children in foster care. Children/youth often enter foster care without having had access to traditional preventive health care services. As a result, children/youth in foster care require an increase in the frequency of their health monitoring.
Medicaid changes, which began taking effect on February 1, 2021, impact the way certain children in the foster care system receive medical and behavioral health services. These changes are part of a phasing in of new rules that will affect most children in foster care by July 2021. The children in care of a Voluntary Foster Care Agency must be enrolled in a Medicaid Managed Care Plan and receive services from the Managed care delivery system. Additionally, a new population called at-risk HCBS level of need (LON) population must do the same.

MMCPs are responsible for covering 29-I Health Facility services for enrollees who are eligible to be served by a 29-I Health Facility, in accordance with the 29-I Billing Guidance. To access the billing guidance please visit https://www.metroplus.org/provider/tools.

12. Behavioral Health & HARP Services

12.1 Introduction

Behavioral Health can be defined as both acute and chronic psychiatric & substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders DSM and/or ICD of the American Psychiatric Association.

The HARP program is a recovery model of care which emphasizes and supports a person's potential for recovery by providing the utmost support to fragile members with significant behavioral and medical health conditions. The HARP program is designed to optimize the quality of life and reduce symptoms of mental illness and substance disorders through empowerment, personal choice, treatment, educational, vocational, housing, and health and wellness goals. The HARP benefit offers a broad range of services that support recovery journeys such as Home and Community Based Services (HCBS) that can be delivered at a member's home and or social setting.

MetroPlus promotes health screening for identification of behavioral health problems and patient education.
Providers are expected to:

- Screen, evaluate, treat and/or refer (as medically appropriate), any behavioral health problem. Primary care providers may treat for mental health and/or substance use disorders within the scope of their practice and bill using DSM and/or ICD codes
- Inform members how and where to obtain behavioral health services
- Understand that members may self-refer to any behavioral health care provider without a referral from the member's primary care provider.
  This can be achieved by providing members with access to a full continuum of mental health and substance use disorder services through MetroPlus' network of contracted providers.

MetroPlus expects providers to practice the same foundational beliefs taken from the NY State Department of Health's Person-Centered Plan of Practices and SAMHSA's Principles of Recovery listed below:

- Provide a way for people to work together
- Focus services and supports based on what is most important to the individual
- Focus on strengths and capacities of the individual
- Empower individuals to retain positive control over their lives
- Involve family members/friends/community workers as full partners
- Support an individual's inclusion in community activities and decisions

Principles of Recovery:

- Person-driven
- Occurs via many pathways
- Supported through relationships
- Culturally based and influenced
- Supported by addressing trauma
- Holistic
- Supported by Peers
- Involves individual, family, and community strengths, and responsibility
- Based on respect and emerges from hope

Recovery-oriented care associated with the MetroPlus Behavioral Health and HARP programs of care builds on the strengths and resiliencies of individuals, their families and their communities, using services and supports that are person centered, prompting real and meaningful changes in the treatment planning process.

12.2 Behavioral Health Description of Services: Medicaid Populations (Age 21+) Office of Mental Health (OMH) Benefits: NYS Office of Mental Health (OMH)

- **Clinic** - A program that provides an array of treatment services for assessment and/or symptom reduction or management. Services include but are not limited to individual and group therapies. The purpose of such services is to improve the person's ability to function in the community. The intensity and duration of visits may vary.
- **Intensive Psychiatric Rehabilitation Treatment (IPRT)** - A time-limited rehabilitative program that focuses on building skills and developing community support to assist individuals to attain specific residential, learning, working, or social goals.
- **Personalized Recovery Oriented Services (PROS)** - A comprehensive recovery-oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support, and rehabilitation in a manner that facilitates the individual's recovery.
- **Continuing Day Treatment (CDT)** - A program that provides seriously mentally ill adults with the skills and supports necessary to remain in the community and/or work toward a more independent level of functioning. Participants often attend several days per week with visits lasting more than an hour.
- **Partial Hospitalization** - A program that provides active treatment designed to stabilize or reduce acute symptoms in a person who would otherwise need hospitalization.
- **Crisis Intervention** - Services provided by a mobile crisis team to a person who is experiencing or is at imminent risk of having a psychiatric crisis and are designed to interrupt and/or lessen a crisis, including a preliminary assessment, immediate crisis resolution and de-escalation.
- **Comprehensive Psychiatric Emergency Program (CPEP)** - A hospital-based emergency program that offers/provides access to crisis outreach, intervention, and residential services; and/ or provides beds for the extended observation (up to 72 hours) to adults who need emergency mental health services.
- **Psychiatric Inpatient** - A hospital-based program that includes 24/7 psychiatric, medical, nursing, and social services to allow for the assessment and/or treatment of a person with a primary diagnosis of mental illness who cannot be adequately served in the community.
- **Second Chance Units**- The **Second Chance** Program is an inpatient psychosocial rehabilitation program for individuals with primary psychotic disorder illnesses (schizophrenia, schizoaffective disorder) who are having difficulty stabilizing in the **hospital** or have a history of frequent hospitalizations.

Office of Addiction Services and Supports (OASAS) Benefits:

- **Clinic** - Provides treatment services to individuals who suffer from substance use disorders and their family members and/or significant others. Delivered at different levels of intensity responsive to the severity of the problems presented by the person.
- **Opioid Treatment Program (OTP)** - Certified sites where methadone or other approved medications are administered to treat opioid dependency following one or more medical treatment.
- **Outpatient Rehabilitation** - Assist individuals with chronic medical and psychiatric

conditions. Higher staff to client ratio compared to other outpatient levels.

- **Intensive Outpatient** - Certified treatment service for individuals who require a time limited, multi-faceted array of services, structure, and support to achieve and sustain recovery.
- **Inpatient Hospital Detoxification** - Medically managed withdrawal and stabilization in a hospital setting. Designed for individuals who are acutely ill from alcohol-related and/or substance-related addictions or dependence
- **Medically Supervised Inpatient Detoxification** - Provides treatment of moderate withdrawal symptoms and non-acute physical or psychiatric complications
- **Inpatient Rehabilitation** - OASAS-certified 24-hour, structured, short-term, intensive treatment services provided in a hospital or free-standing facility.
- **Residential Services (Stabilization, Rehabilitative, and Reintegration)** - Services of varying levels offered in a residence, providing members with the ability to manage their condition in the safety of a residential setting. Residential services normally last3+ months.

Effective 2/1/2022 Community Oriented and Recovery Empowerment (CORE) Benefits for Enhanced (HARP) and HARP eligibles in Partnership in Care (HIVSNP):

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Empowerment Services - Peer Supports
- Family Support and Training (FST)

Home and Community Based Services (HCBS) Benefits for Enhanced (HARP) members:

- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Habilitation Residential Support (Habilitation)
- Non-Medical Transportation

Effective 10/25/2022 NYS Guidance to exceed Adult HCBS Services limits for HARP and HIVSNP:
HARPs and HIV SNPs must adhere to the following Adult BH HCBS Utilization Thresholds:

1. Combined Tier 1 Adult BH HCBS will be limited to an $8,000 annual cap. NYS has defined a 25 percent corridor on this threshold that will allow HARPs and HIV SNPs to reimburse up to $10,000 per calendar year without a disallowance.
2. Combined Tier 1 AND Tier 2 Adult BH HCBS will have an overall annual cap of $16,000 per eligible member. A 25 percent corridor will also be applied to this threshold to enable HARPs and HIV SNPs to reimburse up to $20,000 per calendar year without a disallowance.

If a member is projected to exceed an annual BH HCBS limit beyond the criteria noted in numbers 1 and 2 above, and continuation of these services is deemed as medically necessary by the HARP/HIV SNP BH Medical Director, HARPs and HIV SNPs may override these limits.

12.3 Eligibility and Assessment/Health Home, POC and HCBS For HARP

Health Homes are an option afforded to states under the Patient Protection and Affordable Care Act (Pub. L. 111-148). The purpose of Health Homes is to provide the opportunity to address and receive enhanced integration and coordination of primary, acute, behavioral health, and long-term services for persons with chronic illness.

Health Homes Goals:

- *Reduce the utilization associated with avoidable inpatient stays*
- *Reduce the utilization of associated with avoidable ED visits*
- *Improve outcome for persons with mental illness or substance use disorders*
- *Improve disease-related care for chronic conditions*
- *Improve preventive outcomes*
- *Reporting to be done quarterly to evaluate improvement and effectiveness.*

Health Home Eligibility Requirements

Individuals served in a Health Homes must have a qualifying condition (either Serious Mental Illness or HIV/AIDS) or at have least two chronic conditions and one or more state-selected risk factors (homelessness, recent release from jail or prison, recent discharge from psychiatric hospitalization, frequent ED/inpatient use, lack of adequate social support, learning or cognitive disabilities). Two qualifying chronic conditions include, but are not limited to, being overweight, having mental health issues (including substance use), heart disease, diabetes, asthma, or hypertension.

Health Home Engagement and Oversight

MetroPlusHealth uses individualized reports and regular consistent feedback from Health Homes to monitor the efficiency and quality of care delivered to members. This includes monthly meetings to review assignment and status of assignments, challenges faced with enrolling members, Billing, and the number of care plans submitted for approval. The Plan will keep a data base with information about the member assessments, assessment results, POCs (plans of care), requested and delivered HCBS. This data base will be used to ensure that members served by the plan will receive appropriate care.
MetroPlusHealth will track, monitor and work with Health Homes and BHHCS providers to ensure providers understand and comply with BHHCBS provisions of the special terms and conditions of New York State section 1115 Partnership Plan, including but not limited to credentialing, how to maintain enrollee health and safety, how to report financial accountability and enrollee documentation. MetroPlusHealth will make available to providers training and education material that reviews standards on enrollee evaluation, level of care and adequacy of the service plan while also collecting data in MetroPlusHealth's various platforms to ensure visibility into the aforementioned.

Coordinating with Health Home to promote HCBS/CORE Services

MetroPlusHealth is notified by New York State of a member's eligibility for HARP and eligibility for a Community Assessment. It is the responsibility of the assigned Health Home or CMA worker to complete such assessment which will then determine the level of appropriate need, or eligibility, to have additional services (HCBS) available to them. Therefore, all members enrolled in the HARP program will be offered Health Home care management services which will serve as a primary goal of successful HARP participation.

For those members who are hesitant to enroll initially within a Health Home for complete care coordination; they will be given the option to enroll within an **RCA** (Recovery Coordination Agency) as they are designed to receive referral's directly from the Managed Care Company. RCAs ensure that HARP members and HARP eligible (H9) members who are not enrolled within a specific Health Home, are still given the opportunity to access Adult Behavioral Health HCBS and new (as of 2/1/22) CORE services. The RCAs are designed to fast track members to HCBS/CORE which often enough, can help facilitate a complicated inpatient hospital discharge plan. Reducing overall Emergency Department and Inpatient Behavioral

Health/HARP admissions can be done by ensuring that both case management and utilization management are aligning with the community care managers that are interfacing directly with our members regularly. The hope is that once our members can experience the benefits of supportive HCBS, they will be more trusting of the overall Health Home referral process that is designed to help safely contain members long term, out of the ED and Inpatient settings.

Plan of Care (POC) Development

The HCBS/CORE Plan of Care (POC) is developed by the Health Home (HH) based upon the specialized needs of the member, incorporating the member's goals of care as well as his or her individual functional, medical and psychosocial needs. The POC should be tailored to meet the individualized needs of the member. The Behavioral Health (BH) HARP care manager will monitor and evaluate the POC in relation to identified goals and make modifications or suggestions to the assigned health home as needed. The BHCM will ensure the member receives all approved items and services the member needs including services requested by the member, physician, legal guardian, or other authorized party. The HCBS/CORE POC includes preventative services (e.g., annual physicals) and health education/ promotion services, including nicotine replacement services. Such service requests will be reviewed against plan guidelines and inclusion in the HARP POC.

1. *Care and Service Needs*
   The POC will address all identified care and service needs of the Adult HCBS/CORE and AOT members including the following as needed:
   a. All active chronic problems, current non-chronic problems, and problems that were previously controlled and or classified as maintenance care but have been exacerbated by disease progression and/or other intervening conditions
   b. All current medications taken by the member
   c. For each need identified, the POC will state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated timelines in which to achieve the desired outcomes, and the individual responsible for conducting the interventions and monitoring the outcomes
   d. All services authorized and the frequency and duration of the services authorized including any services that were authorized by the Plan since the last POC review was finalized and that needs to be authorized moving forward
   e. A schedule of preventive service needs and requirements
   f. Member's long and short-term goals; preferences and how they will be addressed, taking into consideration the member's expectations, characteristics, and previous daily routines; and method and frequency of evaluating progress toward goals
   g. Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the member's highest feasible level of well-being
   h. Known needed physical and behavioral health care and overall services
   i. Member requests are taken into consideration during the POC review with the member. Since the MetroPlus BHCM is a hybrid role of case management and utilization management, the MetroPlus BHCM will coordinate updates to the POC with the Health Home case manager and create the requested authorizations.
2. *Review Process*
   The Plan's review process for HCBS/CORE POC will include review and approval of a POC inclusive of HCBS/CORE.
   a. HCBS/CORE will be managed in compliance with CMS HCBS Final Rule and any applicable New York State guidance.

b. The Behavioral Health HARP care manager will ensure that the POC was developed in a person-centered manner, compliant with federal regulations and state guidance, and ensuring that it meets the specific individual needs.
c. The person-centered POC development approach includes health education and health promotion services in the HCBS/CORE POC. This includes evaluation of chronic medical, behavioral and psychosocial conditions. Goals include health promotion and recommendations for preventive care and ongoing care for chronic conditions, keeping in mind the guiding principles of recovery oriented mental health practice.
d. The BHCM will ensure HCBS is authorized pursuant to a POC.
e. The BHCM will utilize a data driven approach to identify service utilization patterns that deviate from any approved POC, conduct outreach to review such deviations and request appropriate adjustments to either service delivery or the POC.

3. *Effectiveness of Plan Evaluation*
On at least a quarterly basis, the MetroPlusHealth BHCM will review various claims, medical and behavioral utilization, and pharmacy reports to evaluate the effectiveness of the member's POC and the overall care management plan to identify any deviation from services on the HCBS POC. The primary mechanism for reporting, analyzing and developing action items of the care management plans is presented to the BH UM subcommittee. The BH UM subcommittee provides oversight of the care management plans to ensure the effectiveness of care plan development and monitoring.

4. *Service Delivery Confirmation and Review*
Elements from assessments and available claims, utilization and pharmacy data are reviewed for confirmation of service delivery, or deviation, absence of approved POC service authorizations. For example, the MetroPlusHealth BHCM will review claims data for service delivery or for supplies such as DME that were previously approved. Any deviations will be investigated by the MetroPlus BHCM to ensure that member's needs are being sufficiently met. During the MetroPlusHealth BHCM review process any gaps in care identified will result in a recommendation by the BHCM to update the POC.

The POC is tailored to meet the individualized needs of the member. In collaboration with the member's assigned Health Home and the member, the BH care manager will review, monitor and evaluate the POC and any needed service authorizations in relation to identified goals and make modifications as needed to ensure services are delivered adequately and timely.

5. *Frequency of Plan Review*
The CM reviews the POC on a quarterly basis or as needed depending on any changes in the health status of the member. The BH Care Manager will review all aspects of the POC and monitor utilization to identify any change in health status and needs. For AOT members, Plans of Care will be updated by the AOT and CMA worker in conjunction with the assigned BHCM in order to avoid any possible duplication of service referrals. The BHCM will closely monitor for inpatient UM (utilization management) activity, alerting the community CMA and AOT workers of such admits so that POC's can be updated if need be, post-hospitalization discharge.

6. *Plan of Care Security and Accessibility*
The POC is documented within the MetroPlusHealth care management system (DCMS),

where it is maintained and accessible by the BH Care Manager. Proper system security measures including unique log-in and password protection, remote backup system is maintained to ensure security and confidentiality of member information.

12.4 A. Behavioral Health HCBS Workflow

- *HH Care Manager* conducts BH HCBS eligibility assessment for HARP enrolled members.
- Determines BH HCBS eligibility, tier, and identifies services.
- Following approval of Level of Service Determination (LOSD) request, identifies available BH HCBS provider(s) and makes referrals to BH HCBS provider(s) of member's choice.
- Sends BH HCBS eligibility assessment summary, LOSD letter, and available POC information to BH HCBS provider(s).
- BH HCBS Provider(s) notify MCO (MetroPlusHealth) of first scheduled initial assessment, via Notification form.
- BH HCBS provider(s) assess scope, duration, and frequency of HCBS services.
- Develops Individual Service Plan and submits to Health Home CM.
- Submits to MCO (MetroPlus) the Adult BH HCBS Authorization Request Form.
- For CORE services request, HARP CM reviews clinical record for any duplication of services. Communicates to Provider and CMA if any such duplication is evident.
- BH HCBS/CORE provider(s) receives auth approval letter.
- Member begins service provision.
- HCBS/CORE Provider remains in contact with Health Home CM and MCO (MetroPlusHealth) team for on-going monitoring, concurrent reviews, and care coordination.

MetroPlusHealth will follow the required appointment and availability standards for access for the following HCBS:

- For Short-Term and Intensive Crisis Respite services, access will be provided within 24 (twenty-four) hours of the request

12.4 B. CORE Services Launching 2/1/2022
Introduction & Background
Community Oriented Recovery and Empowerment (CORE) Services are person-centered, recovery-oriented, mobile behavioral health supports intended to build skills and self-efficacy that promote and facilitate community participation and independence.

CORE Services are authorized under the 1115 Demonstration Waiver and replace Adult Behavioral Health Home and Community Based Services (BH HCBS) as a benefit for Health and Recovery Plan (HARP) enrollees and HARP-eligible HIV/Special Needs Plan (SNP) enrollees. Transitioning four Adult BH HCBS to CORE Services will improve access to services and use the expertise of clinicians and rehabilitation practitioners to support the eligibility and intake process. State Administrative Structure Community Oriented Recovery and Empowerment (CORE) Services are jointly overseen and monitored by the NYS Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS).
Providers are designated by both State agencies and are assigned to OMH or OASAS as a host-agency for the purposes of ongoing oversight and monitoring

Target Population:
(CORE) Services Demonstration includes HARP enrollees and HARP-eligible HIV/SNP enrollees who would benefit from CORE Services in the pursuit of valued recovery goals.
Menu of Services CORE consists of four services:

- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation (PSR)
- Family Support and Training (FST)
- Empowerment Services – Peer Support

Statement of Key Principles:
HARPs were developed to promote significant improvements in the Behavioral Health System as we move into a recovery-based Managed Care delivery model. A recovery model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, educational, employment, housing, and health and well-being goals. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, self-direction, social inclusion, and coping skills.

CORE Services will provide opportunities for eligible adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. CORE designated providers will work together with managed care plans, service providers, plan members, families, and government partners to help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders.

"No Wrong Door" Referral Pathway:
A central pillar of the CORE Service demonstration is the "No Wrong Door" referral pathway, which enables HARP members to easily access the services with as few barriers to admission as possible. HARP members may learn about CORE Services through any number of sources, including through the Managed Care Organization (MCO), Health Home Care Manager (HHCM), inpatient and outpatient clinicians, primary care practitioners, family and friends, or provider outreach and education efforts. Providers may develop their own referral requirements and intake paperwork or forms. Once a HARP member expresses an interest in receiving the services, they may work with any qualified Licensed Practitioner of the Healing Arts (LPHA) to establish eligibility and obtain a recommendation for services.

Eligibility & Recommendation by a Licensed Practitioner of the Healing Arts:
An individual must have met the New York State (NYS) high-needs behavioral health (BH) criteria (commonly referred to as the HARP eligibility algorithm) and be enrolled in an eligible Plan type, HARP or HIV SNP to be eligible for CORE Services. CORE Services require a recommendation of a Licensed Pracitioner of the Healing Arts (LPHA).

Individuals meeting the NYS high-needs BH criteria are assigned a Medicaid Recipient Restriction Exception H-code within eMedNY. You can find out someone's H-code status by looking in ePACES or PSYCKES, or by calling their MCO.

- H1 indicates an individual is enrolled in a HARP and has met the BH high-needs criteria.
- H4 indicates an individual is enrolled in a HIV SNP and has met the BH high-needs criteria.
- H9 indicates an individual has met the NYS BH high-needs criteria (*Individuals falling into this category are eligible to receive CORE Services when enrolled in a HARP or HIV/SNP. Eligible individuals with an H9 wishing to enroll in a HARP or HIV-SNP may contact NY Medicaid Choice at 1-855-789-4277 for enrollment options.)

For the purposes of making a recommendation for CORE Services, LPHA qualifications are as follows: Physician; Physician's Assistant; Nurse Practitioner; Registered Professional

Nurse; Licensed Psychologist; Licensed Psychoanalyst; Licensed Creative Arts Therapist; Licensed Marriage and Family Therapist; Licensed Mental Health Counselor; Licensed Clinical Social Worker; and, Licensed Master Social Worker under the supervision of a Psychiatrist, Psychologist, or LCSW employed by the agency.
The LPHA's recommendation must be in writing and a copy of it should be maintained in the individual's CORE case record. The LPHA does not need to be employed by the CORE designated provider; however, if the LPHA is not a member of the CORE provider's staff, then the recommendation should be also include their National Provider Identifier (NPI).
The LPHA recommendation may be obtained as part of the referral process or during the Intake & Evaluation (I&E) process described below. The LPHA recommendation must be obtained prior to completion of the initial Individual Service Plan.

Intake & Evaluation Process:
Upon acceptance of a referral, the CORE provider will schedule an Intake & Evaluation (I&E) with the individual, at the individual's convenience.
The intake and evaluation process for CORE is a person-centered process intended to engage the individual in a discussion of:

- The individual's recovery goal(s),
- The individual's strengths and resources,
- The individual's barriers and needs,
- The individual's preferences for service delivery (including days, times, staffing, etc.)
- How the CORE service will be used to support attainment of their goal.

Individuals will engage in services for many different reasons, and present at various stages of change, with many different expectations, aspirations, and perspectives about their recovery journey. They will have different ideas of what successful services and supports would look like for them, including the steps they believe will get them to their goal. The intent of the intake and evaluation period is to listen carefully to what the individual is saying and to skillfully work with the individual to a mutual understanding of the problem the individual has presented, the outcome that is desired and some initial steps to begin developing the roadmap to those outcomes.

The I&E process is conducted by a member of the staff qualified to provide the service. I&E sessions must be documented in the individual's CORE case record; this documentation may appear in an intake form and/or progress noes. The documentation should include a description of the discussion and a summary of the individual's goal(s), strengths and resources, barriers and needs. The Intake & Evaluation process results in an initial Individual Service Plan (ISP) (see section 3 below), which should be completed within 30 days of the first session/visit or within 5 sessions, whichever is greater.

MCO Notification:
The provider is responsible for notifying an individual's MCO within three (3) business days after their first Intake & Evaluation session. This notification is completed using the Provider Service Initiation Notification template, which can be submitted electronically to the individual's MCO.

12.5 BH Referrals, Assessments & Functional Transition During Case Management
Referrals
In addition to the risk stratified work queue of all newly enrolled and existing HARP, Core, and CSS members, MetroPlusHealth will receive clinical member case management referrals via multiple pathways. Each referral (can be triggered post hospitalization or via new membership) will be assigned to a case manager for necessary follow up. The highest risk

members will be outreached in a priority fashion. Internal referrals can originate from any department within MetroPlusHealth though most come from the UM department who refer members with high utilizations and/or who need more intensive support.

1. Medication management and mismanagement
2. Transportation issues getting to MD, tests, Grocery store, etc.
3. Financial issues such as paying for food, medication, etc.
4. Frequent / often admission and ED Visits due to unmanaged symptoms, not having a PCP/ Specialist, etc. to manage the comorbidities.
5. Non-Users
6. SI, Depression, substance use,
7. Mental illness etc.
8. For children/youth, the medical/ behavioral issues of the parent/guardian and negative environmental issues
9. Physical Illness or limitations

Once the care plan is created and discussed with the member, the CM will be responsible for actively managing the member and ensuring robust bidirectional communications occur weekly or biweekly (or more depending on the member's needs, goals and interventions). The CM will also be responsible for sharing the care plan with the member and his/her care team so that care can be coordinated across different settings. The CM will regularly update the care plan, noting progress that has been made towards achieving the goals, conducting the interventions and/or addressing the barriers. If the member does not adhere to the care plan, this will be documented in the care plan and addressed with the interdisciplinary care team, which can include the member, his/her caregivers and providers as well as various clinical staff and peers on the BH team. While members can refuse care management services, it is the goal of the BH team to try to engage members as best as possible in their health and wellness. Case Managers will be trained on and encouraged to use tools such as NowPow to find appropriate resources for members. BHCM staff will have access to NowPow (via H+H's One City license) and can use it to look up community-based organizations who can provide detailed services for our members. This type of supportive tool should not only help with engagement, but retention as well. If a member refuses any further, the case management episode will end, and the member will be re-approached only if there is a new hospitalization or at the time the yearly reassessment is to be done.

Functional Transition during Case Management
Members who experience acute Psychiatric or Substance Use Disorder (SUD) events (e.g., hospitalization) while in the MetroPlusHealth case management program will be reevaluated to ensure they have the appropriate services and support to meet the member's current needs. When the case manager is made aware of readmission, the clinician or peer assigned to the member will outreach the facility to assist with discharge planning and care coordination based on the member's current functioning. Assistance around member transition between care settings is an integral part of the Behavioral Health program.

This approach ensures that the member's reintegration into the community following an acute episode of instability is planned and coordinated through the collaboration and transitional planning with the PCP, facility, and community partners. In addition to medication reconciliation and increased monitoring following discharge also support improved outcomes for members, successful reintegration in the outpatient setting, and reduction of avoidable readmissions.

12.6 Behavioral Health, HARP & Children's Quality Committees

Quality Management Committee (QMC)
Purpose: The QMC provides oversight, leadership and direction for quality improvement. The Quality Management Program is the vehicle through which MetroPlus Health Plan measures, analyzes and responds to collected data and program measurement processes. The purpose of the QMC is to systematically use this performance information and data to improve organizational performance through enhancing clinical care and ultimately improving health outcomes for its consumers. The QMC is the decision-making body that is ultimately responsible for the implementation, coordination and integration of medical and behavioral health quality improvement activities. This includes all members in all lines of business including but not limited to the following lines of business: HIV SNP, MLTC, HARP, Medicaid, Medicare, UltraCare and Children's Specialized Services including but not limited to children with mental health or substance use disorders and foster care and medically fragile children. The Committee shall maintain communication between the QAPI of the Board and its senior leadership with management responsibility for matters concerning or relating to the quality of medical care and service delivered to its members. The QMC is chaired by the Plan's Chief Medical Officer. Members of QMC are appointed by the QMC Chair and are approved by existing committee members. Non-Voting members of the QMC include members, family members, peer specialists, and community provider representatives. Their participation is documented within committee minutes and non-voting status identified on the QMC Charters.
Membership is assessed annually.

Responsibilities: The responsibilities of QMC include, but are not limited to, the following:

- Approving and recommending the Board's acceptance of the annual Utilization Program Evaluation, annual Utilization Management Program and annual Utilization Management Work Plan covering all performance domains for all product lines.
- Approving and recommending the Board's acceptance of the annual Case Management Program Evaluation, annual Case Management Program and annual Case Management Work Plan covering all performance domains for all product lines.
- Approving and recommending the Board's acceptance overseeing and directing the Plan's annual Quality Management Program Description, annual Quality Management Program Evaluation and annual Quality Management Work Plan that define, monitor and measure the care and services provided to customers.
- Reviews the annual CVS Quality Improvement Work Plan and Program Description and provides oversight to the Pharmacy & Therapeutics Subcommittee.
- Promoting and leading the Plan's Quality Management Program by identifying, prioritizing, establishing, and approving policy and allocating resources to achieve the Quality Program goals.
- Recommending procedures and practices, reviewing, and evaluating the results of care and service quality improvement activities and ensuring follow-up as appropriate.
- Communicating quality improvement information between the QAPI and customers, which includes members, employers, providers, employees, and service partners as well as regulatory agencies.
- Reviewing and providing oversight of CMS required quality & service performance metrics in the Special Needs Plan (SNP) Model of Care (MOC); Medicaid Advantage Plan (MAP) Model of Care (MOC), and Children's Specialized Services Program and provides feedback to the appropriate committee(s).
- Approving the charters of the committees and subcommittees in the Quality Improvement Committee structure.

Reviewing reports and recommendations from all committees and subcommittees in the Quality Improvement structure as appropriate and provides feedback, follow-up, and direction

to the committees. The QMC Chair has the authority to commit resources and has overall responsibility for the activities and results of the QMC. A summary of QMC activities is reported quarterly to the QAPI.

Meetings: The QMC meets four times a year.

Behavioral Health Quality Management Subcommittee (BHQM)
Purpose: The purpose of the Behavioral Quality Management (BHQM) Subcommittees is to provide oversight of the quality management program. To this end, the subcommittee will review and analyze BH data, interpreting the variances, drawing conclusions, and recommending interventions, with measurable outcomes for the HARP and CORE membership (QMP, Medicaid, Medicare, UltraCare, Exchange, Essential, MAP, and Commercial).

Responsibilities: Responsibilities of the BHQM Subcommittee include but are not limited to the following:

A. Monitoring, tracking, and trending data, related to quality of care, continuity and coordination of medical and behavioral health services, effectiveness and outcomes of care, utilization, access to care, and satisfaction with experience of care. The following data elements are included, but not limited to:
   1. Data produced and reviewed in the QMP/ Core BH UM for Adults and Children Subcommittee;
      - Under and over utilization of behavioral health services data
      - Admission and readmission rates, trends, and the average length of stay for mental health inpatient, SUD inpatient detoxification and rehabilitation as well as SUD residential levels of care
      - Inpatient civil commitments
      - Outpatient civil commitments (AOT)
      - Utilization of emergency services and crisis services
      - BH prior authorizations/denials and notifications of admission
      - Psychotropic medication utilization for adults, and children including those in foster care
      - Rates of initiation and engagement of individuals with First Episode Psychosis (FEP) services
      - Utilization of Medication Assisted Treatments (MAT)
      - Transitional issues for youth ages 18 to 23 years, focusing on continuity of care and service utilization
      - Behavioral Health utilization for children and adolescents in foster care
      - Other metrics determined by the State
      - HCBS utilization for Children
      - HCBS quality assurance performance measures as determined by the State and pending CMS requirements for Children.
      - Enrollment in Health Homes
   2. Data produced and reviewed in the HARP Behavioral Health UM Subcommittee includes but is not limited to the following:
      - Under and overutilization of Behavioral Health services
      - Avoidable hospital admissions (medical), readmission rates, trends, and the average length of stay for Mental Health inpatient, SUD inpatient, detoxification and rehabilitation as well as SUD residential LOC

- Inpatient civil commitments
- Outpatient civil commitments (AOT)
- Follow-up, after discharge, from Mental Health inpatient, SUD inpatient, ED and residential levels of care
- SUD treatment initiation and engagement rates
- Utilization of emergency services and crisis services, including crisis diversion services
- Behavioral Health prior authorizations/denials, and notifications of admissions
- Pharmacy utilization, including physical health, psychotropic and medication assisted treatments
- Provider-specific trends re: readmission rates and length of stay
- Home and Community Based Services (HCBS) utilization including quality assurance reporting
- All physical health measures, required by the MCO model contract
- Initiation and engagement rates, in services, of individuals with FEP
- Health Home engagement rates for HARP and SNP HARP Members
- Tracking Plans of Care received from Health Homes or State Designated Entities (SDE)
- For children placed in foster care, the BH QM Subcommittee will separately report, monitor, and analyze the data elements listed above.
- Discharge planning processes, appeals and retrospective reviews.

B. Quality indicators:

1. Developing, garnering approval for, and implementing intervention strategies, with measurable outcomes, based on above findings
2. Incorporating recommendations from provider and member advisory committees, key stakeholders, including members, families, caregivers, and providers, to improve the quality of care and member outcomes
3. Reviewing and providing recommendations, to MetroPlusHealth, regarding NYS-sponsored, focused behavioral health clinical studies and performance improvement projects (PIP) and CMS focused quality improvement projects (QIP), as required
4. Sharing and discussing the HARP and CORE UM/QM Annual Work Plan and Evaluation Reports
5. Ensuring timely implementation of the Behavioral Health aspects of the MetroPlusHealth Quality Program and Annual Work Plan, referent to HARP and CORE
6. Monitoring, analyzing, and evaluating Medicaid, HARP, HIV SNP, MAP & Commercial QARR, Medicare and HEDIS behavioral health performance measures, required by the NYSDOH, CMS or requested by MetroPlusHealth.
7. Reviewing appropriateness of patient care and patient safety issues, including adverse incidents
8. Assessing continuity and coordination of medical and behavioral health services
9. Analyzing and evaluating behavioral health clinical quality-of-care complaints
10. Reviewing, updating, and adopting appropriate Behavioral Health Clinical Practice Guidelines and behavioral health screening programs, to facilitate the provision of high- quality clinical services
11. Providing feedback to MetroPlusHealth colleagues, in their role as members of the Regional Behavioral Health Planning Consortium (RPC), to aid in developing behavioral health policy in the region, resolving regional service delivery challenges, and recommending training topics for providers
12. Collaborating with MetroPlusHealth colleagues, in providing feedback to NYS OMH, NYS OASAS, NYC DOHMH, and other City agencies, to support improvements to the

behavioral health system
13. Ensuring timely reporting of HARP and CORE performance measurement data
14. Monitoring POC workflow, including receipt of services within established time frames, recording Subcommittee discussions, agreed-upon initiatives, and next steps, in the BH UM/ CM subcommittee meeting minutes.

Meetings: The BHQMS meets no less than four times per year.

Health and Recovery Plan (HARP) Behavioral Health Utilization Management Subcommittee
Purpose: Pursuant to the Standard Clauses the MCO reserves the right to monitor enrollee utilization for all services including Home and Community Based Services (HCBS). The purpose of the HARP Behavioral Health Utilization Management (UM) Subcommittee is to discuss utilization trends with the goals of highlighting positive trends and identifying areas requiring improvement. To this end, this subcommittee monitors, analyzes, evaluates, and reports BH utilization data, for HARP membership.

Responsibilities: Responsibilities include but are not limited to the following:

Collecting, monitoring, analyzing, evaluating, and reporting utilization data, including, but not limited to:

- Under and over utilization of Behavioral Health services and cost data
- Avoidable hospital admissions (medical), readmission rates, trends, and the average length of stay for Mental Health patients, SUD inpatient, medical and residential LOC
- Inpatient civil commitments
- Outpatient civil commitments (AOT)
- Follow up after discharge from MH inpatient, SUD inpatient, ED and residential levels of care
- SUD treatment initiation and engagement rates
- ED utilization and use of crisis services, including crisis diversion services
- Behavioral Health prior authorization/denials, notifications and notices of action
- Pharmacy utilization including physical health, psychotropic and medication assisted treatments
- Provider specific trends re: readmission rates and Length of Stay
- 1915 (i)-like HCBS service utilization
- Home and Community Based Services (HCBS) utilization including quality assurance reporting
- All physical health measures required by the MCO model contract
- Initiation and engagement rates, in services, of individuals with FEP
- Health Home Engagement rates for HARP and SNP HARP Members
- Tracking Plans of Care received and from which Health Homes or State Designated Entities (SDE)
- Discharge planning process appeals and retrospective reviews.

Meetings: This subcommittee meets no less than four times per year.

Qualified Medicaid Program (QMP)/Core Behavioral Health Utilization Management for Adults and Children Subcommittee
Purpose: The purpose of the QMP/Core Behavioral Health (BH) Utilization Management (UM) Subcommittee is to discuss utilization trends of adults and children with the goals of highlighting positive trends and identifying areas requiring improvement. To this end, this subcommittee monitors, analyzes, evaluates, and reports BH utilization data, for QMP, Medicaid, UltraCare, Medicare, Exchange, Essential, and Commercial membership.

Responsibilities:

A. The Behavioral Health UM sub-committee shall review and analyze data for adults and children in the following areas, interpret the variances, review outcomes, and develop and/or approve interventions based on the findings: Responsibilities include but are not limited to the following:
   i. Under and over utilization of Behavioral Health services and cost data
   ii. Admissions and readmission rates, trends, and the average length of stay for all mental health inpatient, SUD inpatient and residential levels of care
   iii. Inpatient civil commitments
   iv. Outpatient civil commitments (AOT)
   v. ED utilization and crisis services use
   vi. BH prior authorization/denial and notifications of admission
   vii. Psychotropic medication utilization for adults and children including those in foster care
   viii. Psychotropic medication utilization for foster children
   ix. Rates of initiation and engagement of individuals with First Episode Psychosis (FEP) services
   x. Utilization of Medication Assisted Treatment (MAT).
   xi. Transitional issues for youth ages 18 to 23 years, focusing on continuity of care and service utilization
   xii. BH Utilization for children/adolescents in foster care:
   xiii. Other metrics determined by the State.

B. For children eligible for Home and Community Based Services (HCBS), the BH UM Subcommittee separately report, monitor findings and recommend appropriate action on the following additional metrics:
   i. Use of crisis diversion and crisis intervention services
   ii. Prior authorization/denial and notices of action
   iii. HCBS utilization
   iv. HCBS quality assurance performance measures as determined by the State and pending CMS requirements,
   v. Enrollment in Health Homes
   vi. Engagement in First Episode Psychosis (FEP) programs

C. For children placed in foster care, the BH UM Subcommittee will separately report, monitor, and analyze the data elements listed above.

Meetings: This subcommittee meets no less than four times per year.

Utilization Management Subcommittee (UMS)

Purpose: The Utilization Management Subcommittee (UMS) is responsible for monitoring the appropriate utilization of medical healthcare resources to promote adherence to standards of care and improve the quality of care and services to all Plan members. The UMS is also responsible for approving, overseeing and directing the Plan's Utilization Management Program Description and Utilization Management Program Work Plan. The UMS monitors the quality and safety of care and services rendered to members, identifies clinical and administrative opportunities for improvement, evaluates results, develops and implements protocols for monitoring effectiveness of care based on patient outcomes and institutes needed actions.

Responsibilities: Include but are not limited to the following:

- Approving, overseeing and directing the Plan's annual Utilization Management (UM) Program Evaluation, UM Program Description and UM Program Work Plan that monitor,

measure and demonstrate improvement in the care and services provided to members.

- Approving and recommending the Board's acceptance of the annual Case Management Program Evaluation, annual Case Management Program and annual Case Management Work Plan covering all performance domains for all product lines.
- Reviews and approves the utilization of clinical review criteria and or scripts including medical necessity criteria, clinical policies and other clinical decision-making tools utilized in making utilization determinations that are:
  - Developed with involvement from appropriate providers and prescribers with current knowledge relevant to the criteria or scripts under review
  - Adopted from nationally recognized medical necessity criteria tool sets
  - Evaluated at least annually and updated if necessary, by the appropriate, actively practicing physicians, pharmacists and other providers with current knowledge relevant to the criteria or scripts which are under review.
  - Reviews and approves clinical criteria that are based on current clinical principles and processes that are recommended by the Medical Director (or equivalent designate), or clinical director (or equivalent designate), P&T Committee or Medical Policy Subcommittee.
- Analyzing utilization of services and cost of health care trends.
- Identifying over and under-utilization issues, analyzes data for trends and recommends corrective action plans as indicated
- Evaluating consistency of the UM decision making process through inter-rater reliability testing, staff documentation audits, and reports.
- Monitor and conduct routine oversight to ensure Mental Health or Substance use disorder (MN/ SUD), and Medical prior authorization reviews occur in a comparable and no more stringent manner.
- Review and identify factors (using evidentiary standards) that trigger application of nonquantitative treatment limitations (NQTL) for MH/SUD and Medical
- Reviewing and evaluating aggregate statistics on appeals rates and makes recommendations for improvements.
- Reviewing internal Utilization Management audits.
- Developing appropriate strategies and programs to improve the delivery of quality health care services.
- Monitoring utilization activity toward the Plan's goals and objectives. Implements corrective actions as needed to meet goals.
- Monitoring, implementing and maintaining systems to enable compliance with accreditation and regulatory requirements of the utilization process.
- Sharing appropriate individual provider performance information with the Credentialing and Recredentialing Committee for review during the credentialing/recredentialing process.
- Developing, implementing and evaluating the impact of care management programs on the quality of care, service utilization, cost and clinical outcomes.
- Reviewing, revising and measuring adherence to medical necessity/level of care criteria.
- Managing the performance of entities to whom UM responsibilities are delegated, including regularly reviewing their annual UM plans, UM data and completing an annual performance evaluation (HealthPlex [through 12/31/2022], DentaQuest [effective 1/1/23] and Integra.)
- Reviewing and providing oversight and feedback to the QHP/Core Behavioral Health Utilization Management Subcommittee and HARP Medicaid Behavioral Health Utilization Management Subcommittee.
- Provides oversight to the Medical Policy Subcommittee (MPS). Reviews all decisions

made by the MPS through quarterly updates/reports.

- *Review and analyze the following Children's Special Services Reports:*
  - POCs and HCBS authorization and utilization report
  - Foster Children UM report
  - Foster children report – complaints, grievances, appeals and denials
  - Medically Fragile Children's UM report(s) that tracks, trends, analyzes, evaluates and follows up on related physical health services metrics as determined by NYS. To the extent possible intervention strategies will be developed that have measurable outcomes.
  - Medically Fragile Children (home care) – complaints, grievances, appeals and denials
  - Foster Children Critical Incidents
- Medically Fragile Children (home care) – critical incidents

Meetings: The UMS shall meet quarterly but no less than four times per year.

Children's Advisory Subcommittee (CAS)
Purpose: The purpose of the Children's Advisory Subcommittee (CAS) is to advise and assist MetroPlusHealth in identifying and resolving issues related to the management of children's health and behavioral health benefits.

Responsibilities: The main responsibilities of the CAS are to:

- Identify and suggest solutions for treatment issues.
- Identify and suggest solutions for coverage issues.
- Identify and suggest solutions for coordination of care.
- Identify and suggest solutions for workflow concerns.
- Discuss members', family members', Voluntary Foster Care Agencies' (VFCAs), Health Homes', and medical and behavioral health providers' concerns.
- Discuss issues related to members' eligibility for Home and Community Based Services (HCBS) and Children and Family Treatment and Support Services (CFTSS) including:
  - Medically fragile children
  - Medically fragile developmentally disabled children
  - Seriously Emotionally Disturbed children
  - Children with diagnoses across multiple HCBS categories.

Meetings: The CAS shall meet bi-annually but no less than twice a year.

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13. Behavioral Health Services

13.1 First Episode Psychosis (FEP)

Providers will assess for and promptly refer members experiencing first episode psychosis to specialty programs or program utilizing evidence based practices for this condition, such as:

OnTrackNY Providers, trained by The Center for Practice Innovations (CPI) at Columbia Psychiatry/ NYS Psychiatric Institute, deliver coordinated, specialty care, for those experiencing FEP, including: "psychiatric treatment, including medication; cognitive-behavioral approaches, including skills training; individual placement and support approach to employment and educational services; integrated treatment for mental health and substance use problems; and family education and support" (CPI website). Each site has the ability to care for up to 35 individuals.

Requirements:

1. **Ages 16-30**
2. Began experiencing psychotic symptoms for more than a week but less than two years prior to referral
3. Borderline IQ or above, such that individual is able to benefit from services offered ((NYC) RFQ 3.13 (f)(iii)
   MMC/FHP 10.19(a); 10.21; 21.11; 10.19 (a)(iv))

13.2 Collaborative Care Model

The Collaborative Care Model (CCM) is an evidence-based and systematic approach to the treatment of depression and anxiety in primary care settings. The CCM involves the integration of care managers and consultant psychiatrists, regular proactive monitoring and treatment to target using validated clinical rating scales and regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement.

CCM is delivered by a team consisting of a primary care provider, care manager (nurse, clinical social worker, or psychologist), and psychiatric consultant. The team cares for a defined group of patients and closely tracks each patient's progress using validated clinical rating scales (e.g. PHQ-9 for depression). Mental health specialists support non-specialist health workers in settings such as primary care and school health centers, bringing MH treatment to where people are comfortable receiving care and work to address treatment gaps widely associated with the population experiencing mental health disorders. Treatment is systematically adjusted if patients are not improving as expected. Patients who don't respond to treatment are referred to more intensive mental health specialist care.

In collaborative care, each patient's progress is closely tracked using validated clinical rating scales (e.g., PHQ-9 for depression). Treatment is systematically adjusted if patients are not improving as expected. Initial adjustments can be made by the primary care treatment team, with input from the psychiatric consultant. Patients who continue not to respond to treatment or have an acute crisis are referred to mental health specialty care, as are patients who seek such referral.

The CCM differs from other attempts to integrate behavioral health services because of the replicated evidence supporting its outcomes, its steady reliance on consistent principles of chronic care delivery, and attention to accountability and quality improvement

Five Essential Elements:

1. Patient-Centered Care Team: Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals. Reduces duplicate assessments, increased patient engagement
2. Population-Based Care: Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.
3. Measurement-Based Treatment to Target: Each patient's treatment plan clearly articulates personal goals and clinical outcomes and are routinely measured by evidence-based tools. Treatments are actively changed if patients are not showing improvement as expected until the clinical goals are achieved.
4. Evidence-Based Care: Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition.

5. Accountable Care: Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Studies have tested collaborative care interventions for different mental health conditions, including depression, anxiety disorders, and more serious conditions such as bipolar disorder and schizophrenia. Across this extensive literature, collaborative care has consistently demonstrated higher effectiveness than usual care. While these services are often provided via in-person patient contact in the patient's primary care clinic, telephonic or other electronic contact can also be effective (and efficient). A typical manager carries an active caseload of 50-100 patients.

14. Behavioral Health Emergency Procedures

MetroPlusHealth has a process when a member calls in crisis, to respond to all urgent behavioral health calls and provide a warm transfer to a behavioral health clinician. MetroPlusHealth will be contracting with a vendor 24/7/365 to ensure that these calls will be transferred via a warm transfer to a live behavioral health clinician. When a Member calls MetroPlusHealth, the IVR process will allow for the member to be connected to a customer service representative for urgent calls. The customer services representative will screen if this is a crisis/emergency call and warm transfer the call to the vendor who will manage and triage all crisis calls.
Once the crisis is stabilized, there is a process for the MetroPlus Behavioral Health Case Management department to follow up with the member as necessary.

RFQ 3.4 (c)(iv); MMC/FHP Contract

10.13 (a) and 12.1 (e) option for urgent matter

IA Outpatient Medical Record Documentation Standards

Concise medical record documentation is critical to providing patients with quality care as well as to receiving accurate and timely reimbursement for furnished services. It chronologically documents the care of the patient and is required to record pertinent facts, findings, and observations about the patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. Medical record documentation also assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring his or her health care over time.

Payers may require reasonable documentation that services are consistent with the insurance coverage provided in order to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services furnished have been accurately reported.

In alignment with NCQA's Guidelines for Medical Record Documentation, to ensure that medical record documentation is accurate, the following principles should be followed:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - Significant illnesses and medical conditions are indicated on the problem list
  - Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record
  - Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses
    - Member-reported services included as past medical history should capture date and place of service, procedure, prescription, test result or finding and practitioner type when applicable.
  - Working diagnoses are consistent with findings
  - Treatment plans are consistent with diagnoses
  - There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure
  - Date and legible identity of the observer

  If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented. The Current Procedural Terminology (CPT) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The following requirements apply to all outpatient medical records:

- A separate medical record is maintained for each patient.
- Every page in the medical record contains the patient's name or identification number.
- Each medical record contains personal biographical data including:
  - Address
  - Date of birth
  - Gender
  - Marital status
  - Next of kin or emergency contact
  - Employer and work or school telephone number (as applicable)
  - Home telephone number (if patient has one)
  - Medicaid or Member identification number
  - Consent and guardian information (as applicable)
- All entries in the medical record contain identification of the author. Author identification may be a handwritten signature, unique electronic identifier or initials. A supervising Participating Provider countersigns all entries by a resident.
- All entries in the medical record are dated.
- The record is legible to someone other than the writer.
- Significant illness and medical conditions are indicated on a problem list. A complete, up to date problem list should be maintained in the medical record for patients with multiple/chronic conditions.
- Medication allergies and adverse drug reactions are noted in the record in a clearly identifiable location. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- A medication list includes the patient's medication history as well as current medications.
- Past medical history is easily identified for any patient seen three or more times, and includes documentation of serious accidents, operations, and illnesses. For children and adolescents (up to 18 years of age), documentation of past medical history includes prenatal care, birth, operations and childhood illnesses.

- For patients 12 years and older who are seen for a routine evaluation, notation concerning the use of tobacco, alcohol and other substances is present in the record. For patients seen three or more times, substance use history is queried.
- Progress Notes should be in S.O.A.P. format as follows:
    - S: The patient's (or caretaker's) subjective statement about the primary problem for which the Physician was consulted.
    - O: The Provider's objective observation of the patient's condition. Any pertinent history or physical examination data relating to chief complaints.
    - A: The Provider's assessment of the patient's condition or their diagnosis impressions.
    - P: The treatment plan, including medications, diagnostic testing and return date.
- For diabetic patients who are seen for routine evaluation, notation concerning results of A1C, Diabetic Eye Exam, Blood Pressure, and Pedal Examination is present in the record.

- Laboratory and other studies are ordered, as appropriate and subsequent results are filed in the medical record.
- Consultations, laboratory and x-ray reports filed in the medical record are initialed or electronically signed by the provider who ordered them to signify review.
- Consultations and abnormal laboratory and imaging study results have an explicit notation in the record with regard to follow-up plans and patient notification.
- The working diagnosis is consistent with the findings from the history taking, physical examination and/or studies or tests performed.
- The treatment plan is consistent with the working diagnosis.
- Encounter forms or progress notes contain a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return should be noted in weeks, months or as needed (PRN).
- The medical record contains documentation indicating that unresolved problems from previous office visits are addressed in subsequent visits.
- The record contains documentation, which supports the use of consultants to address patient complaints/findings.
- When a consultation is ordered, a note from the consultant is present in the record or there is evidence of coordination of care between primary and specialty (consulting) Provider.

- When the patient is referred to a behavioral health Provider or a history of behavioral health treatment is noted, evidence of the coordination of care between the primary care and behavioral health Provider is present in the medical record.
- The record contains evidence that care is medically appropriate and that the risks of diagnostic or therapeutic procedures versus no diagnosis/treatment for specific problems has been explained to the patient.
- For children, the immunization record is up to date and for adults an appropriate history of immunizations has been taken.
- The record contains evidence that preventive health screening and services have been offered to the patient in accordance with the plan's preventive health guidelines, including the growth and BMI chart.

For Evaluation and Management Services documentation it is recommended that providers refer to the following publications:

- *1995 Documentation Guidelines for Evaluation and Management Services*, available at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf on the Centers for Medicare & Medicaid Services (CMS) website;
- *1997 Documentation Guidelines for Evaluation and Management Services*, available at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf on the CMS website;
- Medicare Claims Processing Manual (Pub. 100-4), available at www.cms.hhs.gov/Manuals/ on the CMS website; and
- *Current Procedural Terminology* book, available from the American Medical Association (800.621.8335 or www.amapress.org on the Web).

IB Outpatient Behavioral Health Treatment Record Documentation Standards

The following requirements apply to all Outpatient Behavioral Health Treatment records:

- A separate treatment record is maintained for each patient.
- Every page in the treatment record contains the patient's name or identification number.
- Every medical record contains personal biographical data including:
  - Address
  - Date of birth
  - Gender
  - Marital or legal status
  - Next of kin or emergency contact
  - Employer and work telephone number, or school telephone number (as applicable)
  - Home telephone number (if patient has one)
  - Medicaid or Member identification number
  - Consent and guardian information, if applicable
- All entries in the treatment record are dated.
- The responsible clinician's name, professional degree and relevant identification number, if applicable. A supervising Participating Provider countersigns all entries by a resident or intern.
- The record is legible to someone other than the writer.
- Medication allergies, adverse reactions and relevant medical conditions are clearly documented, dated and recorded in an easily identifiable location.
- Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
- The results of a mental status exam are documented.
- Special status situations, when present, such as imminent risk of harm to self or others are prominently noted, documented and revised overtime as appropriate.
- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- Time element (duration), (where time is an element of the face-to-face contact for the service rendered).
- A medical and psychiatric history is documented including:
  - Previous treatment dates
  - Provider identification
  - Therapeutic interventions and responses
  - Sources of clinical data
  - Relevant family information

For interactive therapy, medical record should indicate the adaptations utilized in the session and the rationale for employing these interactive techniques.

For services that include a medical evaluation and management component, documentation of the medical evaluation or management component of the treatment, including prescriptions, monitoring of medication effects and results of clinical tests.

Group therapy session notes must also be prepared within a reasonable time period after the rendering of professional services consistent with accepted practice, and can be organized according to the general session note guidelines for individual therapy or the clinician may elect to use the following group note format.

One group note that is common to all patients, documenting date, length of time for each session, along with key issues presented. Names of the patients in the group should not appear in this group note.

An additional notation, or addendum to the group note, for each patient's record, commenting on that particular patient's participation in the group process and any significant changes in patient status. As outlined in HIPAA regulations above, the note should exclude content of the patient conversation.

CMS State Medicaid Manual Section 4221:

D. Documentation. – The outpatient program should develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, should consist of material which includes:

1. the specific services rendered.
2. the date and actual time the services were rendered.
3. who rendered the services.
4. the setting in which the services were rendered.
5. the amount of time it took to deliver the services.
6. the relationship of the services to the treatment regimen described in the PoC, and
7. updates describing the patient's progress.

For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

IC Perinatal Medical Record Documentation Standards

Members can go to an Ob/GYN, or other prenatal care practitioner or PCP for prenatal and/or postpartum care.

The following components of prenatal and postpartum care documentation guidelines, in addition to the Outpatient Medical Record Standards, should be reflected in all medical records.

Initial Prenatal Care Visit

1. Date of First Prenatal Visit
2. Gestational age at first visit
3. Expected Delivery Date
4. Physical Examination.
   Note height, pre-pregnancy weight, initial visit weight, blood pressure, head, neck and mouth, breasts, heart, lungs, abdomen, pelvis, uterus, vagina, cervix, rectum, extremities.
   "PE =WNL" is not considered acceptable documentation.
5. Comprehensive Risk Assessment performed during the first 2 visits with the Member (regardless of the stage of pregnancy), the assessment should focus on an analysis of individual characteristics affecting pregnancy including:

   - *Medical/health History*

   Note review of systems, previous and current medical/surgical problems, list of all medications taken within the past 12 months and family history of disease.

   - *Obstetric History*

   Note menstrual history, past pregnancies, number of full-term pregnancies, premature deliveries, spontaneous and induced abortions, number of living children, spacing of previous pregnancies, length of each gestation, route of each delivery, sex and weight of each newborn, exposure to group B strep, and any complications, particularly those that resulted in fetal or neonatal death.

   - *Prenatal Risk Assessment, Screening and Referral for Care*
     Prenatal care (PNC) providers shall conduct a comprehensive prenatal care risk assessment for both maternal and fetal risks, at the earliest prenatal care visit, on all pregnant women. The risk assessment shall include but not be limited to an analysis of individual characteristics affecting pregnancy, such as genetic, nutritional, environmental, behavioral health, psychosocial and history of previous and current obstetrical/fetal and medical/surgical risk factors.
   - *Nutritional Screening, Counseling and Referral for Care*

     Note eating habits and screening for specific nutritional risk conditions. A notation of "diet adequate," 24-hour diet recall, or similar statement are acceptable forms of documentation. Documentation that simply notes prescription/advice for prenatal vitamins is not acceptable.
   - *Psychosocial Risk Assessment, Screening, Counseling and Referral for Care*

The assessment shall include a broad range of social, economic, psychological and emotional problems. Note assessment of barriers to care, unstable housing, communication barriers (i.e. language and /or cultural barriers), nutrition, tobacco use, substance use, depression or other psychiatric illness, safety, domestic violence, sexual abuse, and stress. Listing of demographic information alone is not acceptable documentation.

- *Genetic Risk Factors*
- Note that the history obtained during the initial evaluation was reviewed to detect risk factors for genetic disorders. The assessment should be comprehensive and consistent with current standards of practice.
- *Home/Work Environment*
- Note exposure to secondhand smoke, lead, chemicals and toxoplasmosis.
- *History and Current Use of Tobacco, Alcohol and Drugs*
- Use of prescribed and over-the-counter medications should be included in the history.
- *Infectious Disease Screening*
- Note exposure to HIV, rubella, tuberculosis and sexually transmitted diseases.

6. Care Plan which addresses the problems identified as a result of the initial risk assessment. The care plan shall describe the implementation and coordination of all services required by the pregnant woman, be routinely updated and implemented jointly by the pregnant woman, her family and the appropriate members of the health care team.

Care Plan Development and Care Coordination

1. A problem list with the care plan.
2. Evidence of ongoing assessment of risk factors throughout pregnancy including review of symptoms, awareness of fetal movements, occurrence of contractions or rupture of membranes, review of laboratory data, emerging nutritional, medical and psychosocial factors, with appropriate documentation that symptoms, findings or changes in patient status are being addressed in the care plan.
3. Regular care plan updates.
4. Referrals and assessments including, when appropriate, evidence of social work referral and assessment, referral to a nutritionist and nutrition assessment, and referral to high-risk care.

Prenatal Care Visits

All lab tests are conducted on a risk-appropriate basis, except for syphilis and hepatitis B testing mandated by law. Indication that the test was performed and the results of the test should be present in the record.

Initial Testing:

1. Hemoglobin electrophoresis with documentation of the women's ethnicity. HgB electrophoresis is strongly recommended by NYSDOH rather than the sickle prep test.
2. Hemoglobin/hematocrit
3. Hepatitis B Surface Antigen
4. Blood Type
5. Rh Type
6. Antibody Screen
7. Rubella
8. VDRL or RPR
9. PPD
10. Chlamydia
11. GC Screen
12. Vaginal/cervical cytology: document if testing was done within one year and the results were negative.
13. Urine screen

Additional Testing:

1. Maternal Serum AFP (14-18 weeks)
2. Glucose Challenge (24-28 weeks)
3. Hemoglobin/Hematocrit (third trimester)
4. Group B Strep (35-37 weeks)
5. HbsAg (28-36 weeks)
6. VDRL (28-36 weeks
7. Chlamydia (third trimester)
8. GC Screen (third trimester)
9. Ultrasound
10. Amniocentesis

Rhogam: Given at 28 weeks, when indicated.

HIV Counseling/testing, document if the Member's HIV status is known prior to testing or if the Member refused the test.

Patient Education

Documentation in the medical record should include the specific health education topics covered. If the patient attended prenatal or childbirth classes, document if the course was completed. If a woman had previous deliveries, document assessment of her level of knowledge (e.g. signs and symptoms of labor). Specific patient education topics must be covered:

1. Basic nutrition, including dietary intake and weight gain
2. Avoidance of harmful practices/substances, including alcohol, non-prescription medications, nicotine and other drugs
3. Risk of HIV infection/risk reduction behavior
4. Signs/symptoms of pregnancy complications
5. Signs/symptoms of labor
6. Relaxation techniques in labor
7. Childbirth education/class attendance
8. Labor and delivery process
9. OB anesthesia and analgesia
10. Breastfeeding/infant feeding choices
11. Preparation for parenting, including infant development, care and safety
12. Family planning, including methods of contraception
13. Pediatric care, including infant care education (e.g. immunization and well child visit schedule)

Postpartum Care

1. Documentation of the visit scheduled on or between 7 and 84 days after delivery should include:
2. Information such as delivery date, type of delivery, number of infant(s) delivered, sex(es),birth weight(s), and gestational age(s).
3. Perineal or Cesarean incision/ wound check, if applicable.
4. A physical check- up after delivery including breasts, blood pressure, abdomen, external and internal genitalia, and weight.
5. Depression screening – Screening should be coupled with appropriate follow-up and treatment when indicated.
6. Family planning services provided or referrals made.
7. Preconception counseling on improving nutritional status, genetic counseling, and correction of chronic health problems that could lead to poor future pregnancy outcomes.
8. Postnatal needs assessment of nutritional factors, medical issues, pre-existing mental health disorders, social determinants of health, psychosocial factors, breast- feeding, smoking/vaping, alcohol and substance use treatment needs.
9. Referrals as needed.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

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	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9] →	→	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←	←	●[10] →	→	←	●[10] →	→	←	●[10] →	→	→
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20] →	→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	←	→	●	→	→
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←	●	→	★	★	★	★
Hepatitis B Virus Infection[31]		★ →	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
Hepatitis C Virus Infection[32]																													●	→	→	→
Sudden Cardiac Arrest/Death[33]																						★	→	→	→	→	→	→	→	→	→	→
Cervical Dysplasia[34]																																●
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★	★	★															
Fluoride Varnish[37]							←	→	→	→	●	→	→	→	→	→	→															
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2011-3552). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (https://doi.org/10.1542/peds.2007-2329C).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←★ or ●→ = range during which a service may be provided

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14. Screen for behavioral and social-emotional problems per "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (https://doi.org/10.1542/peds.2014-3716), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders" (https://pubmed.ncbi.nlm.nih.gov/32439401), and "Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative" (https://pubmed.ncbi.nlm.nih.gov/32510990). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See "Poverty and Child Health in the United States" (https://doi.org/10.1542/peds.2016-0339), "The Impact of Racism on Child and Adolescent Health" (https://doi.org/10.1542/peds.2019-1765), and "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health" (https://doi.org/10.1542/peds.2021-052582).
15. A recommended assessment tool is available at http://crafft.org.
16. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management" (https://doi.org/10.1542/peds.2017-4081), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Suicide and Suicide Attempts in Adolescents" (https://doi.org/10.1542/peds.2016-1420), and "The 21st Century Cures Act & Adolescent Confidentiality" (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (https://doi.org/10.1542/peds.2011-0322).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by Children The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (https://doi.org/10.1542/peds.2009-0329).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (https://doi.org/10.1542/peds.2011-3211).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://publications.aap.org/redbook/pages/immunization-schedules. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (https://doi.org/10.1542/peds.2016-1493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (https://www.cdc.gov/nceh/lead/docs/final_document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the US Preventive Services Task Force (USPSTF) recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
33. Perform a risk assessment, as appropriate, per "Sudden Death in the Young: Information for the Primary Care Provider" (https://doi.org/10.1542/peds.2021-052044).
34. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (https://doi.org/10.1542/peds.2010-1564).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
36. Perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/). See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2014-2984).
37. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).
38. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in November 2021 and published in July 2022. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN NOVEMBER 2021

HEPATITIS B VIRUS INFECTION

Assessing risk for HBV infection has been added to occur from newborn to 21 years (to account for the range in which the risk assessment can take place) to be consistent with recommendations of the USPSTF and the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.

- Footnote 31 has been added to read as follows: "Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient."

SUDDEN CARDIAC ARREST AND SUDDEN CARDIAC DEATH

Assessing risk for sudden cardiac arrest and sudden cardiac death has been added to occur from 11 to 21 years (to account for the range in which the risk assessment can take place) to be consistent with AAP policy ("Sudden Death in the Young: Information for the Primary Care Provider").

- Footnote 33 has been added to read as follows: "Perform a risk assessment, as appropriate, per 'Sudden Death in the Young: Information for the Primary Care Provider' (https://doi.org/10.1542/peds.2021-052044)."

DEPRESSION AND SUICIDE RISK

Screening for suicide risk has been added to the existing depression screening recommendation to be consistent with the GLAD-PC and AAP policy.

- Footnote 16 has been updated to read as follows: "Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See 'Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management' (https://doi.org/10.1542/peds.2017-4081), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Suicide and Suicide Attempts in Adolescents' (https://doi.org/10.1542/peds.2016-1420), and 'The 21st Century Cures Act & Adolescent Confidentiality' (https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2019-(1)/NASPAG-SAHM-Statement.aspx)."

BEHAVIORAL/SOCIAL/EMOTIONAL

The Psychosocial/Behavioral Assessment recommendation has been updated to Behavioral/Social/Emotional Screening (annually from newborn to 21 years) to align with AAP policy, the American College of Obstetricians and Gynecologists (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines.

- Footnote 14 has been updated to read as follows: "Screen for behavioral and social-emotional problems per 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (https://doi.org/10.1542/peds.2014-3716), 'Mental Health Competencies for Pediatric Practice' (https://doi.org/10.1542/peds.2019-2757), 'Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders' (https://pubmed.ncbi.nlm.nih.gov/32439401), and 'Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative' (https://pubmed.ncbi.nlm.nih.gov/32510990/). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See 'Poverty and Child Health in the United States' (https://doi.org/10.1542/peds.2016-0339), 'The Impact of Racism on Child and Adolescent Health' (https://doi.org/10.1542/peds.2019-1765), and 'Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health' (https://doi.org/10.1542/peds.2021-052582)."

FLUORIDE VARNISH

- Footnote 37 has been updated to read as follows: "The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

FLUORIDE SUPPLEMENTATION

- Footnote 38 has been updated to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (https://doi.org/10.1542/peds.2020-034637)."

CHANGES MADE IN NOVEMBER 2020

DEVELOPMENTAL

- Footnote 12 has been updated to read as follows: "Screening should occur per 'Promoting Optimal Development: Identifying Infant and Young Children With Developmental Disorders Through Developmental Surveillance and Screening' (https://doi.org/10.1542/peds.2019-3449)."

AUTISM SPECTRUM DISORDER

- Footnote 13 has been updated to read as follows: "Screening should occur per 'Identification, Evaluation, and Management of Children With Autism Spectrum Disorder' (https://doi.org/10.1542/peds.2019-3447)."

HEPATITIS C VIRUS INFECTION

- Screening for HCV infection has been added to occur at least once between the ages of 18 and 79 years (to be consistent with recommendations of the USPSTF and CDC).
- Footnote 32 has been added to read as follows: "All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually."

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BONUS DIGITAL CONTENT

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(as of May 9, 2022)*

To be used in conjunction with USPSTF recommendation statements (for additional details see tables and references at https://www.aafp.org/afp/PHCS)

Only grade A/B recommendations are shown

Age	18	21	24	25	35	40	45	50	55	59	65	70	74	75	80
USPSTF screening recommendations															
Alcohol misuse[1]	(B)														
Unhealthy drug use[2]	(B)														
Depression[3]	(B)														
Hypertension[4]	(A)														
Obesity/weight loss[5]	(B) if BMI 30 kg per m² or greater														
Tobacco use and cessation[6]	(A)														
Hepatitis C virus infection[7]	(B)														
HIV infection[8]	(A)											(A) if at increased risk			
Hepatitis B virus infection[9]	(B) if at increased risk														
Syphilis[10]	(A) if at increased risk														
Tuberculosis[11]	(B) if at increased risk														
BRCA gene risk assessment[12]	(B) if appropriate personal or family history of ***BRCA***-related cancer or ancestry														
Chlamydia and gonorrhea[13]	(B) if sexually active			(B) if at increased risk											
Intimate partner violence[14]	(B) women of childbearing age														
Cervical cancer[15]		(A) See p. 3 for test options and screening intervals													
Prediabetes and type 2 diabetes[16]					(B) if overweight or obese										
Colorectal cancer[17]							(B)	(A)							
Breast cancer[18]								(B) biennial screening							
Lung cancer[19]								(B) if 20-pack-year history and current or former smoker (quit in past 15 years)							
Osteoporosis[20]							(B) if postmenopausal and elevated risk				(B)				
Abdominal aortic aneurysm[21]											(B) if an "ever smoker"				
USPSTF preventive therapies recommendations															
HIV preexposure prophylaxis[22]	(A) if at high risk of HIV infection														
Primary prevention of breast cancer[23]	(B) offer if at increased risk for breast cancer and low risk for side effects														
Folic acid supplementation[24]	(A) if capable of conceiving														
Statins for primary prevention of CVD[25]						(B) see criteria on p. 4									
Fall prevention in community-dwelling older adults[26]											(B) exercise interventions if at increased fall risk				
USPSTF counseling recommendations															
Sexually transmitted infection prevention[27]	(B) if at increased risk														
Diet/activity for CVD prevention[28]	(B) adults with CVD risk factors														
Skin cancer prevention[29]	(B) if fair skinned														
Healthy weight gain in pregnancy[30]	(B) all pregnant women														

Legend	Normal risk	With specific risk factor
Recommendation for men and women		
Recommendation for men only		
Recommendation for women only		

Recommendation grades	
A	Recommended (likely significant benefit)
B	Recommended (likely moderate benefit)
C	Do not use routinely (benefit is likely small)
D	Recommended against (likely harm or no benefit)
I	Insufficient evidence to recommend for or against

BMI = body mass index; CVD = cardiovascular disease; USPSTF = U.S. Preventive Services Task Force.

Visual adaptation from recommendation statements by Swenson PF, Lindberg C, Carrilo C, and Clutter J.

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USPSTF

HIV RISK FACTORS

- IV drug use
- Men who have sex with men
- Other STI
- Requesting STI testing
- Sex exchanged for drugs or money
- Sex with individuals who are IV drug users, bisexual, or HIV positive
- Unprotected sex, including anal intercourse

Patients in whom to consider PrEP:

Sexually active men who have sex with men who have any of the following:

- Sexual relationship with serodiscordant partner
- Inconsistent use of condoms during anal sex
- Syphilis, gonorrhea, or chlamydia infection in past six months

Sexually active heterosexual patients with any of the following:

- Sexual relationship with serodiscordant partner
- Inconsistent use of condoms with high-risk partner
- Syphilis or gonorrhea infection in past six months

Injection drug users with any of the following:

- Shared drug-injection equipment
- Risks of infection through sex (see above)

IV = intravenous; PrEP = preexposure prophylaxis; STI = sexually transmitted infection.

HEPATITIS B INFECTION RISK FACTORS

- HIV infection
- Infected sex partner
- Intravenous drug use
- Living with an infected individual
- Men who have sex with men
- Origin from regions* with prevalence ≥ 2%
- U.S.-born children of immigrants from regions* with prevalence ≥ 8%, if unvaccinated

*—Risk of regions can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5708a1.htm.

SYPHILIS RISK FACTORS

- High-risk sexual behaviors
- Incarceration
- Local prevalence
- Men who have sex with men
- Sex exchanged for drugs or money

TUBERCULOSIS RISK FACTORS

- Health professionals*
- Homelessness, including former
- Immunosuppression*
- Prisoners, including former
- Residents of high-risk regions, including former

*—Evidence for screening not reviewed by the USPSTF because this is standard practice in public health and standard of care for patients with immunosuppression, respectively.

CHLAMYDIA AND GONORRHEA RISK FACTORS

- New or multiple sex partners
- Other STI, including history of STI
- Partner with STI
- Partners who have multiple sex partners
- Sex exchanged for drugs or money
- Unprotected sex or inconsistent condom use

STI = sexually transmitted infection.

CARDIOVASCULAR DISEASE RISK FACTORS

- Atherosclerotic cardiovascular disease risk ≥ 7.5%
- Dyslipidemia
- Hypertension or elevated blood pressure
- Metabolic syndrome

BREAST CANCER RISK FACTORS

Consider use of a risk-assessment model for patients with a history of biopsy or positive family history

SEXUALLY TRANSMITTED INFECTION RISK FACTORS

Similar to those risk factors listed previously for sexually transmitted infections; consider local and population-based prevalence in individual risk assessment

USPSTF

Adult Preventive Health Care Schedule: Recommendations from the USPSTF

Grade A/B Recommendations (with Associated Grade C/D/I Recommendations):

Alcohol misuse screening[1]

(B) Screen adults and provide brief behavioral interventions for risky alcohol use

Unhealthy Drug Use Screening[2]

(B) Screen all adults older than 18 years for unhealthy drug use (by asking questions, not biological specimens)

Depression screening[3]

(B) Screen adults with systems for evaluation and management

Hypertension screening[4]

(A) Screen adults; exclude white coat hypertension before starting therapy

Obesity/weight loss screening[5]

(B) Refer adults with obesity to intensive behavioral interventions for weight loss

Tobacco use and cessation screening[6]

(A) Screen all nonpregnant adults and provide behavior therapy and U.S. Food and Drug Administration–approved intervention therapy for cessation

(A) Screen all pregnant women and provide behavior therapy.

(I) IETRFOA electronic nicotine delivery systems for tobacco cessation

(I) Pharmacotherapy for tobacco cesation in pregnant persons

Hepatitis C virus infection screening[7]

(B) Screen adults 18 to 79 years of age

HIV infection screening[8]

(A) Screen individuals 15 to 65 years of age

(A) Screen older and younger persons who are at increased risk

Hepatitis B virus infection screening[9]

(B) Screen adolescents and adults at high risk

Syphilis screening[10]

(A) Screen individuals at increased risk

Tuberculosis screening[11]

(B) Screen individuals at increased risk

***BRCA*-related cancer risk assessment/screening[12]**

(B) Use a familial risk assessment tool (evaluated assessment tools listed in full text) in women with either:

- Personal or family history of breast, ovarian, tubal, or peritoneal cancers
- Ashkenazi Jewish ancestry (i.e., ancestry with increased risk of *BRCA* mutation)

For positive risk tools, offer genetic counseling and genetic testing, if indicated.

(D) Recommend against screening for patients without appropriate family history, personal history, or ancestry

Chlamydia and gonorrhea screening[13]

(B) Screen sexually active women 24 years and younger, and women at increased risk who are 25 years and older

(I) IETRFOA screening sexually active men

Intimate partner violence screening[14]

(B) Screen women of childbearing age and refer to appropriate services

(I) IETRFOA screening all vulnerable and older adults for abuse or neglect

Cervical cancer screening[15]

(A) Screen women

- 21 to 29 years of age every three years with cytology alone
- Frequency of screening may increase to every five years for women 30 to 65 years of age with cytology and high-risk human papillomavirus cotesting or high-risk human papillomavirus testing alone

(D) Recommend against screening in women

- 20 years and younger
- Older than 65 years if adequately screened previously and no increased risk of cervical cancer
- With hysterectomy (including cervix) without history of cervical intraepithelial neoplasia grade 2 or 3 or cervical cancer
- Younger than 30 years with human papillomavirus testing alone or in combination with cytology

Prediabetes and type 2 diabetes screening[16]

(B) Screen adults 35 to 70 years of age who are overweight or obese and refer patients with abnormal glucose levels for intensive counseling for healthy diet and exercise

Colorectal cancer screening[17]

(A) Screen patients 50 to 75 years of age with fecal occult blood (or immunochemical) test, sigmoidoscopy, colonoscopy, computed tomography colonography, or multitargeted stool DNA test

(B) Screen patients 45 to 49 years of age with fecal occult blood (or immunochemical) test, sigmoidoscopy, colonoscopy, computed tomography colongraphy, or multitargeted stool DNA test

(C) Selectively offer screening to patients 76 to 85 years of age

Breast cancer screening[18]

(B) Biennial screening mammography in women 50 to 74 years of age

(C) Screening is an individualized decision for women 40 to 49 years of age

(I) IETRFOA

- Mammography after 75 years of age
- Screening with digital breast tomosynthesis
- Adjunctive screening in women with dense breast tissue and negative screening mammogram

Lung cancer screening[19]

(B) Screen annually with low-dose computed tomography for individuals 50 to 80 years of age with a 20-pack-year history who currently smoke or quit within the past 15 years; discontinue screening once a person has not smoked for 15 years or develops a health problem that limits life expectancy

Osteoporosis screening[20]

(B) Screen women 65 years and older

(B) Screen postmenopausal women if increased fracture risk shown with an osteoporosis risk tool (e.g., 8.4% in 10 years by U.S. FRAX tool)

(I) IETRFOA screening men

continues

CHD = coronary heart disease; CVD = cardiovascular disease; FRAX = Fracture Risk Assessment; IETRFOA = insufficient evidence to recommend for or against; PrEP = preexposure prophylaxis; USPSTF = U.S. Preventive Services Task Force.

USPSTF

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(continued)*

Grade A/B Recommendations (with Associated Grade C/D/I Recommendations): (continued)

Abdominal aortic aneurysm screening[21]

(B) Screen men 65 to 75 years of age who ever smoked (100 or greater lifetime cigarettes) with one-time abdominal aortic aneurysm ultrasonography

(C) Recommend selective screening of men 65 to 75 years who have never smoked

(I) IETRFOA women 65 to 75 years of age who ever smoked

(D) Recommend against routine screening in women 65 to 75 years of age who have never smoked

HIV prevention with PrEP[22]

(A) Offer PrEP to persons at high risk of infection. See original text for considerations in patient selection

Primary prevention of breast cancer[23]

(B) Consider medications (such as tamoxifen, raloxifene, or aromatase inhibitors) that reduce risk of breast cancer in women at increased risk though with low risk of adverse effects

(D) Recommend against routine use if no increased risk

Folic acid supplementation[24]

(A) 0.4 to 0.8 mg daily for women capable of conceiving

Statins for primary prevention of CVD[25]

(B) Recommend low- to moderate-dose statin therapy in patients meeting all three criteria:

(1) 40 to 75 years of age

(2) Dyslipidemia, diabetes, hypertension, or smoker

(3) 10-year CVD risk of 10% or greater

(C) Consider low- to moderate-dose statin therapy in appropriate candidates meeting the first two criteria but with a 10-year CVD risk of 7.5% to 10%

(I) IETRFOA initiating statin therapy after 75 years of age for primary prevention

Fall prevention in community-dwelling older adults[26]

(B) Recommend exercise interventions for individuals 65 years and older at increased risk of falls

(C) Recommend multifactorial interventions for appropriate individuals 65 years and older; see Clinical Considerations in original recommendation statement for patient selection

(D) Recommend against vitamin D supplementation for fall prevention

Counseling to prevent sexually transmitted infection[27]

(B) Recommend counseling to prevent sexually transmitted infection for adolescents and adults at increased risk

Counseling to promote healthy diet and physical activity[28]

(B) Recommend that patients with other CVD risk factor(s) who are overweight or obese be offered or referred for intensive behavioral counseling

Counseling for skin cancer prevention[29]

(B) Recommend counseling fair-skinned patients six months to 24 years of age about minimizing ultraviolet radiation

(C) Recommend selectively counseling fair-skinned patients older than 24 years about minimizing exposure to ultraviolet radiation

(I) IETRFOA counseling adults about skin self-examination

Counseling to promote healthy weight gain in pregnancy[30]

(B) Offer behavioral counseling interventions to promote health weight gain and to prevent excessive weight gain to all pregnant women

Grade C Recommendations:

Initiation of low-dose aspirin for adults 40 to 59 years of age who have a 10% or greater 10-year CVD risk[31]

Physical activity and healthy diet counseling to reduce cardiovascular risk in adults without obesity or known CVD risk factors[32]

Prostate cancer screening with prostate-specific antigen testing in men 55 to 69 years of age after shared decision-making[33]

Grade D Recommendations:

Bacteriuria (asymptomatic) screening in nonpregnant adults[34]

Beta carotene or vitamin E supplementation for CVD or cancer risk reduction[35]

Carotid artery stenosis screening[36]

CVD screening with resting or exercise electrocardiography in low-risk patients[37]

Chronic obstructive pulmonary disease screening with spirometry[38]

Combined estrogen-progesterone for prevention of chronic conditions or estrogen for the same in patients with hysterectomy[39]

Genital herpes screening[40]

Initiation of low-dose aspirin for adults 60 years or older[31]

Ovarian cancer screening[41]

Pancreatic cancer screening[42]

Prostate cancer screening with prostate-specific antigen testing in men 70 years and older[33]

Testicular cancer screening[43]

Thyroid cancer screening[44]

Vitamin D (≤ 400 IU) and calcium (≤ 1,000 mg) supplementation daily for primary prevention of fracture in postmenopausal women[45]

Grade I Statements:

Atrial fibrillation screening[46]

Bladder cancer screening[47]

Celiac disease screening[48]

CVD screening in patients with nontraditional risk factors[49]

CVD screening with resting or exercise electrocardiography in intermediate- to high-risk patients[37]

Chronic kidney disease screening[50]

Cognitive impairment screening in older adults[51]

Eating disorders screening[52]

Gynecologic condition screening with pelvic examination[53]

Hearing loss screening in older adults[54]

Impaired visual acuity screening in older adults[55]

Multivitamin, single nutrient, or paired nutrients for CVD or cancer risk reduction (beta carotene and vitamin E, as above)[35]

Obstructive sleep apnea screening[56]

Oral cancer screening[57]

Peripheral artery disease and CVD risk screening with ankle-brachial index[58]

continues

CHD = coronary heart disease; CVD = cardiovascular disease; FRAX = Fracture Risk Assessment; IETRFOA = insufficient evidence to recommend for or against; PrEP = preexposure prophylaxis; USPSTF = U.S. Preventive Services Task Force.

USPSTF

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(continued)*

Primary open-angle glaucoma screening[59]

Primary prevention of fractures with vitamin D and calcium supplementation (alone or combined; dose unspecified) in men or premenopausal women, and in postmenopausal women with daily dosages > 400 IU of vitamin D and > 1,000 mg of calcium[45]

Skin cancer screening[60]

Suicide risk screening[61]

Thyroid dysfunction screening[62]

Vitamin D deficiency screening in community-dwelling nonpregnant adults[63]

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USPSTF

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(continued)*

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Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES 2022

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
Dengue vaccine	DEN4CYD	Dengvaxia®
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	DT	No trade name
Haemophilus influenzae type b vaccine	Hib (PRP-T) Hib (PRP-OMP)	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IIV4	Multiple
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D	Menactra®
	MenACWY-CRM	Menveo®
	MenACWY-TT	MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C	Bexsero®
	MenB-FHbp	Trumenba®
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax 23®
Poliovirus vaccine (inactivated)	IPV	IPOL®
Rotavirus vaccine	RV1 RV5	Rotarix® RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Tetanus and diphtheria vaccine	Td	Tenivac® Tdvax™
Varicella vaccine	VAR	Varivax®
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix®
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	DTaP-IPV/Hib	Pentacel®
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix® Quadracel®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Vaxelis®
Measles, mumps, rubella, and varicella vaccine	MMRV	ProQuad®

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child and adolescent immunization schedule

1 Determine recommended vaccinations by age **(Table 1)**

2 Determine recommended interval for catch-up vaccination **(Table 2)**

3 Assess need for additional recommended vaccines by medical condition or other indication **(Table 3)**

4 Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**

5 Review contraindications and precautions for vaccine types **(Appendix)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.org).

Report

Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department

Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html

Helpful information

Complete Advisory Committee on Immunization Practices (ACIP) recommendations:
www.cdc.gov/vaccines/hcp/acip-recs/index.html

General Best Practice Guidelines for Immunization (including contraindications and precautions):
www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html

Vaccine information statements:
www.cdc.gov/vaccines/hcp/vis/index.html

Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response):
www.cdc.gov/vaccines/pubs/surv-manual

ACIP Shared Clinical Decision-Making Recommendations
www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

Scan QR code for access to online schedule

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Table 1

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Hepatitis B (HepB)	1st dose	◄----- 2nd dose -----►			◄---------- 3rd dose----------►												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			◄----- 4th dose ----- ►				5th dose					
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes		◄3rd or 4th dose, See Notes --►										
Pneumococcal conjugate (PCV13)			1st dose	2nd dose	3rd dose		◄----- 4th dose ---- ►										
Inactivated poliovirus (IPV <18 yrs)			1st dose	2nd dose	◄---------- 3rd dose ----------►							4th dose					
Influenza (IIV4) or					Annual vaccination 1 or 2 doses									Annual vaccination 1 dose only			
Influenza (LAIV4)											Annual vaccination 1 or 2 doses			Annual vaccination 1 dose only			
Measles, mumps, rubella (MMR)					See Notes		◄----- 1st dose ----- ►					2nd dose					
Varicella (VAR)							◄----- 1st dose ----- ►					2nd dose					
Hepatitis A (HepA)					See Notes		2-dose series, See Notes										
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														1 dose			
Human papillomavirus (HPV)														See Notes			
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See Notes											1st dose		2nd dose	
Meningococcal B (MenB-4C, MenB-FHbp)														See Notes			
Pneumococcal polysaccharide (PPSV23)											See Notes						
Dengue (DEN4CYD; 9-16 yrs)														Seropositive in endemic areas only (See Notes)			

Range of recommended ages for all children | Range of recommended ages for catch-up vaccination | Range of recommended ages for certain high-risk groups | Recommended vaccination can begin in this age group | Recommended vaccination based on shared clinical decision-making | No recommendation/ not applicable

Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2022

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the Notes that follow.**

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib®, Pentacel®, Hiberix®), Vaxelis® or unknown **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; OR if both doses were PedvaxHIB® and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was administered before the 1st birthday **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months and previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was administered before age 12 months	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria, tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	**6 months** if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

Table 3

Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2022

Always use this table in conjunction with Table 1 and the Notes that follow.

VACCINE	INDICATION									
	Pregnancy	Immunocompromised status (excluding HIV infection)	<15% or total CD4 cell count of <200/mm³	≥15% and total CD4 cell count of ≥200/mm³	Kidney failure, end-stage renal disease, or on hemodialysis	Heart disease or chronic lung disease	CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Chronic liver disease	Diabetes
Hepatitis B										
Rotavirus		SCID2								
Diphtheria, tetanus, and acellular pertussis (DTaP)										
Haemophilus influenzae type b										
Pneumococcal conjugate										
Inactivated poliovirus										
Influenza (IIV4)										
or Influenza (LAIV4)						Asthma, wheezing: 2–4yrs³				
Measles, mumps, rubella										
Varicella										
Hepatitis A										
Tetanus, diphtheria, and acellular pertussis (Tdap)										
Human papillomavirus										
Meningococcal ACWY										
Meningococcal B										
polysaccharide										
Dengue										

- Vaccination according to the routine schedule recommended
- Recommended for persons with an additional risk factor for which the vaccine would be indicated
- Vaccination is recommended, and additional doses may be necessary based on medical condition or vaccine. See Notes.
- Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction
- Contraindicated or not recommended—vaccine should not be administered
  *Vaccinate after pregnancy
- No recommendation/not applicable

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the *General Best Practice Guidelines for Immunization*, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.
2 Severe Combined Immunodeficiency
3 LAIV4 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2022.

Additional information

COVID-19 Vaccination

COVID-19 vaccines are recommended for use within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html**.**

CDC's interim clinical considerations for use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html**.**

Consult relevant ACIP statements for detailed recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html.

For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.

Within a number range (e.g., 12–18), a dash (–) should be read as "through."

Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.

Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.

For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).

For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.

The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

Dengue vaccination (minimum age: 9 years)

Routine vaccination

Age 9–16 years living in dengue endemic areas **AND** have laboratory confirmation of previous dengue infection

- 3-dose series administered at 0, 6, and 12 months

Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/vaccine/hcp/index.html

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix® or Quadracel®])

Routine vaccination

5-dose series at age 2, 4, 6, 15–18 months, 4–6 years

- **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
- **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.

For other catch-up guidance, see Table 2.

Special situations

Wound management in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

ActHIB®, Hiberix®, Pentacel®, or Vaxelis®: 4-dose series (3 dose primary series at age 2, 4, and 6 months, followed by a booster dose* at age 12–15 months)

- *Vaxelis® is not recommended for use as a booster dose. A different Hib-containing vaccine should be used for the booster dose.

PedvaxHIB®: 3-dose series (2-dose primary series at age 2 and 4 months, followed by a booster dose at age 12–15 months)

Catch-up vaccination

Dose 1 at age 7–11 months: Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).

Dose 1 at age 12–14 months: Administer dose 2 (final dose) at least 8 weeks after dose 1.

Dose 1 before age 12 months and dose 2 before age 15 months: Administer dose 3 (final dose) at least 8 weeks after dose 2.

2 doses of PedvaxHIB® before age 12 months: Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.

1 dose administered at age 15 months or older: No further doses needed

Unvaccinated at age 15–59 months: Administer 1 dose.

Previously unvaccinated children age 60 months or older who are not considered high risk: Do not require catch-up vaccination

For other catch-up guidance, see Table 2. Vaxelis® can be used for catch-up vaccination in children less than age 5 years. Follow the catch-up schedule even if Vaxelis® is used for one or more doses. For detailed information on use of Vaxelis® see www.cdc.gov/mmwr/volumes/69/wr/mm6905a5.htm.

Special situations

Chemotherapy or radiation treatment:

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.

Hematopoietic stem cell transplant (HSCT):

- 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history

Anatomic or functional asplenia (including sickle cell disease):

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated persons age 5 years or older*

- 1 dose

Elective splenectomy:

Unvaccinated persons age 15 months or older*

- 1 dose (preferably at least 14 days before procedure)

HIV infection:

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

Unvaccinated persons age 5–18 years*

- 1 dose

Immunoglobulin deficiency, early component complement deficiency:

Age 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

**Unvaccinated* = Less than routine series (through age 14 months) OR no doses (age 15 months or older)

Hepatitis A vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

2-dose series (minimum interval: 6 months) at age 12–23 months

Catch-up vaccination

Unvaccinated persons through age 18 years should complete a 2-dose series (minimum interval: 6 months).

Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.

Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel

Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):

- **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses, separated by at least 6 months, between age 12–23 months.
- **Unvaccinated age 12 months or older**: Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination (minimum age: birth)

Birth dose (monovalent HepB vaccine only)

Mother is HBsAg-negative:

- **All** medically stable infants ≥2,000 grams: 1 dose within 24 hours of birth
- Infants <2,000 grams: Administer 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams).

Mother is HBsAg-positive:

- Administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight. For infants <2,000 grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
- Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.

Mother's HBsAg status is unknown:

- Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
- For infants <2,000 grams, administer **HBIG** in addition to HepB vaccine (in separate limbs) within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
- Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine series

3-dose series at age 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)

Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).

Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.

Minimum age for the final (3rd or 4th) dose: 24 weeks

Minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations)

Catch-up vaccination

Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.

Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB®** only).

Adolescents age 18 years or older may receive a 2-dose series of HepB **(Heplisav-B®)** at least 4 weeks apart.

Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

For other catch-up guidance, see Table 2.

Special situations

Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.

Post-vaccination serology testing and revaccination (if anti-HBs < 10mIU/mL) is recommended for certain populations, including:

- **Infants born to HBsAg-positive mothers**
- **Hemodialysis patients**
- **Other immunocompromised persons**

For detailed revaccination recommendations, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html

Human papillomavirus vaccination (minimum age: 9 years)

Routine and catch-up vaccination

HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated

2- or 3-dose series depending on age at initial vaccination:

- **Age 9–14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
- **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)

Interrupted schedules: If vaccination schedule is interrupted, the series does not need to be restarted.

No additional dose recommended when any HPV vaccine series has been completed using the recommended dosing intervals.

Special situations

Immunocompromising conditions, including HIV infection: 3-dose series, even for those who initiate vaccination at age 9 through 14 years.

History of sexual abuse or assault: Start at age 9 years.

Pregnancy: Pregnancy testing not needed before vaccination; HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant

Influenza vaccination (minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

Routine vaccination

Use any influenza vaccine appropriate for age and health status annually:

- 2 doses, separated by at least 4 weeks, for **children age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2021, or whose influenza vaccination history is unknown (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2)
- 1 dose for **children age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2021
- 1 dose for **all persons age 9 years or older**

For the 2021-2022 season, see www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm.

For the 2022–23 season, see the 2022–23 ACIP influenza vaccine recommendations.

Special situations

Egg allergy, hives only: Any influenza vaccine appropriate for age and health status annually

Egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: see Appendix listing contraindications and precautions

Severe allergic reaction (e.g., anaphylaxis) to a vaccine component or a previous dose of any influenza vaccine: see Appendix listing contraindications and precautions

Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

2-dose series at age 12–15 months, age 4–6 years

MMR or MMRV may be administered

Note: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

Catch-up vaccination

Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart

The maximum age for use of MMRV is 12 years.

Minimum interval between MMRV doses: 3 months

Special situations

International travel

Infants age 6–11 months: 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.

Unvaccinated children age 12 months or older: 2-dose series at least 4 weeks apart before departure

Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra], 2 years [MenACWY-TT, MenQuadfi])

Routine vaccination

2-dose series at age 11–12 years; 16 years

Catch-up vaccination

Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)

Age 16–18 years: 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

Menveo

- Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6 and 12 months)
- Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
- Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Menactra

- **Persistent complement component deficiency or complement inhibitor use:**
  - Age 9–23 months: 2-dose series at least 12 weeks apart
  - Age 24 months or older: 2-dose series at least 8 weeks apart
- **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
  - Age 9–23 months: Not recommended
  - Age 24 months or older: 2-dose series at least 8 weeks apart
  - **Menactra®** must be administered at least 4 weeks after completion of PCV13 series.

MenQuadfi®

- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/):

Children less than age 24 months:

- **Menveo® (age 2–23 months)**
  - Dose 1 at age 2 months: 4-dose series (additional 3 doses at age 4, 6 and 12 months)
  - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
- **Menactra® (age 9–23 months)**
  - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)

Children age 2 years or older: 1 dose Menveo®, Menactra®, or MenQuadfi®

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:

1 dose **Menveo®**, **Menactra®**, or **MenQuadfi®**

Adolescent vaccination of children who received MenACWY prior to age 10 years:

Children for whom boosters are recommended because of an ongoing increased risk of meningococcal disease (e.g., those with complement deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.

Children for whom boosters are not recommended (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

Note: Menactra® should be administered either before or at the same time as DTaP. MenACWY vaccines may be administered simultaneously with MenB vaccines if indicated, but at a different anatomic site, if feasible.

For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero®; MenB-FHbp, Trumenba®])

Shared clinical decision-making

Adolescents not at increased risk age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:

- **Bexsero®:** 2-dose series at least 1 month apart
- **Trumenba®:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

Bexsero®: 2-dose series at least 1 month apart

Trumenba®: 3-dose series at 0, 1–2, 6 months

Note: Bexsero® and **Trumenba®** are not interchangeable; the same product should be used for all doses in a series.

For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Pneumococcal vaccination (minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13

4-dose series at age 2, 4, 6, 12–15 months

Catch-up vaccination with PCV13

1 dose for healthy children age 24–59 months with any incomplete* PCV13 series

For other catch-up guidance, see Table 2.

Special situations

Underlying conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during same visit.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral corticosteroids); diabetes mellitus:

Age 2–5 years

Any incomplete* series with:

- 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
- Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)

No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Age 6–18 years

No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Cerebrospinal fluid leak, cochlear implant:

Age 2–5 years

Any incomplete* series with:

- 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
- Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)

No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years

No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later

Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13

PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years

Any incomplete* series with:

- 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
- Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)

No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a dose 2 of PPSV23 5 years later

Age 6–18 years

No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)

Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)

PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a dose 2 of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Chronic liver disease, alcoholism:
Age 6–18 years
No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

Routine vaccination

Poliovirus vaccination (minimum age: 6 weeks)

4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.

4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.

IPV is not routinely recommended for U.S. residents age 18 years or older.

Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV-only series:

Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_%20cid=mm6601a6_w.

Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.

- Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
- Doses of OPV administered on or after April 1, 2016, should not be counted.
- For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.

For other catch-up guidance, see Table 2.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

Rotarix®: 2-dose series at age 2 and 4 months

RotaTeq®: 3-dose series at age 2, 4, and 6 months

If any dose in the series is either **RotaTeq®** or unknown, default to 3-dose series.

Catch-up vaccination

Do not start the series on or after age 15 weeks, 0 days.

The maximum age for the final dose is 8 months, 0 days.

For other catch-up guidance, see Table 2.

Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

Adolescents age 11–12 years: 1 dose Tdap

Pregnancy: 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36.

Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

Adolescents age 13–18 years who have not received Tdap: 1 dose Tdap, then Td or Tdap booster every 10 years

Persons age 7–18 years not fully vaccinated* with DTaP: 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.

Tdap administered at age 7–10 years:

- **Children age 7–9 years** who receive Tdap should receive the routine Tdap dose at age 11–12 years.
- **Children age 10 years** who receive Tdap do not need the routine Tdap dose at age 11–12 years.

DTaP inadvertently administered on or after age 7 years:

- **Children age 7–9 years**: DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
- **Children age 10–18 years**: Count dose of DTaP as the adolescent Tdap booster.

For other catch-up guidance, see Table 2.

Special situations

Wound management in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.

For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

**Fully vaccinated* = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

Varicella vaccination (minimum age: 12 months)

Routine vaccination

2-dose series at age 12–15 months, 4–6 years

VAR or MMRV may be administered*

Dose 2 may be administered as early as 3 months after dose 1 (a dose inadvertently administered after at least 4weeks may be counted as valid)

***Note**: For dose 1 in children age 12–47 months, it is recommended to administer MMR and varicella vaccines separately. MMRV may be used if parents or caregivers express a preference.

Catch-up vaccination

Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:

- **Age 7–12 years**: routine interval: 3 months (a dose inadvertently administered after at least 4 weeks may be counted as valid)
- **Age 13 years and older**: routine interval: 4–8 weeks (minimum interval: 4 weeks)
- The maximum age for use of MMRV is 12 years

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html *and ACIP's Recommendations for the Prevention and Control of 2021-22 seasonal influenza with Vaccines available at* www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm.

Interim clinical considerations for use of COVID-19 vaccines including contraindications and precautions can be found at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Vaccine	Contraindications[1]	Precautions[2]
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using egg-based IIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable [(ccIIV4), Flucelvax® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable [(RIV4), Flublok® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg- based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated [LAIV4, Flumist® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Children age 2 – 4 years with a history of asthma or wheezing • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear or any other cranial CSF leak • Children and adolescents receiving aspirin or salicylate-containing medications • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years old or older • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using LAIV4 (which is egg based), administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states

Vaccine	Contraindications[1]	Precautions[2]
Dengue (DEN4CYD)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long- term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised)	• Pregnancy • HIV infection without evidence of severe immunosuppression • Moderate or severe acute illness with or without fever
Diphtheria, tetanus, pertussis (DTaP) Tetanus, diphtheria (DT)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For DTaP only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP or DTaP	• Guillain-Barré syndrome (GBS) within 6 weeks after previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid— containing or tetanus-toxoid– containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid- containing vaccine • For DTaP only: Progressive neurologic disorder, including infantile spasms, uncontrolled epilepsy, progressive encephalopathy; defer DTaP until neurologic status clarified and stabilized • Moderate or severe acute illness with or without fever
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Hiberix, ActHib, and PedvaxHIB only: History of severe allergic reaction to dry natural latex • Less than age 6 weeks	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • For Heplisav-B only: Pregnancy	• Moderate or severe acute illness with or without fever
Hepatitis A- Hepatitis B vaccine [HepA-HepB, (Twinrix®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever
Meningococcal ACWY (MenACWY) [MenACWY-CRM (Menveo®); MenACWY-D (Menactra®); MenACWY-TT (MenQuadfi®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For MenACWY-D and Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid– or CRM197–containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• For MenACWY-CRM only: Preterm birth if less than age 9 months • Moderate or severe acute illness with or without fever
Meningococcal B (MenB) [MenB-4C (Bexsero®); MenB-FHbp (Trumenba®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV13)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid– containing vaccine or its component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Poliovirus vaccine, inactivated (IPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • Moderate or severe acute illness with or without fever
Rotavirus (RV) [RV1 (Rotarix®), RV5 (RotaTeq®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe combined immunodeficiency (SCID) • History of intussusception	• Altered immunocompetence other than SCID • Chronic gastrointestinal disease • RV1 only: Spina bifida or bladder exstrophy • Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid— containing or tetanus-toxoid– containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid– containing vaccine • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized • Moderate or severe acute illness with or without fever
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long- term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

Recommended Adult Immunization Schedule for ages 19 years or older

UNITED STATES
2022

How to use the adult immunization schedule

1 Determine recommended vaccinations by age **(Table 1)**

2 Assess need for additional recommended vaccinations by medical condition or other indication **(Table 2)**

3 Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**

4 Review contraindications and precautions for vaccine types **(Appendix)**

Vaccines in the Adult Immunization Schedule*

Vaccine	Abbreviation(s)	Trade name(s)
Haemophilus influenzae type b vaccine	Hib	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB® Heplisav-B®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IIV4	Many brands
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Influenza vaccine (recombinant)	RIV4	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM MenACWY-TT	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal 15-valent conjugate vaccine	PCV15	Vaxneuvance™
Pneumococcal 20-valent conjugate vaccine	PCV20	Prevnar 20™
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax 23®
Tetanus and diphtheria toxoids	Td	Tenivac® Tdvax™
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Varicella vaccine	VAR	Varivax®
Zoster vaccine, recombinant	RZV	Shingrix

*Administer recommended vaccines if vaccination history is incomplete or unknown. Do not restart or add doses to vaccine series if there are extended intervals between doses. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American College of Physicians (www.acponline.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), and American Academy of Physician Associates (www.aapa.org), and Society for Healthcare Epidemiology of America (www.shea-online.org).

Report

Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department

Clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System at www.vaers.hhs.gov or 800-822-7967

Injury claims

All vaccines included in the adult immunization schedule except pneumococcal 23-valent polysaccharide (PPSV23) and zoster (RZV) vaccines are covered by the Vaccine Injury Compensation Program. Information on how to file a vaccine injury claim is available at www.hrsa.gov/vaccinecompensation.

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information

Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html

General Best Practice Guidelines for Immunization (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html

Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html

Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual

Travel vaccine recommendations: www.cdc.gov/travel

Recommended Child and Adolescent Immunization Schedule, United States, 2022: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

Scan QR code for access to online schedule

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS310021-A

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
Influenza inactivated (IIV4) or **Influenza recombinant** (RIV4) or	1 dose annually or			
Influenza live, attenuated (LAIV4)	1 dose annually			
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)			
	1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses	
Zoster recombinant (RZV)	2 doses for immunocompromising conditions (see notes)		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal (PCV15, PCV20, PPSV23)	1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (see notes)			1 dose PCV15 followed by PPSV23 OR 1 dose PCV20
Hepatitis A (HepA)	2 or 3 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or conditio		n	
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, see notes for booster recommendations			
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations			
	19 through 23 years			
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication			

lack documentation of vaccination, lack evidence of past infection
Recommended vaccination for adults a who meet age requirement,

additional risk factor or notfhoerraidnudlitcsatwioitnh an
Recommended vaccinati

clinical decision-making i n based on shared
Recommended vaccinat

No recommendation/ Not applicable

Table 2 Recommended Adult Immunization Schedule by Medical Condition or Other Indication, United States, 2022

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 percentage and count		Asplenia, complement deficiencies	End-stage renal disease, or on hemodialysis	Heart or lung disease; alcoholism[1]	Chronic liver disease	Diabetes	Health care personnel2	Men who have sex with men
			<15% or <200 mm³	≥15% and ≥200 mm³							
IIV4 or RIV4 or	1 dose annually										
LAIV4	Contraindicated					Precaution				1 dose annually	
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	Contraindicated*	Contraindicated		1 or 2 doses depending on indication							
VAR	Contraindicated*	Contraindicated			2 doses						
RZV		2 doses at age ≥19 years			2 doses at age ≥50 years						
HPV	Not Recommended*	3 doses through age 26 years			2 or 3 doses through age 26 years depending on age at initial vaccination or condition						
Pneumococcal (PCV15, PCV20, PPSV23)		1 dose PCV15 followed by PPSV23 OR 1 dose PCV20 (s								e notes)	
HepA					2 or 3 d		es depending		on vaccine		
HepB	3 doses (see notes)	2, 3, or 4 doses depending on vaccine or condition									
MenACWY		1 or 2 dose	depending on indication, see notes for			booster recommendations					
MenB	Precaution	2 or 3 doses depend			ing on vaccin	and indication, see notes for booster recommendations					
Hib		3 doses HSCT3 recipients only			1 dose						

No recommendation/ vaccination f dults who meet lack evidence of past infection clinical

Recommended vaccination for adults withan additional might be indica ted if

Recommende vaccination based on share age requireme t, lack recommended—vaccine benefit of prot ection

Precaution—vaccination risk factor or an other should not be administered.

Contraindicated or not decision-makin documentation of indication vaccination, or outweighs risk of adverse

*Vaccinate after pregnancy. Reaction

Not applicable **1.** Precaution for LAIV4 does not apply to alcoholism. **2.** See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. **3.** Hematopoietic stem cell transplant.

Notes

Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2022

For vaccine recommendations for persons 18 years of age or younger, see the Recommended Child and Adolescent Immunization Schedule.

COVID-19 Vaccination

COVID-19 vaccines are recommended within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html**.**

CDC's interim clinical considerations for use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html**.**

Haemophilus influenzae type b vaccination

Special situations

Anatomical or functional asplenia (including sickle cell disease): 1 dose if previously did not receive Hib; if elective splenectomy, 1 dose, preferably at least 14 days before splenectomy

Hematopoietic stem cell transplant (HSCT): 3-dose series 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history

Hepatitis A vaccination

Routine vaccination

Not at risk but want protection from hepatitis A (identification of risk factor not required): 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

Special situations

At risk for hepatitis A virus infection: 2-dose series HepA or 3-dose series HepA-HepB as above

- **Chronic liver disease** (e.g., persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal)
- **HIV infection**
- **Men who have sex with men**
- **Injection or noninjection drug use**
- **Persons experiencing homelessness**
- **Work with hepatitis A virus** in research laboratory or with nonhuman primates with hepatitis A virus infection
- **Travel in countries with high or intermediate endemic hepatitis A** (HepA-HepB [Twinrix] may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months)
- **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)
- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy
- **Settings for exposure, including** health care settings targeting services to injection or noninjection drug users or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

Hepatitis B vaccination

Routine vaccination

Age 19 through 59 years: complete a 2- or 3-, or 4-dose series

- 2-dose series only applies when 2 doses of Heplisav-B* are used at least 4 weeks apart
- 3-dose series Engerix-B or Recombivax HB at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks])
- 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])
- 4-dose series HepA-HepB (Twinrix) accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months
- 4-dose series Engerix-B at 0, 1, 2, and 6 months for persons on adult hemodialysis (note: each dosage is double that of normal adult dose, i.e., 2 mL instead of 1 mL)

***Note:** Heplisav-B not recommended in pregnancy due to lack of safety data in pregnant women

Special situations

Age 60 years or older* and at risk for hepatitis B virus infection: 2-dose (Heplisav-B) or 3-dose (Engerix-B, Recombivax HB) series or 3-dose series HepA-HepB (Twinrix) as above

- **Chronic liver disease** (e.g., persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice upper limit of normal)
- **HIV infection**
- **Sexual exposure risk** (e.g., sex partners of hepatitis B surface antigen [HBsAg]-positive persons; sexually active persons not in mutually monogamous relationships; persons seeking evaluation or treatment for a sexually transmitted infection; men who have sex with men)
- **Current or recent injection drug use**
- **Percutaneous or mucosal risk for exposure to blood** (e.g., household contacts of HBsAg-positive persons; residents and staff of facilities for developmentally disabled persons; health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids; hemodialysis, peritoneal dialysis, home dialysis, and predialysis patients; patients with diabetes)
- **Incarcerated persons**
- **Travel in countries with high or intermediate endemic hepatitis B**

***Note:** Anyone age 60 years or older who does not meet risk-based recommendations may still receive Hepatitis B vaccination.

Human papillomavirus vaccination

Routine vaccination

HPV vaccination recommended for all persons through age 26 years: 2- or 3-dose series depending on age at initial vaccination or condition:

- **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
- **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed

Notes Recommended Adult Immunization Schedule, United States, 2022

Interrupted schedules: If vaccination schedule is interrupted, the series does not need to be restarted

No additional dose recommended when any HPV vaccine series has been completed using the recommended dosing intervals.

Shared clinical decision-making

Some adults age 27–45 years: Based on shared clinical decision-making, 2- or 3-dose series as above

Special situations

Age ranges recommended above for routine and catch-up vaccination or shared clinical decision-making also apply in special situations

- **Immunocompromising conditions, including HIV infection**: 3-dose series, even for those who initiate vaccination at age 9 through 14 years.
- **Pregnancy**: Pregnancy testing is not needed before vaccination; HPV vaccination is not recommended until after pregnancy; no intervention needed if inadvertently vaccinated while pregnant

Influenza vaccination

Routine vaccination

Age 19 years or older: 1 dose any influenza vaccine appropriate for age and health status annually

For the 2021–2022 season, see www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm

For the 2022–23 season, see the 2022–23 ACIP influenza vaccine recommendations.

Special situations

Egg allergy, hives only: any influenza vaccine appropriate for age and health status annually

Egg allergy–any symptom other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: see Appendix listing contraindications and precautions

Severe allergic reaction (e.g., anaphylaxis) to a vaccine component or a previous dose of any influenza vaccine: see Appendix listing contraindications and precautions

History of Guillain-Barré syndrome within 6 weeks after previous dose of influenza vaccine: Generally, should not be vaccinated unless vaccination benefits outweigh risks for those at higher risk for severe complications from influenza

Measles, mumps, and rubella vaccination

Routine vaccination

No evidence of immunity to measles, mumps, or rubella: 1 dose

- **Evidence of immunity:** Born before 1957 (health care personnel, see below), documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

Special situations

Pregnancy with no evidence of immunity to rubella: MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose

Nonpregnant women of childbearing age with no evidence of immunity to rubella: 1 dose

HIV infection with CD4 percentages ≥15% and CD4 count ≥200 cells/mm³ for at least 6 months and no evidence of immunity to measles, mumps, or rubella: 2-dose series at least 4 weeks apart; MMR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm³

Severe immunocompromising conditions: MMR contraindicated

Students in postsecondary educational institutions, international travelers, and household or close, personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella: 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR

Health care personnel:

- **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for measles or mumps or 1 dose for rubella
- **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart for measles or mumps or at least 1 dose for rubella

Meningococcal vaccination

Special situations for MenACWY

Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use: 2-dose series MenACWY-D (Menactra, Menveo, or MenQuadfi) at least 8 weeks apart and revaccinate every 5 years if risk remains

Travel in countries with hyperendemic or epidemic meningococcal disease, or microbiologists routinely exposed to *Neisseria meningitidis*: 1 dose MenACWY (Menactra, Menveo, or MenQuadfi) and revaccinate every 5 years if risk remains

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits: 1 dose MenACWY (Menactra, Menveo, or MenQuadfi)

For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Shared clinical decision-making for MenB

Adolescents and young adults age 16–23 years (age 16–18 years preferred) not at increased risk for meningococcal disease: Based on shared clinical decision-making, 2-dose series MenB-4C (Bexsero) at least 1 month apart or 2-dose series MenB-FHbp (Trumenba) at 0, 6 months (if dose 2 was administered less than 6 months after dose 1, administer dose 3 at least 4 months after dose 2); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series)

Special situations for MenB

Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, or microbiologists routinely exposed to *Neisseria meningitidis*:

2-dose primary series MenB-4C (Bexsero) at least 1 month apart or 3-dose primary series MenB-FHbp (Trumenba) at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series); 1 dose MenB booster 1 year after primary series and revaccinate every 2–3 years if risk remains

Pregnancy: Delay MenB until after pregnancy unless at increased risk and vaccination benefits outweigh potential risks

For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm

Note: MenB vaccines may be administered simultaneously with MenACWY vaccines if indicated, but at a different anatomic site, if feasible.

Pneumococcal vaccination

Routine vaccination

Age 65 years or older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups.

For guidance for patients who have already received a previous dose of PCV13 and/or PPSV23, see www.cdc.gov/mmwr/volumes/71/wr/mm7104a1.htm.

Special situations

Age 19–64 years with certain underlying medical conditions or other risk factors** who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition,* cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups.

For guidance for patients who have already received a previous dose of PCV13 and/or PPSV23, see www.cdc.gov/mmwr/volumes/71/wr/mm7104a1.htm.

***Note:** Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus, Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies.

****Note:** Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies.

Tetanus, diphtheria, and pertussis vaccination

Routine vaccination

Previously did not receive Tdap at or after age 11 years: 1 dose Tdap, then Td or Tdap every 10 years

Special situations

Previously did not receive primary vaccination series for tetanus, diphtheria, or pertussis: 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks after Tdap and another dose Td or Tdap 6–12 months after last Td or Tdap (Tdap can be substituted for any Td dose, but preferred as first dose), Td or Tdap every 10 years thereafter

Pregnancy: 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36

Wound management: Persons with 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm

Varicella vaccination

Routine vaccination

No evidence of immunity to varicella: 2-dose series 4–8 weeks apart if previously did not receive varicella-containing vaccine (VAR or MMRV [measles-mumps-rubella-varicella vaccine] for children); if previously received 1 dose varicella-containing vaccine, 1 dose at least 4 weeks after first dose

- Evidence of immunity: U.S.-born before 1980 (except for pregnant women and health care personnel [see below]), documentation of 2 doses varicella-containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease

Special situations

Pregnancy with no evidence of immunity to varicella: VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose if previously received 1 dose varicella-containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980

Health care personnel with no evidence of immunity to varicella: 1 dose if previously received 1 dose varicella-containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980

HIV infection with CD4 percentages ≥15% and CD4 count ≥200 cells/mm³ with no evidence of immunity: Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm³

Severe immunocompromising conditions: VAR contraindicated

Zoster vaccination

Routine vaccination

Age 50 years or older: 2-dose series RZV (Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of zoster vaccine live (ZVL, Zostavax) vaccination (administer RZV at least 2 months after ZVL)

Special situations

Pregnancy: There is currently no ACIP recommendation for RZV use in pregnancy. Consider delaying RZV until after pregnancy.

Immunocompromising conditions (including HIV): RZV recommended for use in persons age 19 years or older who are or will be immunodeficient or immunosuppressed because of disease or therapy. For detailed information, see www.cdc.gov/mmwr/volumes/71/wr/mm7103a2.htm.

PROVIDER MANUAL APPENDIX IV

Guide to Contraindications and Precautions to Commonly Used Vaccines

Adapted from Table 4-1 in Advisory Committee on Immunization Practices (ACIP) General Best Practice Guidelines for Immunization: Contraindication and Precautions available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html and ACIP's Recommendations for the Prevention and Control of 2021-22 Seasonal Influenza with Vaccines available at www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm

Interim clinical considerations for use of COVID-19 vaccines including contraindications and precautions can be found at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Vaccine	Contraindications[1]	Precautions[2]
Influenza, egg-based, inactivated injectable (IIV4)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg)	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using egg-based IIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, cell culture-based inactivated injectable [(ccIIV4), Flucelvax® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency, or to any component[3] of ccIIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, RIV, or LAIV of any valency. If using ccIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, recombinant injectable [(RIV4), Flublok® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency, or to any component[3] of RIV4	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Persons with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency. If using RIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Moderate or severe acute illness with or without fever
Influenza, live attenuated [LAIV4, Flumist® Quadrivalent]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine (i.e., any egg-based IIV, ccIIV, RIV, or LAIV of any valency) • Severe allergic reaction (e.g., anaphylaxis) to any vaccine component[3] (excluding egg) • Adults age 50 years or older • Anatomic or functional asplenia • Immunocompromised due to any cause including, but not limited to, medications and HIV infection • Close contacts or caregivers of severely immunosuppressed persons who require a protected environment • Pregnancy • Cochlear implant • Active communication between the cerebrospinal fluid (CSF) and the oropharynx, nasopharynx, nose, ear, or any other cranial CSF leak • Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days.	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of any type of influenza vaccine • Asthma in persons aged 5 years old or older • Persons with egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress) or required epinephrine or another emergency medical intervention: Any influenza vaccine appropriate for age and health status may be administered. If using LAIV4 (which is egg based), administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions. May consult an allergist. • Persons with underlying medical conditions (other than those listed under contraindications) that might predispose to complications after wild-type influenza virus infection [e.g., chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurologic, hematologic, or metabolic disorders (including diabetes mellitus)] • Moderate or severe acute illness with or without fever

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

Vaccine	Contraindications[1]	Precautions[2]
Haemophilus influenzae type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Hiberix, ActHib, and PedvaxHIB only: History of severe allergic reaction to dry natural latex	• Moderate or severe acute illness with or without fever
Hepatitis A (HepA)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin	• Moderate or severe acute illness with or without fever
Hepatitis B (HepB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including yeast • For Heplisav-B only: Pregnancy	• Moderate or severe acute illness with or without fever
Hepatitis A- Hepatitis B vaccine [HepA-HepB, (Twinrix®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] including neomycin and yeast	• Moderate or severe acute illness with or without fever
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Measles, mumps, rubella (MMR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long-term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing or interferon-gamma release assay (IGRA) testing • Moderate or severe acute illness with or without fever
MeningococcalACWY (MenACWY) [MenACWY-CRM (Menveo®); MenACWY-D (Menactra®); MenACWY-TT (MenQuadfi®)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For MenACWY-D and Men ACWY-CRM only: severe allergic reaction to any diphtheria toxoid– or CRM197–containing vaccine • For MenACWY-TT only: severe allergic reaction to a tetanus toxoid-containing vaccine	• Moderate or severe acute illness with or without fever
Meningococcal B (MenB) [MenB-4C (Bexsero); MenB-FHbp (Trumenba)]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Pregnancy • For MenB-4C only: Latex sensitivity • Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV15)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid–containing vaccine or to its vaccine component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal conjugate (PCV20)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe allergic reaction (e.g., anaphylaxis) to any diphtheria-toxoid– containing vaccine or to its vaccine component[3]	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever
Tetanus, diphtheria, and acellular pertussis (Tdap) Tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures), not attributable to another identifiable cause, within 7 days of administration of previous dose of DTP, DTaP, or Tdap	• Guillain-Barré syndrome (GBS) within 6 weeks after a previous dose of tetanus-toxoid–containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of diphtheria-toxoid—containing or tetanus-toxoid– containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid–containing vaccine • Moderate or severe acute illness with or without fever • For Tdap only: Progressive or unstable neurological disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
Varicella (VAR)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3] • Severe immunodeficiency (e.g., hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, long- term immunosuppressive therapy or patients with HIV infection who are severely immunocompromised) • Pregnancy • Family history of altered immunocompetence, unless verified clinically or by laboratory testing as immunocompetent	• Recent (≤11 months) receipt of antibody-containing blood product (specific interval depends on product) • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination) • Use of aspirin or aspirin-containing products • Moderate or severe acute illness with or without fever
Zoster recombinant vaccine (RZV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component[3]	• Moderate or severe acute illness with or without fever • Current herpes zoster infection

1. When a contraindication is present, a vaccine should NOT be administered. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
2. When a precaution is present, vaccination should generally be deferred but might be indicated if the benefit of protection from the vaccine outweighs the risk for an adverse reaction. Kroger A, Bahta L, Hunter P. ACIP General Best Practice Guidelines for Immunization. www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html
3. Vaccination providers should check FDA-approved prescribing information for the most complete and updated information, including contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at www.fda.gov/vaccines-blood-biologics/approved-products/vaccines-licensed-use-united-states.

V. Clinical Practice Guidelines

TOPIC	SOURCE/TITLE/VERSION	Web Site
Acquired Pneumonia in Adults	Infectious Diseases Society of America/American Thoracic Society Consensus Guidelines on the Management of Community-Acquired Pneumonia in Adults; 2007	idsaats-cap.pdf (thoracic.org)
	Management of Adults with Hospital- acquired and Ventilator-associated Pneumonia: 2016 Clinical Practice Guidelines by the Infectious Diseases Society of America and the American Thoracic Society	Management of Adults With Hospital- acquired and Ventilator-associated Pneumonia: 2016 Clinical Practice Guidelines by the Infectious Diseases Society of America and the American Thoracic Society
Adult PCP Checkup	Healthcare.gov - Preventive Care Benefits for Adults	Preventive care benefits for adults | HealthCare.gov
Aspirin Use	USPSTF: Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication; 2016	Recommendation: Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Asthma	2019 GINA Report, Global Strategy for Asthma Management and Prevention	Reports - Global Initiative for Asthma - GINA (ginasthma.org)
Cancer Screenings	American Cancer Society Guidelines for the Early Detection of Cancer	Cancer Screening Guidelines | Detecting Cancer Early
Cancer, Breast	USPSTF - Breast Cancer: Screening; 2016	https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast- cancer-screening
Cancer, Cervical	USPSTF - Cervical Cancer: Screening; 2018	https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical- cancer-screening
	CDC: Cervical Cancer Screening	What Should I Know About Cervical Cancer Screening? | CDC
Cancer, Colon	USPSTF - Colorectal Cancer: Screening; 2016	Clinician Summary: Colorectal Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Cardiovascular Disease	American College of Cardiology/American Heart Association: Guideline on the Primary Prevention of Cardiovascular Disease, 2019	2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines

		| Journal of the American College of Cardiology (jacc.org)
Children Health	World Health Organization: Guidelines for Children	https://www.who.int/health-topics/child-health#tab=tab_1
Cholesterol Management	USPSTF - High Blood Pressure in Adults: Screening; 2015	Recommendation: Hypertension in Adults: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
	American College of Cardiology/American Heart Association Task Force: Guideline on the Management of Blood Cholesterol, 2018	2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines | Journal of the American College of Cardiology (jacc.org)
Chronic Kidney Disease	National Kidney Foundation - Guidelines	Chronic Kidney Disease, Classification | National Kidney Foundation
Chronic Obstructive Pulmonary Disease	Global Initiative for Chronic Obstructive Lung Disease: Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease; 2020	2020 Gold Reports - Global Initiative for Chronic Obstructive Lung Disease - GOLD (goldcopd.org)
Diabetes	ADA Diabetes Care: Standards of Medical Care in Diabetes; 2019	Practice Guidelines Resources | American Diabetes Association
	USPSTF – Prediabetes and Type 2 Diabetes: Screening (2021)	https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes
	ADA Diabetes Care: Diabetic Retinopathy: A Position Statement by the American Diabetes Association; 2017	Diabetic Retinopathy: A Position Statement by the American Diabetes Association | Diabetes Care (diabetesjournals.org)
Falls Prevention: Interventions	USPSTF - Falls Prevention in Community-Dwelling Older Adults: Interventions; 2018	Clinical Summary: Falls Prevention in Community-Dwelling Older Adults: Interventions | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Glaucoma	National Institute for Health and Care Excellence - Glaucoma: diagnosis and management; 2017	Overview | Glaucoma: diagnosis and management | Guidance | NICE

	International Council of Ophthalmology - ICO Guidelines for Glaucoma Eye Care	ICOGlaucomaGuidelines.pdf (icoph.org)
Gonorrhea	USPST - Chlamydia and Gonorrhea: Screening; 2014	Recommendation: Chlamydia and Gonorrhea: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Heart Failure	American College of Cardiology - 2017 ACC/AHA/HFSA Focused Update Guideline for the Management of Heart Failure	2017 ACC/AHA/HFSA Focused Update Guideline for the Management of Heart Failure - American College of Cardiology
Hepatitis C	USPSTF - Hepatitis C Virus Infection in Adolescent and Adults: Screening; March 2020	Recommendation: Hepatitis C Virus Infection in Adolescents and Adults: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
HIV/AIDS	US Department of Health and Human Services: AIDS Info	HIV/AIDS Treatment Guidelines | ClinicalInfo
	New York State Department of Health AIDS Institute: Clinical Guidelines Program	HOME - AIDS Institute Clinical Guidelines (hivguidelines.org)
	Current U.S. Public Health Service treatment guidelines for HIV/AIDS and hepatitis B and C treatment, exposure management, and prevention, plus additional treatment protocol resources; (Reviewed and Updated 2016)	HIV/AIDS Guidelines | National Clinician Consultation Center (ucsf.edu)
	National Clinical Consultation Center/Clinician-to-Clinician Advice; How are we responding to the COVID-19 pandemic as it relates to HIV?	National Clinician Consultation Center (ucsf.edu)
	Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV; 2021	What's New in the Guidelines? | Adult and Adolescent ARV | ClinicalInfo (hiv.gov)
	USPSTF - Human Immunodeficiency Virus (HIV) Infection: Screening; 2019	Recommendation: Human Immunodeficiency Virus (HIV) Infection: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
	USPSTF - Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis, 2019	Final Recommendation Statement: Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

	Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States	Recommendations for HIV Prevention with Adults and Adolescents with HIV | Guidelines | HIV/AIDS | CDC
Human Papillomavirus Vaccine	CDC: Human Papillomavirus Vaccine	CDC - STDs - HPV
Hypertension	2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines	2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines - ScienceDirect
Immunization Schedule	CDC: Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2021	Adult Immunization Schedule by Vaccine and Age Group | CDC
	Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger; 2021	2021 Recommended Child and Adolescent Immunization Schedule (cdc.gov)
	CDC: Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021	Birth-18 Years Immunization Schedule | CDC
Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Screening	USPSTF - Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening; 2018	Recommendation: Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Lead Exposure for Children	NYC DOHMH - Lead Exposure in Children; 2019	lead-guidelines-children.pdf (nyc.gov) https://www.health.ny.gov/publications/ 6671.pdf
Low Back Pain	ACP Guidelines for the Diagnosis and Treatment of Low Back Pain; 2008	ACP Guidelines for the Diagnosis and Treatment of Low Back Pain - Practice Guidelines - American Family Physician (aafp.org)
Management of Overweight and Obesity in Adults	2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart	2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice

	Association Task Force on Practice Guidelines and The Obesity Society.	Guidelines and The Obesity Society - PubMed (nih.gov)
Menopause Management	American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for the Diagnosis and Treatment of Menopause; 2017 Update	AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS AND AMERICAN COLLEGE OF ENDOCRINOLOGY POSITION STATEMENT ON MENOPAUSE-2017 UPDATE - PubMed (nih.gov)
Obesity	NHLBI: Managing Overweight and Obesity in Adults: Systematic Evidence Review from the Obesity Expert Panel; 2013	Managing Overweight and Obesity in Adults: Systematic Evidence Review from the Obesity Expert Panel | NHLBI, NIH
	USPSTF – Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions; 2018	Recommendation: Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
	USPSTF - Final Recommendation Statement Obesity in Children and Adolescents: Screening; 2017	Final Recommendation Statement: Obesity in Children and Adolescents: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Opioids for Chronic Pain	CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016	rr6501e1.pdf (cdc.gov)
Osteoarthritis	Evidence-Based Guidelines for the Comprehensive Management of Osteoarthritis (OA) 2019	https://www.rheumatology.org/Portals/0/Files/Osteoarthritis-Guideline-Early-View-2019.pdf
Osteoporosis	USPSTF - Screening Osteoporosis to Prevent Fractures; 2018	Final Recommendation Statement: Osteoporosis to Prevent Fractures: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Pediatric PCP Checkup	Bright Futures/American Academy of Pediatrics - Recommendations for Preventive Pediatric Health Care; 2020	periodicity_schedule.pdf (aap.org)
Perinatal Care	March of Dimes and ACOG: Prenatal and Postpartum Care USPSTF Perinatal Depression Screening	https://www.marchofdimes.org/pregnancy/prenatal-care.aspx# https://www.acog.org/en/Clinical/Search#sort=relevancy&f:topic=[Pregnancy] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions

	Maternal Immunization	https://www.acog.org/programs/immuni zation-for-women/activities- initiatives/immunization-for-pregnant-women-a-call-to-action
Post-Partum Care	ACOG - Optimizing Postpartum Care; 2018	https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care
Preconception Care	USPSTF - Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication; 2017	Final Recommendation Statement: Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
	One key Question Initiative - The Preconception Resource Guide is designed to help primary care providers meet their patient's needs based on the response to this "vital sign" question: "Would you like to become pregnant in the next year?" Her answer will allow you and your colleagues to individualize her primary care to best meet her overall and reproductive health needs.	Resource Guide for Clinicians - Before, Between & Beyond Pregnancy (beforeandbeyond.org)
Preventive Services for Children and Adolescents	MQIC: Routine Preventive Services for Children and Adolescents (Ages 2-21)	mqic_routine_preventive_services_for_children_and_adolescents_ages_2_to_21_cpg.pdf
Sexually Transmitted Disease	CDC Resource: Sexually Transmitted Disease	Sexually Transmitted Diseases - Information from CDC
	USPSTF - Syphilis Infection in Nonpregnant Adults and Adolescents: Screening; 2016	Final Recommendation Statement: Syphilis Infection in Nonpregnant Adults and Adolescents: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Smoking Cessation	AHRQ: Treating Tobacco Use and Dependence: 2008 Update - Overview	Treating Tobacco Use and Dependence: 2008 Update - Overview | Agency for Healthcare Research and Quality (ahrq.gov)
	USPSTF - Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions; 2021 CDC: Interim Guidance for Health Care Providers Evaluating and Caring for	Recommendation: Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

	Patients with Suspected E-cigarette, or Vaping, Product Use Associated Lung Injury (EVALI)	Update: Interim Guidance for Health Care Providers Evaluating and Caring for Patients with Suspected E-cigarette, or Vaping, Product Use Associated Lung Injury — United States, October 2019 | MMWR (cdc.gov)
Stroke	Primary Prevention of Ischemic Stroke; 2006 *A Guideline from the American Heart Association/American Stroke Association Stroke Council: Cosponsored by the Atherosclerotic Peripheral Vascular Disease Interdisciplinary Working Group; Cardiovascular Nursing Council; Clinical Cardiology Council; Nutrition, Physical Activity, and Metabolism Council; and the Quality of Care and Outcomes Research Interdisciplinary Working Group: The American Academy of Neurology affirms the value of this guideline*.	Primary Prevention of Ischemic Stroke | Stroke (ahajournals.org)
	Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack; 2014 *A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association*	Guidelines for the Prevention of Stroke in Patients With Stroke and Transient Ischemic Attack | Stroke (ahajournals.org)
Transition of Care in the Long-Term Continuum	Transition of Care in the Long-Term Care Continuum (2021)	https://qioprogram.org/sites/default/files/Transitions_of_Care_in_LTC.pdf
Tuberculosis	CDC: Tuberculosis Resources	Professional Resources & Tools | TB | CDC
	USPSTF – Latent Tuberculosis Infection: Screening; 2016	Recommendation: Latent Tuberculosis Infection: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Upper Respiratory Tract Infections	AAFP - Antibiotic Use in Acute Upper Respiratory Tract Infections; 2012	Antibiotic Use in Acute Upper Respiratory Tract Infections - American Family Physician (aafp.org)
	CDC - Antibiotic Prescribing and Use in Doctor's Offices	Adult Outpatient Treatment Recommendations | Antibiotic Use | CDC
Urinary Incontinence	Non-surgical Management of Urinary Incontinence in Women: A Clinical Practice Guideline from the American College of Physicians; 2014	https://annals.org/aim/fullarticle/1905131/nonsurgical-management-urinary-incontinence-women-clinical-practice-guideline-from-american
Viral Hepatitis	CDC - Viral Hepatitis Guidelines and Recommendations; 2015	Viral Hepatitis Guidelines and Recommendations | NPIN (cdc.gov)

Vision	American Academy of Ophthalmology - Resources	Practice Guidelines - American Academy of Ophthalmology (aao.org)

Behavioral Health Clinical Practice Guidelines

TOPIC	SOURCE/TITLE/VERSION	Web Site
Twelve Step Facilitation Therapy Manual	National Institute on Alcohol Abuse and Alcoholism Project MATCH Monograph Series, 1998; reprinted 1999	https://pubs.niaaa.nih.gov/publications/ProjectMatch/match01.pdf
Assertive Community Treatment (ACT)	Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT/SAMHSA Publication and Digital Products	https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344
Cognitive-Behavioral Therapy for Substance Use Disorder	Psychiatric Clinics of North America: September 2010	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2897895/
Medications for Opioid Use Disorder	SAMHSA Publication: May 2021	https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-02-01-002.pdf
Motivational Enhancement Therapy Manual	U.S. Department of Health and Human Services: National Institute on Alcohol Abuse and Alcoholism: 1999	https://pubs.niaaa.nih.gov/publications/projectmatch/match02.pdf
OMH First Episode Psychosis (FEP) Practice Guidelines	National Institute of Mental Health: 2014	https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh
SAMHSA's Family Psychoeducation Family Psychoeducation Evidence-Based Practices (EBP) KIT CPG	SAMSHA: 2010	https://store.samhsa.gov/sites/default/files/d7/priv/buildingyourprogram-fp_0.pdf
SAMHSA's Integrated Dual Disorder Treatment	SAMHSA – Case Western Reserve University: 2012	https://easacommunity.org/Toolkit/IDDT%20Clinical%20Guide.pdf#:~:text=The%20Integrated%20Dual%20Disorder%20Treatment%20%28IDDT%29%20model%20is

(IDDT) for Co-occurring Disorders		,mental%20illness%20and%20a%20co-occurring%20substance%20use%20disor der
SAMHSA's Supported Employment (Individual Placement and Support) Transforming Lives Through Supported Employment/SAMHSA: Supported Employment Evidence-Based Practice (EBP) KIT/SAMHSA	SAMHSA: 2010	https://store.samhsa.gov/product/Suppo rted-Employment-Evidence-Based- Practices-EBP-Kit/SMA08-4364 https://store.samhsa.gov/product/Suppo rted-Employment-Evidence-Based- Practices-EBP-Kit/SMA08-4364
Seeking Safety: Treatment Innovations	This study is funded by the National Institute on Health and Treatment Innovations	https://www.treatment-innovations.org/seeking-safety.html
Acute Stress Disorder PTSD	The APA (American Psychiatry Association) National Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd.pdf
Attention Deficit Hyperactivity Disorder in Children and Adolescent	American Academy of Pediatrics - ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents; 2011	ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents | American Academy of Pediatrics (aappublications.org)
Alcohol Withdrawal Management – Ambulatory and Inpatient Care	Evidence-Based Guidelines for Alcohol Withdrawal Management Adopted by the ASAM Board of Directors	https://s21151.pcdn.co/wp-content/uploads/ASAM-CPG-on-Alcohol-Withdrawal-Management-Published- 2020.pdf

Level of Care for Alcohol and Drug Treatment Referral	Designed for substance abuse treatment providers and referral sources working with individuals who experience substance use disorders, the LOCADTR guides decision making regarding the appropriate level of care for a client.	https://oasas.ny.gov/system/files/documents/2019/10/LOCADTRManual3.0.pdf
Guidance on Medical Protocols for Withdrawal Management for OASAS Programs	To obtain and maintain a certification from OASAS to provide withdrawal management and stabilization services, programs must obtain and maintain approval of medical protocols from the Chief Medical Officer (CMO) of the New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS)	https://oasas.ny.gov/system/files/documents/2019/10/MedicalProtocolsforWithdrawalManagementatOASASPrograms.pdf
Alcohol Misuse: Screening	USPSTF: Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions; 2018	Recommendation: Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
Alzheimer	The APA (American Psychiatry Association) National Practice Guideline for Treatment of Patients With Alzheimer's Disease and Other Dementias	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/alzheimers.pdf
Opioid Use Disorder Treatment for Pregnant and Parenting Women and Their Infants	Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants; SAMSHA, March 2021	https://s21151.pcdn.co/wp-content/uploads/SAMHSA-OUD- Pregnant-Women-and-their-infants-SRC- 5-11-18-CMMC-5-15-18.pdf
Opioids	Prescription painkillers, heroin, and fentanyl can be dangerous and potentially addictive (Office of Addiction Services and Supports)	https://oasas.ny.gov/opioids
Opioid Use Disorder	The ASAM (American Society of Addiction Medicine) National Practice Guideline for the Treatment of Opioid Use Disorder; 2020 Focused Update	https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2

Schizophrenia	Practice Guideline for the Treatment of Patient with Schizophrenia; APA, 2021	https://s21151.pcdn.co/wp-content/uploads/APA-Practice-Guideline- for-the-Trmt-of-Patients-with- Schizophrenia-3rd-Edition-SRC-1-8-21-CMMC-1.pdf
Delirium	The APA (American Psychiatry Association) National Practice Guideline for the Treatment of Patients with Delirium	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/delirium.pdf
Depression Screening	USPSTF - Depression in Adults: Screening; 2016	Final Recommendation Statement: Depression in Adults: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
	USPSTF - Depression in Children and Adolescents: Screening; 2016	Final Recommendation Statement: Depression in Children and Adolescents: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
	American Academy of Pediatrics - Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management; 2018	Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management | American Academy of Pediatrics (aappublications.org)
Appropriate Use of Drug Testing in Clinical Addiction	Evidence-Based Guidelines for Appropriate Use of Drug Testing in Clinical Addiction Medicine; American Society of Addiction Medicine (ASAM) 2017	https://s21151.pcdn.co/wp-content/uploads/ASAM-lab-consensus- stmt-SRC-12-13-17-CMMC-12-19-17.pdf
Bipolar Disorder	NCBI - The Clinical Management of Bipolar Disorder: A Review of Evidence- Based Guidelines; 2011	The Clinical Management of Bipolar Disorder: A Review of Evidence-Based Guidelines (nih.gov)
	The APA (American Psychiatric Association) Practice Guideline for the Treatment of Bipolar Disorder; 2020 Focused Update	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf
Drug Use	NIH - Resource Guide: Screening for Drug Use in General Medical Settings; 2018	Screening for Substance Use | National Institute on Drug Abuse (NIDA)

Obsessive-Compulsive Disorder	The APA (American Psychiatry Association) National Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder; 2020 Focus Update	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/ocd.pdf
Pharmacological Treatment of Patients with Alcohol Use Disorder	Practice Guideline for the Pharmacological Treatment of Patients with Alcohol Use Disorder; 2021	https://s21151.pcdn.co/wp-content/uploads/APA-Practice-Guideline-_-AUD-SRC-2-9-18-CMMC-2-20-18.pdf
Psychiatric Evaluation of Adults	Practice Guidelines for the Psychiatric Evaluation of Adults; 2021	https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760
Borderline Personality Disorder	Treatment of Borderline Personality Disorder; 2021 Updated Guideline	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bpd.pdf
Eating Disorder	Treatment of Eating Disorder: American Psychiatric Association (APA)	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf
Major Depression Disorder	Treatment of Major Depression Disorder; American Psychiatric Association (APA)	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf
Panic Disorder	Treatment of Panic Disorder; American Psychiatric Association (APA)	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/panicdisorder.pdf
Substance Use Disorders	Treatment of Substance Use Disorders; American Psychiatric Association (APA)	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf
Use of Antipsychotic s to Treat Agitation or Psychosis in Patients with Dementia	Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia; The American Psychiatric Association	https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426807

The Assessment and Treatment of Patients with Suicidal Behavior	The APA (American Psychiatry Association) National Practice Guideline for The Assessment and Treatment of Patients with Suicidal Behaviors; 2020 Focused Update	https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf
Suicide Prevention	Suicide Risk in Adolescents, Adults and Older Adults: Screening; 2014	Recommendation: Suicide Risk in Adolescents, Adults and Older Adults: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
	American Psychiatric Association - Suicide Prevention	Suicide Prevention (psychiatry.org)

2021 FREE OR LOW-COST PREVENTIVE HEALTH CARE SERVICES

At **MetroPlus**Health, we always want you to be at your best. That's why we encourage you and your family to take advantage of preventive care services available to you at low or no cost. We've listed dozens of FREE preventive services here for adults, women and children that just may help you be your healthiest yet.

WHAT ARE PREVENTIVE CARE SERVICES?

Preventive care helps your doctor find potential health problems before you feel sick. By finding medical problems early, your doctor can see you get the care you need to stay healthy.

Be sure to visit your doctor regularly to get preventive care.

Preventive care includes some:

Immunizations.

Physical exams

Lab tests

Prescriptions

The free preventive care services we list in these guidelines are based on recommendations from the U.S. Preventive Services Task Force, Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA) and the latest medical research from organizations like the American Medical Association.

DO YOU KNOW THE DIFFERENCE BETWEEN PREVENTIVE AND DIAGNOSTIC SERVICES?

The same service could be preventive (free) or diagnostic (copayments, coinsurance or deductibles apply).

- A list of free preventive care services can be found in our online guide at **metroplus.org/plans/marketplace/know-your-benefits**.
- Preventive care services are free when provided by an in-network doctor. Go to **https://www.metroplus.org/find-doctor** and use our Find a Doctor tool to find in-network doctors.

	REASON FOR SERVICE	WHAT YOU'LL PAY
Preventive care	To prevent health problems. You don't have symptoms.	You won't pay anything.
Diagnostic care	You have a symptom, or you're being checked because of a known health issue.	This is a medical claim. Your deductible, copayments and coinsurance may apply.

7 in 10 American deaths each year result from chronic diseases like heart disease and diabetes. Did you know many of these deaths can be prevented through early detection and the right care?

Source: CDC

Questions about preventive care?
Find more information at
metroplus.org/plans/marketplace/know-your-benefits
or call Member Services at the number on the back of your member ID card.

HOW DO I KNOW IF A SERVICE IS PREVENTIVE OR DIAGNOSTIC?

A service is diagnostic when it's done to monitor, diagnose or treat health problems. That means:

- If you have a chronic disease like diabetes, your doctor may monitor your condition with tests. Because the tests manage your condition, they're diagnostic.
- If you have a preventive screening and a health problem shows up, your doctor may order follow-up tests. In this case, the follow-up tests are diagnostic.
- If your doctor orders tests based on symptoms you're having, like a stomachache, these tests are diagnostic.

If you receive services listed in this guide for a diagnostic reason, there may be a cost to you.

COMPARE COSTS AND QUALITY FOR DIAGNOSTIC SERVICES

Did you know that the cost of medical tests and procedures can vary 300% or more depending on where you have these performed. Compare costs and quality for 200+ health services at **http://marketplustcc.metroplus.org**.

SERVICE	IT'S PREVENTIVE (FREE) WHEN…	IT'S DIAGNOSTIC WHEN…
DIABETES SCREENING	A blood glucose test is used to detect problems with your blood sugar, even though you don't have symptoms.	You're diagnosed with diabetes and your doctor checks your A1c.
OSTEOPOROSIS SCREENING	Your doctor recommends a bone density test based on your age or family history.	You've had a health problem, or your doctor wants to determine the success of a treatment.
COLON CANCER SCREENING	Your doctor wants to screen for signs of colon cancer based on your age or family history. If a polyp is found and removed during your preventive colonoscopy, the colonoscopy and polyp removal are preventive. If the polyp is sent for lab testing, the testing is considered diagnostic.	You're having a health problem, like bleeding or irregularity, or if the polyp you have removed is sent to a lab to be tested, the lab test is diagnostic.
COMPLETE BLOOD COUNT (CBC)	Never preventive.	Always diagnostic. Studies show there's no need for this test unless you have symptoms.
METABOLIC PANELS	Newborns 0 – 90 days	Always diagnostic. Studies show that a metabolic panel isn't the best test for detecting or preventing illnesses.
URINALYSIS	Never preventive.	Always diagnostic. National Guidelines say there's no need for this test unless you have symptoms.
PROSTATE EXAM (PSA)	Never preventive.	Always diagnostic. National Guidelines have changed recently because this test gives many false results.

2021 FREE PREVENTIVE HEALTH CARE SERVICES GENERAL ADULT HEALTH

CARE FOR ALL ADULTS

You can keep track of services by completing the "Date Received" column.

PHYSICAL EXAMS

AGE	RECOMMENDATION	DATE RECEIVED
19 – 21 years	Once every 2 – 3 years; annually if desired	
22 – 64 years	Once every 1 – 3 years; annually if desired	
65 and older	65 – 70: Once every year 70 – 80: Twice every year Over 80: Every three months or as recommended	

IMMUNIZATIONS

Doses, ages and recommendations vary.

VACCINE	RECOMMENDATION	DATE RECEIVED
Chickenpox (varicella)	2 doses, 28 days apart, for those with no history of the vaccination or disease.	
Flu (influenza)	1 dose annually.	
Hepatitis A	2 – 3 doses, 6 months apart, for those at high risk.	
Hepatitis B	2 – 3 doses for those at high risk.	
HPV (human papillomavirus)	19 – 26: 2 or 3 doses depending on age at first vaccination or condition	
Measles, mumps, rubella (MMR)	1 – 2 doses if no history of the vaccination or disease.	
Meningitis (meningococcal)	1 or 3 doses for adults with an additional risk factor or another indication.	
Pneumonia (Pneumococcal)	19 – 64: 1 dose for adults with an additional risk factor or another indication. 65 and over: Recommended vaccination based on shared clinical decision-making.	
Shingles (herpes zoster)	50 years+: 2 dose series RZV 2-6 months apart regardless of previous herpes zoster or history of ZVL. 60 years+: 2 dose series RZV 2-6 months apart.	
Tetanus, diphtheria and whooping cough (pertussis)	1 dose if no history of pertussis vaccine regardless of interval since last tetanus vaccine, followed by tetanus every 10 years.	

DOCTOR VISITS AND TESTS

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Abdominal aortic aneurysm screening	Once for men ages 65 – 75 with a history of smoking.	
Alcohol misuse screening and counseling	At physical exam.	
Preventive guidance for family and intimate partner violence, breast self-exam, menopause counseling, safety, falls and injury prevention	Separate intimate partner violence in women of reproductive age.	
Blood pressure screening	18+: Every wellness visit.	
Cholesterol test	Age 40-75: Every 4 – 6 years. More frequently depending on heart risk.	
Colon cancer screening	Age 50 – 75 years: Stool test every year. Colonoscopy every 10 years is highly recommended	
Depression screening	Every year, during physical exam. For pregnant women, during prenatal and postpartum visits.	
Diabetes screening	For adults with high blood pressure and those ages 40 – 70 who are overweight or obese.	
Diet/nutrition counseling	At your doctor's discretion if you're at high risk for heart and diet related chronic diseases.	
Haemophilus influenza b (Hib)	Recommended for older children (< 5 years old) or adults with asplenia or sickle cell disease, before surgery to remove the spleen, or following a bone marrow transplant. Hib vaccine may also be recommended for people 5 to 18 years old with HIV.	
Hepatitis B screening	Adults at high risk and pregnant women at their first prenatal visit.	
Hepatitis C screening	Adults at high risk and a one-time screening in adults ages 18 – 79 years.	
HIV screening	Ages 15 – 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. Pregnant women including those who present in labor or at delivery whose HIV status is unknown.	

HIV Infection	Pre-exposure Prophylaxis: The USPSTF recommends that clinicians offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. This includes kidney function testing (creatinine)	
Lung cancer screening	Annual screening (including CT) for adults ages 55 – 80 who have a 30-pack-a-year smoking history and currently smoke or quit smoking within the past 15 years.	
Obesity screening and counseling	Every year during physical exam.	
Sexually transmitted infection (STI) counseling and screening	Every year for adults at increased risk.	
Tobacco–use screening and counseling	Tobacco/Vaping use screening and counseling. Adults and pregnant women: At each visit. Includes counseling on tobacco use, counseling on quitting, behavioral interventions and approved drugs for smoking cessation. See tobacco and electronic nicotine delivery systems (vaping) cessation products in the "Drugs" section below.	
Latent Tuberculosis Infection	Ages 18 years and up for asymptomatic adults at increased risk	
Tuberculosis (TB) Testing	Screening for latent tuberculosis infection (LTBI) in populations at increased risk.	

DRUGS

Prescription required.

PRESCRIPTION	RECOMMENDATION	DATE RECEIVED
Tobacco cessation products	FDA-approved tobacco/vaping cessation prescription medication and OTC nicotine replacement (NRT). (For MetroPlus Gold, this is only covered with a prescription rider.)	

2021 FREE PREVENTIVE HEALTH CARE SERVICES WOMEN'S HEALTH

CARE THAT'S RECOMMENDED FOR WOMEN

You can keep track of the services you've had by completing the "Date Received" column. See the "Adult Health" section for more care that's recommended for all adults.

DOCTOR VISITS AND TESTS

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Screening for Anxiety	Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.	
BRCA risk assessment and genetic counseling/testing	For women with a personal or family history with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	
Breast cancer screening (mammogram)	Once every 2 years for women ages 50 – 74.	
Contraceptive counseling and contraception methods	Routine counseling to address contraceptive needs, expectations, and concerns. FDA-approved. contraceptive methods, sterilization procedures, education and counseling.	
Domestic violence and intimate partner violence screening and counseling	Annually.	
HIV counseling and screening	All women should be tested for HIV at least once during their lifetime. Ages 15 to 65 years, and younger adolescents and older adults who are at increased risk of infection.	
Osteoporosis screening (bone density testing)	Women 65 and older, and postmenopausal women younger than 65 years who are at increased risk of osteoporosis	

Pap and HPV test (cervical cancer screening)	Pap tests every 3 years in women aged 21–29 years. 29 – 65 years, every 3 years with Pap test only, every 5 years with HPV testing alone, or every 5 years with pap test and HPV together.	
Sexually transmitted infection (STI) prevention counseling and screening	Screening and counseling for chlamydia, gonorrhea and syphilis for women who are at high risk.	
Well-woman visits (physical exams)	Annually.	
Well-woman visits (screening for urinary incontinence)	Screen all women age 18 and older and younger women if postpartum.	

DRUGS

Prescription required.

PRESCRIPTION	RECOMMENDATION	DATE RECEIVED
Breast cancer prevention medication	Risk-reducing medications for women with an increased risk of breast cancer who have never been diagnosed with breast cancer and and a low risk for adverse medication effects.	
Folic acid supplements	Women planning to become or who are pregnant: 0.4 to 0.8 mg.	

CONTRACEPTIVES

Prescription required.

TYPE	METHOD	BENEFIT LEVEL
Hormonal	• Oral contraceptives • Injectable contraceptives • Patch • Ring	Generic contraceptive methods and the ring methods for women are covered. Your deductible and/or prescription copayment applies for brand name contraceptives when there is a generic available. *Medicare* Coverage is provided for prescription contraceptive drugs or devices approved by the FDA or generic equivalents approved by the FDA. Copayments apply. Part B: 0% *or* 20% cost. Part D: If you receive “Extra Help” to pay your prescription drugs, your deductible amount will be either $0 or $89.
Barrier	• Diaphragms • Condoms • Contraceptive sponge • Cervical cap • Spermicide	
Implantable	• IUDs • Implantable rod	

Emergency	• Ella® • Next Choice® • Next Choice® One Dose • My Way™	Covered. *Medicare* Coverage is provided for prescription contraceptive drugs or devices approved by the FDA or generic equivalents approved by the FDA. Copayments apply. Part B: 0% *or* 20% cost. Part D: If you receive “Extra Help” to pay your prescription drugs, your deductible amount will be either $0 or $89.
Permanent	• Tubal ligation	Covered at outpatient facilities and if received during an inpatient stay. *Medicare* Coverage is provided for prescription contraceptive drugs or devices approved by the FDA or generic equivalents approved by the FDA. Copayments apply. Part B: 0% *or* 20% cost. Part D: If you receive “Extra Help” to pay your prescription drugs, your deductible amount will be either $0 or $89.

2021 FREE PREVENTIVE HEALTH CARE SERVICES

PREGNANT WOMEN'S HEALTH

CARE THAT'S RECOMMENDED FOR PREGNANT WOMEN

If you're pregnant, plan to become pregnant or recently had a baby, we recommend the preventive care that's listed here. You can keep track of the services you've had by completing the "Date Received" column.

DOCTOR VISITS AND TESTS

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Bacteriuria screening with urine culture	Between 12 – 16 weeks' gestation or during first prenatal visit if later.	
Breastfeeding support, supplies and counseling	Lactation support and counseling to pregnant and postpartum women, including costs for breastfeeding equipment.	
Gestational diabetes screening	Women 24 – 28 weeks pregnant or at the first prenatal visit for those identified as high risk for gestational diabetes.	
Screening for Diabetes Mellitus After Pregnancy	Women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus should be screened for diabetes mellitus. Women with a negative initial postpartum screening test result should be rescreened at least every 3 years for a minimum of 10 years after pregnancy	
Hematocrit or hemoglobin screening	During the first prenatal visit.	
Hepatitis B screening	During the first prenatal visit.	
HIV screening	All pregnant women during each pregnancy including those who present in labor or at delivery whose HIV status is unknown.	
Iron-deficient anemia screening	On a routine basis.	
Rh incompatibility screening	All pregnant women and follow-up testing for women at high risk.	

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Routine maternity care	Routine prenatal and postpartum visits for all pregnant women: • Office visit at 8-10 weeks of pregnancy (or earlier if at risk for ectopic pregnancy) • Every 4 weeks for first 28 weeks. • Every 2 – 3 weeks until 36 weeks gestation. • Every week after 36 weeks' gestation. Frequency of visits is determined by individual needs and assessed risk factors.	
Sexually transmitted infection (STI) screening	Screening and counseling for chlamydia, gonorrhea, and syphilis.	
Perinatal Depression	Pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions. Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits	

IMMUNIZATIONS

Doses, ages, and recommendations vary.

VACCINE	BEFORE PREGNANCY	DURING PREGNANCY	AFTER PREGNANCY	DATE RECEIVED
Chickenpox (varicella)	Yes; avoid getting pregnant for 4 weeks	No	Yes, immediately postpartum	
Hepatitis A	Yes, if at risk	Yes, if at risk	Yes, if at risk	
Hepatitis B	Yes, if at risk	Yes, if at risk	Yes, if at risk	
HPV (human papillomavirus)	Yes, if between ages 9 and 26	No	Yes, if between ages 9 and 26	
Flu nasal spray	Yes, if less than 50 years of age and healthy. Avoid getting pregnant for 4 weeks.	No	Yes, if less than 50 years of age and healthy. Avoid getting pregnant for 4 weeks.	
Flu shot	Yes	Yes	Yes	
Measles, mumps, rubella (MMR)	Yes; avoid getting pregnant for 4 weeks	No	No	
Meningococcal	If indicated	If indicated	If indicated	
Pneumococcal	If indicated	If indicated	If indicated	
Tetanus	Yes (Tdap preferred)	If indicated, preferably between 27 and 36 weeks pregnant.	Yes (Tdap preferred)	
Tetanus, diphtheria, whooping cough (1 dose only)	Yes	Yes	Yes	

2021 FREE PREVENTIVE HEALTH CARE SERVICES CHILDREN'S HEALTH

CARE FOR NEWBORNS THROUGH AGE 18

You can keep track of services by completing the "Date Received" column.
More than one child? **Click here** for additional copies.

PHYSICAL EXAMS (WELL-CHILD VISITS)

AGE	RECOMMENDATION	DATE RECEIVED
Newborn	1 visit 3 – 5 days after discharge	
0 – 2 years	1 visit at 2, 4, 6, 9, 12, 15, 18 and 24 months	
3 – 6 years	1 visit at 30 months and 1 visit every year for ages 3 – 6	
7 – 10 years	1 visit every year	
11 – 18 years	1 visit every year	

IMMUNIZATIONS

VACCINE	RECOMMENDATION	DATE RECEIVED
Chickenpox (varicella)	First dose between 12 – 15 months old. Second dose between 4 – 6 years old. For kids 7 – 18 years old with no history of the vaccination or disease, 2 doses 28 days apart.	
Diphtheria, tetanus, whooping cough (pertussis)	There are four combination vaccines available. Talk to your child's doctor about the right choice. **DTaP and DT:** 5 doses, 1 dose at 2, 4, 6 and 18 months old, 1 dose between ages 4 – 6 years.	
Flu (influenza)	Children over 6 months should receive the flu vaccine annually.	
Haemophilus influenza type b	1 dose at 2, 4 and 6months and once between 12 – 15 months old.	
Hepatitis A	2 dose series 6 months apart beginning at age 12 months. Children not previously immunized through 18 years should complete 2-dose series 6 months apart.	
Hepatitis B	1 dose at birth, 2 doses before 18 months. All children should receive vaccine if not immunized as a baby.	

VACCINE	RECOMMENDATION	DATE RECEIVED
HPV (human papillomavirus)	HPV vaccination routinely recommended at ages **11 – 12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated 2 or 3 dose series depending on age at initial vaccination: **Age 9 through 14 years at initial vaccination:** 2 dose series at 0, 6 – 12 months **Age 15 years or older at initial vaccination:** 3 dose series at 0, 1 –2 months, 1 –2 months, 6 months	
Measles, mumps, rubella (MMR)	4 dose series at ages 2, 4, 6 –18 months, 4 – 6 years	
Meningitis (meningococcal)	**Routine vaccination** 2 dose series at 11 – 12 years, 16 years **Catch-up vaccination** Age 13 – 15 years: 1 dose now and booster at age 16 – 18 years Age 16 – 18 years: 1 dose	
Pneumonia (Pneumococcal)	4 dose series at 2, 4 and 6 months and 12 to 15 months. 1 dose for a healthy child aged 24 – 59 months who did not complete the series.	
Rotavirus	1 dose at 2, 4 and 6 months old.	

DRUGS

Prescription required.

PRESCRIPTION	RECOMMENDATION	DATE RECEIVED
Iron supplements	Children ages 6 – 12 months at risl for iron deficiency.	
Oral fluoride supplements	Starting age 6 months for children without fluoride in their primary water source.	

DOCTOR VISITS AND TESTS

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Alcohol and drug use assessment	Ages 11 – 18.	
Autism screening	At 18 and 24 months.	
Blood pressure	Blood pressure screening for children ages: 0 – 11 months, 1 – 4 years, 5 – 10 years, 11 – 14 years, 15 – 17 years.	

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Congenital hypothyroidism screening	Once at birth.	
Dental Visits	Annually starting at age 1.	
Cavity prevention	Primary care clinicians should prescribe oral fluoride supplements starting at age 6 months for children whose water supply is deficient in fluoride. They should also apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	
Dental sealants	Apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption through age 7 years	
Depression screening and behavioral assessments	Behavioral assessments for children ages: 0 – 11 months, 1 – 4 years, 5 – 10 years, 11 – 14 years, 15 – 17 years Depression screening: ages 12 – 18	
Developmental screening	For children under age 3.	
Dyslipidemia screening	Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years. Screening for children at higher risk of Dyslipidemia screening lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	
Gonorrhea preventive medication	Once at birth.	
Hearing loss screening	Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. Also includes screening at 4 years, 5 years, 6 years; 8 years; 10 years.	
Hearing Risk Assessment	Recommended at ages 4 mo, 6 mo, 9 mo, 12 mo, 15 mo, 18 mo, 24 mo, 30 mo, 3 years, 7 years, and 9 years.	
Height, weight, and body mass percentile	At each visit.	
Hematocrit or hemoglobin screening	For all children.	
Hepatitis B screening	Adolescents at high risk.	
HIV screening	Adolescents starting at age 15. Children under 15 if they're at high risk.	
Lead screening	Lead screening for children at risk of exposure.	

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Medical history	At each well-child visit.	
Newborn screenings as identified by the Federal Health Resources and Services Administration	Once at birth.	
Metabolic Screening Panel (Newborns)	Ages 0 – 90 days. Does not have diagnosis code requirements for the preventive benefit to apply.	
Obesity screening and physical activity and nutrition counseling	Annual screening for children starting at age 6, and offer comprehensive, intensive behavioral interventions to promote improvements in weight status.	
Oral health risk assessment	At wellness visits for children ages: 0 –11 months, 1 – 4 years, 5 – 10 years.	
Sexually transmitted infection (STI) prevention, screening, and counseling	Screening and behavioral counseling for all adolescents who are at increased risk for infection.	
Tobacco-use screening and counseling	Screening during each visit and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy to help smokers quit.	
Tuberculosis (TB) testing	For children at higher risk of tuberculosis.	
Vision Screening	Screening for all children at least once between the ages of 3 and 5 years.	

VII Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10). Although physicians have primary responsibility for reporting, school nurses, laboratory directors, infection control practitioners, daycare center directors, health care facilities, state institutions and any other individuals/locations providing health care services are also required to report communicable diseases.

Reports should be made to the local health department in the county in which the patient resides and need to be submitted within 24 hours of diagnosis. However, some diseases warrant prompt action and should be reported immediately to local health departments by phone. A list of diseases and information on properly reporting them can be found under Communicable Disease Reporting Requirements.

For more information on communicable disease reporting, call your local health department or the New York State Department of Health's Bureau of Communicable Disease Control at 518.473.4439 or, after hours, at 1.866.881.2809; to obtain reporting forms (DOH-389), call 518.474.0548. In New York City, call 1.866.NYC.DOH1 (1.866.692.3641) for additional information. Health care personnel in New York City should use the downloadable Universal Reporting Form (PD-16); those belonging to NYC MED can complete and submit the form online.

NEW YORK STATE DEPARTMENT OF HEALTH
Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

SAMPLE

Anaplasmosis
Amebiasis
- Animal bites for which rabies prophylaxis is given[1]
- Anthrax[2]
- Arboviral infection[3]
  Babesiosis
- Botulism[2]
- Brucellosis[2]
  Campylobacteriosis Chancroid
  Chlamydia trachomatis infection
- Cholera
- Coronavirus (severe or novel) 2019 Novel Coronavirus (COVID-19)
  Severe Acute Respiratory Syndrome (SARS)
  Middle East Respiratory Syndrome (SARS)

Cryptosporidiosi
Cyclosporiasis
- Diphtheria
  E. coli O157:H7 infection
  Ehrlichiosis
- Encephalitis
- Foodborne Illness
  Giardiasis
- Glanders[2]
  Gonococcal infection
  Haemophilus influenzae[5] (Invasive disease)
- Hantavirus disease
  Hemolytic uremic syndrome
  Hepatitis A
- Hepatitis A in a food handler
  Hepatitis B (specify acute or chronic)
  Hepatitis C (specify acute or chronic)

Pregnant hepatitis B carrier
Herpes infection, infants aged 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory-confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
- Measles
- Melioidosis[2]
  Meningitis
  Aseptic or viral
- Haemophilus
- Meningococcal
  Other (specify type)
- Meningococcemia

- Monkeypox
Mump
Pertussis
- Plague[2]
- Poliomyelitis
Psittacosis
- Q Fever[2]
- Rabies[1]
Rocky Mountain spotted fever
- Rubella
  (Including congenital rubella syndrome)
Salmonellosis
Shigatoxin-producing E. coli[4] (STEC)
Shigellosis[4]
- Smallpox[2]
Staphylococcus aureus[6] (due to strains showing reduced susceptibility or resistance to vancomycin)

- Staphylococcal enterotoxin B poisoning[2]
Streptococcal infection (invasive disease)[5]
  Group A beta-hemolytic strep
  Group B strep
  Streptococcus pneumoniae
- Syphilis, specify stage[7]
Tetanus
Toxic shock syndrome
Transmissable spongiform encephalopathies[8] (TSE)
Trichinosis
- Tuberculosis current disease (specify site)
- Tularemia[2]
- Typhoid
- Vaccinia disease[9]
Vibriosis[6]
- Viral hemorrhagic fever[2]
Yersiniosis

SPECIAL NOTES

- Diseases listed in **bold type** warrant prompt action and should be reported **immediately** to local health departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparentor emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies, and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- Cases of HIV infection, HIV-related illness and AIDS are reportable on form DOH-4189 which may be obtained by contacting:

  Division of Epidemiology, Evaluation and Research
  P.O. Box 2073, ESP
  Station Albany, NY
  12220-2073
  (518) 474-4284

  In NYC: New York City Department of Health and Mental Hygiene For HIV/AIDS reporting, call:
  (212 442-3388

WHO SHOULD REPORT?
Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

WHERE SHOULD REPORT BE MADE?
Report to local health department where patient resides.

Contact Person_____

Name_____

Address_____

Phone_____Fax_____

WHEN SHOULD REPORT BE MADE?
Within 24 hours of diagnosis:

- Phone diseases in bold type,
- Mail case report, DOH-389, for all other diseases.
- In New York City use form PD-16.

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1. Local health department must be notified prior to initiatingrabies prophylaxis.
2. Diseases that are possible indicators of bioterrorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nilevirus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatoxin test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test ≥1:16 or any positive prenatal or delivery test regardless of titer or any primary or secondary stage disease, should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, cases should also be reported to the NYCDOHMH.
9. Persons with vaccinia infection due to contact transmission and persons with the following complications from vaccination; eczema vaccinatum, erythema multiforme major or Stevens- Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the infection site, and any other serious adverse events.

ADDITIONAL INFORMATION
For more information on disease reporting, call your local health department or the
New York State Department of Health Bureau of Communicable Disease Control at (518) 473-4439
or (866) 881-2809 after hours.
In New York City, 1 (866) NYC-DOHI.
To obtain reporting forms (DOH-389), call (518) 474-0548.

PLEASE POST THIS CONSPICUOUSLY

VIII Coordinating Treatment with a Member's Primary Care and Behavioral Health Providers
Coordinating Treatment with a Member's Primary Care Provider

1. Initial Evaluation Meeting

Written consent is not required when communicating within or between facilities licensed by the New York State Office of Mental Health.

If consent is needed, ask each MetroPlusHealth Member or the Member's guardian for written consent to allow you to share basic clinical information such as the diagnosis and initial treatment plan with the PCP. A sample consent form is attached (Side 1 – Attachment A.) Members should be encouraged to provide consent for this collaboration using the rationale that such coordination of care is essential to effective treatment. If the Member refuses to provide consent to release information to his/her PCP, document the refusal on the Refusal to Consent Form (Side 2 – Attachment A) and place the form in the Member's medical record.

2. Complete the Release of Information Form

Attachment A is a recommended consent form for your use. You are not required to use Attachment A. You may use an appropriate release form of your choice. However, under state and federal regulation, behavioral health information may only be exchanged between Providers with the expressed consent of the Member or the Member's legal guardian.

- For Members referred by their PCP location: the PCP's name, address and phone number should be present on the referral form provided at the outset of treatment.
- For self-referred Members: the name of the Member's PCP and the PCP location should be printed on the Member's MetroPlusHealth enrollment card.

3. Communication with the Primary Care Provider:

A. Initial Communication

Attachment B is a recommended communication form for your use. You are not required to use Attachment B. You may use an appropriate communication form of your choice. Once a signed consent form is obtained, send the Member's PCP the following information via mail or fax:

- Your name, address and phone number
- Date of first encounter
- Initial diagnosis
- Initial treatment plan, including a list of psychotherapeutic medications, and
- Reason for Referral/Request for any information needed from the PCP regarding the Member.
  The Member's PCP is expected to send you:
- Results of Member's recent history and physical examination
- A list of Member's current medications
- A response to your request for information.

B. Ongoing Communication

As treatment progresses, you and the Member's PCP should inform each other of the following:

- Any medical, psychiatric or substance use hospitalizations
- Addition or changes to medication regimes
- Identification of substance use problems and
- Any condition or proposed treatment that may impact a member's medical or behavioral health care

At minimum, annual communication with the PCP is required.

C. Final Communication

When the treatment is completed, a clinical disposition note should be forwarded to the PCP. The note should include a summary of treatment and any further treatment that the PCP should consider for the Member.

D. Documentation

Documentation of all attempts at communication with the PCP should be documented in the Member's behavioral health record.

Coordinating Treatment with a Member's Behavioral Health Provider (a provider who treats members with mental health conditions and/or substance use disorders)

1. Initial Evaluation Meeting

Written consent is not required when communicating within or between facilities licensed by the New York State Office of Mental Health.

If consent is needed, ask each MetroPlusHealth Member or the Member's guardian for written consent to allow you to share basic clinical information with the Behavioral Health Provider such as the results of Member's recent history and physical examination and a list of Member's current medications. A sample consent form is attached (Side 1 – Attachment A.) Members should be encouraged to provide consent for this collaboration using the rationale that such coordination of care is essential to effective treatment. If the Member refuses to provide consent to release information to his/her behavioral health Provider, document the refusal on the Refusal to Consent Form (Side 2 – Attachment A) and place the form in the Member's medical record.

2. Complete the Release of Information Form

Attachment A is a recommended consent form for your use. You are not required to use Attachment A. You may use an appropriate release form of your choice. However, under state and federal regulation, behavioral health information may only be exchanged between Providers with the expressed consent of the Member or the Member's legal guardian.

- Members may receive services from more than one behavioral health Provider (e.g., psychotherapist, psychiatrist, substance use provider). Ask the Member to identify the name and location of the behavioral health Provider with whom they have the most frequent contact or with whom they have the most contact regarding their treatment planning.

3. Communication with the Behavioral Health Provider:

A. Initial Communication

Attachment B is a recommended communication form for your use. You are not required to use Attachment B. You may use an appropriate communication form of your choice. Once a signed consent form is obtained, send the Member's Behavioral Health Provider the following information via mail or fax:

- Your name, address, and phone number
- Results of Member's recent history and physical examination
- A list of Member's current medications
- Reason for referral/Request for information needed from the Behavioral Health Provider.

(Note: MetroPlusHealth can assist in providing mailing addresses for behavioral health Providers, if needed.)

The Member's Behavioral Health Provider is expected to send you:

- Date of first encounter
- Initial diagnosis
- Initial treatment plan, including a list of psychotropic medications, and
- A response to your request for information

B. Ongoing Communication

As treatment progresses, you and the Member's Behavioral Health Provider should inform each other of the following:

- Any medical, psychiatric or substance use hospitalizations
- Addition or changes to medication regimens
- Identification of substance use problems and
- Any condition or proposed treatment that may impact a member's medical or behavioral health care At minimum, annual communication with the Behavioral Health Provider is required.

C. Documentation

Documentation of all attempts at communication with Behavioral Health Providers should be documented in the Member's behavioral health record.

Attachment IV, A
Information for the Primary Care Provider:

_____
Today's Date

_____
Behavioral Health Provider's Name

_____
Office Location / Address

_____
Street Address

_____
City, State, Zip Code

(_____)_____
Fax Number

(_____)_____
Phone Number

_____
Email Address

_____
Primary Care Provider's Name

_____
Office Location / Address

_____
Street Address

_____
City, State, Zip Code

(_____)_____
Fax Number

(_____)_____
Phone Number

_____
Email Address

☐ **Signed copy of Member Release of Information Form attached:** (Not required if communication within or between facilities licensed by the New York State office of Mental Health.)

Behavioral Health Provider's List:

1. Date of First Contact with Member: _____
2. Initial Diagnoses:

   _____ _____
   _____ _____
   _____ _____

3. Initial Treatment Plan:

   _____
   _____
   _____

4. Current Medications (including dosage and frequency):

   _____ _____
   _____ _____

5. Reason for Referral to the PCP/Request for information from the PCP:

   _____
   _____

PROHIBITION OF REDISCLOSURE

To the person receiving this release of information: This information has been disclosed to you from records protected by federal confidentiality rules or state confidentiality law. These regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical information or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

Attachment IV, B
Information for the Behavioral Health Provider:

_____
Today's Date

_____
Primary Care Provider's Name

_____
Office Location / Address

_____
Street Address

_____
City, State, Zip Code

(_____)_____
Fax Number

(_____)_____
Phone Number

_____
Email Address

_____
Behavioral Health Provider's Name

_____
Office Location / Address

_____
Street Address

_____
City, State, Zip Code

(_____)_____
Fax Number

(_____)_____
Phone Number

_____
Email Address

☐ **Signed copy of Member Release of Information Form attached:** (Not required if communication within or between facilities licensed by the New York State office of Mental Health.)

Behavioral Health Provider's List:

1. Date of Most Recent Contact with Member:
   _____
2. Results of Member's most recent history and physical examination (a copy of the completed history and physical form is acceptable):
   _____
3. Current Medical Diagnoses (if applicable):
   _____ _____
   _____ _____
4. Current Medications (including dosage and frequency):
   _____ _____
   _____ _____
   _____ _____
5. Reason for Referral to the PCP/Request for information from the PCP:
   _____
   _____

PROHIBITION OF REDISCLOSURE

To the person receiving this release of information: This information has been disclosed to you from records protected by federal confidentiality rules or state confidentiality law. These regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical information or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

IX NYSDOH Quality Assurance Reporting Requirements (QARR) Guide

The NYSDOH Quality Assurance Reporting Requirements (QARR) are indicators measured annually by health plans throughout the State. The QARR MY (measurement year) 2022 consists of measures from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), Center for Medicare and Medicaid Services (CMS) QRS Technical Specifications, and New York State-specific measures. The QARR MY 2022 incorporates measures from HEDIS® 2022. Use of the standardized measurement methodologies enables the NYSDOH to compare the performance of health plans throughout the state, with local and national benchmarks. Moreover, the NYSDOH uses the results to establish quality improvement goals for health plans, set the length of health plan Medicaid contracts, and determine the number of Medicaid members automatically assigned to the health plan. Health plan results are published in the Medicaid Consumer Health Plan Consumer Guide and are made available to the public.

A health plan's performance is based largely on the performance of the Providers in its network. As such, health plans expect Participating Providers to adhere to the standards of care associated with HEDIS, participate in data collection, and initiate quality improvement activities when necessary. Most health plans report QARR performance back to facilities and PCPs. Organizational and PCP QARR results are also used to compare performance across a range of Providers. Organizational and PCP performance on QARR can have an impact on a health plan's contracting and re-credentialing decisions. Some health plans, including MetroPlusHealth, offer incentives or financial awards for exemplary performance on QARR/quality measures.

QARR performance is largely measured from claims submitted by Participating Providers. It is therefore critical that complete, accurate CPT and ICD-10 codes are entered onto coding sheets in a timely fashion. MetroPlusHealth has developed a HEDIS/QARR reference guide and code list to assist providers when submitting claims and encounters. The most recent version of these tools is available in the provider portal. Performance is also based on medical record review. Comprehensive, legible, dated and signed documentation is necessary for measurement. The encounter template has been developed to prompt Providers to document components of QARR indicators that have been rendered but not accurately coded. Providers should refer to the directions included with the encounter template to ensure all submissions are accepted.

The major areas of performance included in the QARR MY 2022 measurement set include but is not limited to the following domains:

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care
4. Utilization and Risk Adjusted Utilization
5. NYS-specific measures include:
   - Viral Load Suppression
   - Initiation of Pharmacotherapy upon New Episode of Opioid Dependence
   - Use of Pharmacotherapy for Alcohol Use or Dependence
   - Potentially Preventable Mental Health Related Readmission Rate 30 Days
   - Prenatal Care Measures from the Live Birth file
   - Utilization of Recovery-Oriented Services for Mental Health
   - Developmental Screening in the First Three Years of Life
   - AHRQ Quality Indicators™

     Prevention Quality Indicators (PQIs) and Pediatic Quality Indicatord (PDIs) quantify hospital admissions that most likely could have been avoided through high-quality outpatient care.

For more detailed information, please go to NYS DOH 2022 Quality Assurance Reporting Requirements Technical Specifications (ny.gov)

XA Medicaid Managed Care Benefit Summary

A comprehensive benefits package is provided to Medicaid Managed Care members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at 1.800.303.9626 with any questions regarding MetroPlusHealth benefits. The following services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services including second medical/surgical opinion
- Inpatient and outpatient medical and surgical service
- Inpatient stay pending alternate level of medical care
- Preventive care, including well-baby care, well-child care, smoking/vaping cessation counseling, HIV education and risk reduction, and early and periodic screening, diagnosis and treatment (EPSDT) services
- Family planning and reproductive health care services, including abortions
- Medically necessary infertility drugs and medical services related to prescribing and monitoring the use of such drugs. This benefit is limited to coverage for three (3) cycles of treatment per lifetime.
  - The infertility benefit includes: infertility drugs, office visits, x-rays of the uterus and fallopian tubes, pelvic ultrasound, and blood testing.
  - In order to be eligible for this benefit, members must meet the following criteria: 21-34 years old and unable to get pregnant after 12 months of regular, unprotected sex or 35-44 years old and unable to get pregnant after 6 months of regular, unprotected sex.
- Maternity care, including pregnancy care, doctors/midwife and hospital services, newborn nursery care, screening for depression during pregnancy and up to a year after delivery
- Smoking/Vaping cessation treatment includes: - Smoking cessation treatment includes screening, behavioral interventions and Food Drug and Administration approved pharmacotherapy for adults, and behavioral interventions for school-aged children and adolescents, as appropriate.
  - Treatment for smoking cessation counseling for e-cigarettes and vaping of nicotine products must meet the following criteria:
    - Smoking cessation counseling must be provided face to face by a physician, dentist, registered physician assistant (PA), registered nurse practitioner (RNP), or licensed midwife (LM).
    - Smoking cessation counseling may take place during individual or group counseling sessions.
    - Only one procedure code per day may be billed.
    - Claims must include the appropriate ICD-10-CM diagnosis code for nicotine dependence.
  - Medicaid coverage includes all medications to treat smoking cessation listed on the Medicaid Pharmacy List of Reimbursable Drugs found at https://www.emedny.org/info/formfile.aspx.
- Diagnostic and laboratory tests and radiology services, including mammograms
- Vision services, including exams, eyeglasses and medically necessary contact lenses and polycarbonate lenses. One pair of glasses per 24 months. Lost or broken glasses will be replaced with an identical replacement pair. Members with diabetes may self-refer for an annual retinal exam
- Psychosocial Rehabilitation
- Rehabilitation services, including physical, occupational and speech therapy (limited to 20 visits each calendar year). (does not include Psychosocial Rehabilitation)
- Speech therapy is covered for conditions that will likely improve within a two-month period, beginning with the first day of therapy (authorization required for services over ten [10] visits per year)

- Hearing (audiology) services, including hearing aids, ear molds, special fittings and replacement parts
- Durable medical equipment, including orthotics and prosthetics, from a contracted vendor
- Emergency care and post-stabilization services
- Inpatient and Outpatient Substance use disorder treatment
  - Inpatient and Outpatient SUD Detoxification, Rehabilitation services and treatment
  - SUD Residential Addiction Treatment services
  - SUD Medically supervised outpatient withdrawal
  - Mental Health Care
- Adult Behavioral health home and community-based services (BHHCBS) include *psychosocial rehabilitation (PSR), *community psychiatric support and treatment (CPST), habilitation, *family support and training, short term respite, intensive respite, education support services, Pre-vocational, transitional employment, intensive/ongoing support employment, *Empowerment Services -Peer Support

  *(*will transition under CORE services effective 2/1/2022*)

- Radiation therapy and chemotherapy
- Dialysis
- Skilled nursing facility rehabilitative services
- Home health services
- Dental services and Orthodontic services (MHP covers braces for under 21 for severe issues with teeth)
- Prescription drugs and Non-Prescription (OTC) drugs, medical supplies, and enteral formula
- Personal care services/Home Health aide/Consumer Directed Personal Assistance Services (CDPAS)
- Hospice services
- Residential health care facility - Nursing Home – Adult only
- Diabetic supplies and equipment
- Consumer-directed personal assistance services
- Adult day health care
- Aids adult day health care
- Private duty nursing
- Foot care services
- Tuberculosis directly observed therapy
- Crisis intervention services
- Harm reduction services
- Urgent care
- Court ordered services
- Buprenorphine Prescribers
- Effective 1/1/23, Gambling Disorder Treatment
- Effective 1/1/23, Applied Behavior Analysis

Effective 2/1/2022,the following services are covered for Medicaid members aged 21 and older in the Crisis Intervention Crisis Residence Services benefit:

- Short Term Crisis Respite
- Intensive Crisis Respite

Effective 12/1/2022, benefit expansion coverage for Remote Patient Monitoring for Maternal Care:

- Expanded coverage for RPM during pregnancy and up to 84 days postpartum to further improve and expand access to prenatal and postpartum care.
- This expansion of coverage includes an additional monthly fee to cover the cost of RPM devices/equipment.

Coverage is provided by Medicaid, not MetroPlusHealth, for the following services:

- Disposable medical supplies and hearing aid batteries
- Residential Health Care Facility (Nursing Home) - under 21
- Emergency and non-emergency medical transportation
- Developmental disabilities
- Effective 1/1/23 Applied Behavioral Analysis (ABA) coverage provided to Children/Youth under the age of 21 with a diagnosis of Autism Spectrum Disorder and/or Rett Syndrome. ABA Services include:
  - Assessment and treatment by a physician, licensed behavioral analyst, or certified behavior analyst assistant
  - individual treatments delivered in the home or other setting,
  - group adaptive behavior treatment, and
  - training and support to family and caregivers
- Applied Behavior Analysis (ABA) therapy services covered when provided by:
  - Licensed Behavior Analyst (LBA), or
  - Certified Behavior Analyst Assistant (CBAA) under the supervision of an LBA
- Medicaid Coverage of Limited Infertility:
  - Medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs for individuals ages 21-44 experiencing "infertility":
    - Office visits
    - Hysterosalpingogram (x-ray of the uterus and fallopian tubes)
    - Pelvic ultrasounds
    - Blood testing
    - Ovulation enhancing drugs included in the Medicaid formulary (bromocriptine, clomiphene citrate, letrozole, tamoxifen)
  - Infertility benefits will be limited to coverage for three (3) cycles of treatment per lifetime

Services Not covered by Medicaid or MetroPlusHealth

- Services of a Podiatrist (for those 21 years and older unless you are a diabetic)
- Cosmetic Surgery (if not medically needed)
- In Vitro Fertilization (IVF)
- The following Basic Infertility Services:
  - postcoital test
  - endometrial biopsy
  - testis biopsy
- The following Comprehensive Infertility Services:
  - Hysteroscopy
  - Laparascopy
- Advanced Infertility Services
- Chiropractor services (except when ordered through EPSDT)
- Personal and comfort items

XB Child Health Plus Benefit Summary

A comprehensive benefits package is provided to ChildHealthPlus members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at 1.800.303.9626 with any questions regarding MetroPlusHealth benefits. The following services are covered:

- Well child care visits, including immunizations, health education, developmental screening, lead screening and related services
- Diagnostic and laboratory tests and radiology services
- Reproductive health services
- Maternity care, including pre and post-natal services, labor and delivery and post-partum services
- Inpatient and outpatient hospital, medical and surgical care including acute rehabilitation services
- Outpatient hospital ambulatory procedures or freestanding ambulatory surgery centers, medical and surgical care including acute rehabilitation services
- Second surgical opinion by a qualified physician or specialist
- Pre-surgical testing
- Dental services, including emergency, preventive and routine dental care provided through MetroPlusHealth's dental benefit manager. Limited orthodontic services for children with a severe medical condition such as cleft lip or cleft palate.
- Emergency, preventive, and routine vision care services, including exams, eyeglasses, and medically necessary contact lenses. One pair of glasses per year. Lost or broken glasses will be replaced with an identical replacement pair, including frame selection.
- Hearing services, one examination per year and necessary follow-up, including hearing aids
- Short term inpatient and outpatient physical therapy and occupational therapy (authorization required for services over ten [10] visits per year)
- Speech therapy is covered for conditions that will likely improve within a two-month period, beginning with the first day of therapy (authorization required for services over ten [10] visits per year)
- Durable medical equipment, prosthetic appliances, and orthotic devices
- Emergency medical services
- Emergency ambulance services; *(*listed under *not covered)*
- Outpatient and inpatient mental health, alcohol, and substance use services
- Prescription and non-prescription drugs when ordered by a physician. Prescription drugs, including enteral formulas, nutritional supplements when necessary to treat a diagnosed illness or condition
- Diabetic supplies and equipment
- Skilled home health services (limited to 40 visits per year)
- Home health care services provided by a certified home health agency
- Hospice services
- Applied Benefit Analysis (ABA) – limited to 680 hours/calendar year (under *Autism Spectrum Disorder*)
- Therapeutic Outpatient services (chemotherapy, hemodialysis)
- Radiation Therapy
- Diagnosis and treatment for illness or injury.
- Annual Cervical cancer screenings
- Ostomy equipment and supplies
- Effective 1/1/2023 Blood clotting factor

- Contraceptive devices and drugs
- Diabetic self-management education
- Reconstructive surgery when medically necessary

Expansion of benefits for CHP members:

- Available in January 2023:
  - Assertive Community Treatment Services (ACT), Young Adult ACT and Youth ACT
  - CFTSS (Children and Family Treatment Supports and Services)
  - Screening, Brief Intervention and Referral to Treatment (SBIRT) covered under CFTSS
  - Medical Supplies
  - Ambulance services: transportation between hospitals
  - Air ambulance transportation
  - Orthodontic Services for a Severe Physically Handicapping Malocclusion
  - 29-I Health Facility Core Limited Health-Related Services
  - Diagnosis and Treatment of an Autism Spectrum Disorder (Assistive Communicative Device)
- Available in April 2023:
  - Coverage for RRSY (Residential Rehabilitation Services for Youth)
- Available in July 2023
  - Coverage for Home and Community Based Services (HCBS) for members who meet eligibility criteria

Non-covered services include:

- Non-emergent transportation
- Orthodontia, private duty nursing, and chiropractic services
- Inpatient services in Skilled Nursing facility or rehabilitation facility including physician services (not cited contractually)
- Home Health Care, except as defined
- Experimental or investigational medical or surgical procedures or drugs unless approved by the plan
- Prescription drugs used for purposes of treating erectile dysfunction
- Prescription drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia, or mercy killing of a person
- Non-prescription drugs, except as described above
- Disposable supplies, except for diabetes and ostomy supplies
- Autologous blood donation
- Routine foot care
- Cosmetic surgery (unless medically necessary).
- Physical manipulation of services
- Custodial care
- IVF, artificial insemination or other means of conception and infertility services
- Care in connection with the detection and correction by manual or mechanical means or structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or resulted to distortion, misalignment or sublaxation of or in the vertebral column
- Personal or comfort items
- Services which are not medically necessary

XC Medicaid HIV Special Needs Plan Benefit Summary

A comprehensive benefits package is provided to Medicaid HIV Special Needs Plan members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at 1.800.303.9626 with any questions regarding MetroPlusHealth benefits. These services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services, and HIV medical care
- Inpatient and outpatient medical and surgical services including second opinion
- Inpatient stay pending alternate level of medical care Private duty nursing services when medically necessary
- Well child care
- Family planning and reproductive health care services, including abortions
- Medically necessary infertility drugs and medical services related to prescribing and monitoring the use of such drugs. This benefit is limited to coverage for three (3) cycles of treatment per lifetime.
  - The infertility benefit includes: infertility drugs, office visits, x-rays of the uterus and fallopian tubes, pelvic ultrasound, and blood testing.
  - In order to be eligible for this benefit, members must meet the following criteria: 21-34 years old and unable to get pregnant after 12 months of regular, unprotected sex OR 35-44 years old and unable to get pregnant after 6 months of regular, unprotected sex.
- Maternity care, including pre and postnatal visits, labor and delivery, post-partum home health visits
- Smoking/vaping cessation treatment includes:
  - Smoking cessation treatment includes screening, behavioral interventions and Food Drug and Administration approved pharmacotherapy for adults, and behavioral interventions for school-aged children and adolescents, as appropriate.
  - Treatment for smoking cessation counseling for e-cigarettes and vaping of nicotine products must meet the following criteria: - Smoking cessation counseling must be provided face to face by a physician, dentist, registered physician assistant (PA), registered nurse practitioner (RNP), or licensed midwife (LM).
    - Smoking cessation counseling may take place during individual or group counseling sessions.
    - Only one procedure code per day may be billed.
    - Claims must include the appropriate ICD-10-CM diagnosis code for nicotine dependence.
  - Medicaid coverage includes all medications to treat smoking cessation listed on the Medicaid Pharmacy List of Reimbursable Drugs found at https://www.emedny.org/info/formfile.aspx.
- Diagnostic and laboratory tests and radiology services, including mammograms
- Vision services, including exams, eyeglasses and medically necessary contact lenses and polycarbonate lenses. One pair of glasses per 24 months. Lost or broken glasses will be replaced with an identical replacement pair, including frame selection. Members with diabetes can self-refer for an annual retinal exam from an in-Network provider

- Short term outpatient physical therapy and occupational therapy, speech therapy (authorization required for services over twenty [20] visits per calendar year).
- Hospice services
- Adult day health care
- AIDS adult day health care
- Prescription and non-prescription (OTC) drugs, diabetic supplies and equipment, medical supplies, and enteral formula
- Routine dental and Orthodontic services (MHP covers braces for children under 21 with severe issues with teeth)
- Speech therapy is covered for conditions that will likely improve within a two-month period, beginning with the first day of therapy (authorization required for services over ten [10] visits per year)
- Hearing services, including hearing aids, ear molds, special fittings and replacement parts, and hearing aid batteries
- Durable medical equipment, including orthotics and prosthetics, orthopedic footwear.
- Emergency room visits
- Inpatient and Outpatient SUD Detoxification, Rehabilitation and Treatment services
- SUD Residential Addiction Treatment services
- SUD Medically supervised outpatient withdrawal
- Mental Health Care
- Dialysis
- Home health services
- Adult Behavioral health home and community-based services (BHHCBS) include *psychosocial rehabilitation (PSR), *community psychiatric support and treatment (CPST), habilitation, *family support and training, short term respite, intensive respite, education support services, Pre-vocational, transitional employment, intensive/ongoing support employment, *Empowerment Services -Peer Support
- *(*will transition under CORE services effective 2/1/2022*)
- Personal care services/Home Health Aide/ Consumer Directed Personal Assistance Services (CDPAS)
- Tuberculosis directly observed therapy
- Treatment adherence services
- HIV prevention and risk reduction education
- HIV SNP Care and Benefits Coordination
- HIV Treatment Adherence Services
- Foot Care Services
- Therapy including diagnosis and treatment for Tuberculosis
- Court ordered services
- Buprenorphine Prescribers
- Experimental and/or Investigational Treatment (*case by case basis*)
- Effective 1/1/23, Gambling Disorder Treatment
- Effective 1/1/23, Applied Behavior Analysis, starting 1/1/23

Effective 12/1/2022, benefit expansion coverage for Remote Patient Monitoring for Maternal Care:

- Expanded coverage for RPM during pregnancy and up to 84 days postpartum to further improve and expand access to prenatal and postpartum care.
- This expansion of coverage includes an additional monthly fee to cover the cost of RPM devices/equipment.

Coverage is provided by Medicaid, not MetroPlusHealth, for the following services:

- COBRA case management services
- Emergency and/or non-emergency transportation
- HIV resistance tests
- Short term, rehab, or long term custodial services in a residential health care facility (Nursing Home) – authorization rules apply.
- Services rendered by a personal care agency which is approved by the Local Department of Social Services when ordered by an enrollee's PCP. District will determine applicants need for personal care agency services.
- Developmental disabilities
- Observation services
- Effective 1/1/23 Applied Behavioral Analysis (ABA) coverage provided to Children/Youth under the age of 21 with a diagnosis of Autism Spectrum Disorder and/or Rett Syndrome. ABA Services include:
  - Assessment and treatment by a physician, licensed behavioral analyst, or certified behavior analyst assistant
  - individual treatments delivered in the home or other setting, group adaptive behavior treatment, and training and support to family and caregivers
- Applied Behavior Analysis (ABA) therapy services covered when provided by:
- Licensed Behavior Analyst (LBA), or
- Certified Behavior Analyst Assistant (CBAA) under the supervision of an LBA
- Medicaid Coverage of Limited Infertility Benefit:
  - Medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs for individuals ages 21-44 experiencing "infertility"
    - Office visits
    - Hysterosalpingograms (X-ray of the uterus and fallopian tubes)
    - Pelvic ultrasounds
    - Blood testing
    - Ovulation enhancing drugs included in the Medicaid formulary (bromocriptine, clomiphene citrate, letrozole, tamoxifen)
  - Infertility benefits will be limited to coverage for three (3) cycles of treatment per lifetime

Services not covered by Medicaid or MetroPlusHealth

- Cosmetic surgery (if not medically necessary)
- In Vitro Fertilization (IVF)
- The following Basic Infertility Services:
  - Postcoital test
  - Endometrial biopsy
  - Testis biopsy
- The following Comprehensive Infertility Services:
  - Hysteroscopy
  - Laparoscopy
- Advanced Infertility Services
- Personal and comfort items

XD Enhanced (HARP) Plan Benefit Summary

A comprehensive benefits package is provided to Enhanced (HARP) plan members. HARP product includes physical health, mental health and substance use services in an integrated way for adults 21 years and over, with significant behavioral health needs (mental health or substance use.) All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at 1.800.303.9626 with any questions regarding MetroPlusHealth benefits. The following services are covered by MetroPlusHealth:

A HARP member is covered for all medical and behavioral health services covered under Medicaid. In addition, they are covered for an enhanced benefit package of Home and Community Based Services (HCBS) and Community Oriented Recovery and Empowerment Services (CORE). CORE services includes HARP enrollees and HARP eligible in Partnership in Care (HIV/SNP).

- Effective 2/1/2022 CORE consists of 4 services:
  - Psychosocial Rehabilitation (PSR)
  - Community Psychiatric Support and Treatment (CPST)
  - Family Support and Training (FST)
  - Empowerment Services - Peer Support
- BH HCBS services include:
  - Pre-vocational Services
  - Transitional Employment
  - Intensive Supported Employment (ISE)
  - Ongoing Supported Employment (OSE)
  - Education Support Services
  - Habilitation
  - Non-Medical Transportation

Effective 12/1/2022, benefit expansion coverage for Remote Patient Monitoring for Maternal Care:

- Expanded coverage for RPM during pregnancy and up to 84 days postpartum to further improve and expand access to prenatal and postpartum care.
- This expansion of coverage includes an additional monthly fee to cover the cost of RPM devices/equipment.

XE MetroPlusHealth Gold Benefit Summary

A comprehensive benefits package is provided to MetroPlusHealth Gold members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and for authorized out-of-network services. Please call Member Services at 1.877.475.3795 with any questions regarding MetroPlusHealth benefits or refer to the Certificate of Coverage on www.metroplus.org. The following services are covered:

- All visits to your Primary Care Provider (PCP)
- Specialty visits referred by your PCP
- Second opinion visits arranged by your PCP or by MetroPlusHealth for medical and surgical conditions
- Initial (baseline) and periodic physical examinations for adults and children
- Basic infertility services, Comprehensive infertility services, including 3 cycles per lifetime of IVF
- Gynecological and obstetrical care including maternity and newborn care
- Diagnostic and laboratory tests and radiology services, including mammograms
- Speech therapy, physical therapy and occupational therapy is covered for 20 days per Plan Year
- Radiation therapy and chemotherapy
- Dialysis
- Eye examinations and treatments for eye diseases, not including glasses and contact lenses
- Emergency ambulance services; routine transportation is not covered
- Durable medical equipment, including orthotics and prosthetic appliances and devices
- Chiropractic care
- Diabetic medications and supplies
- Inpatient medical and surgical services and related hospital and anesthesia
- Ambulatory surgery
- Inpatient mental health, alcohol and drug detoxification and treatment
- Outpatient mental health (long term mental health services are not covered), alcohol and substance use treatment
- Skilled home health services (limited to 40 visits per calendar year)
- Skilled Nursing Facility rehabilitative care (limited to 200 days per calendar year)
- Hospice care (inpatient: 210 days per plan year and five (5) visits for family bereavement counseling)
- Transportation: Reimbursement for up to 4 trips per Plan Year with a maximum of $15 per trip
- Gym: Reimbursement Up to $250 per six (6) month period; up to an additional $250 per six (6) month period for Spouse
- Weight Loss Program Reimbursement: Up to $100 per six (6) month period; up to an additional $50 per six (6) month period for Spouse

The following services require a co-payment:

- Prescription drug benefits offered through the Optional Prescription Drug Rider
- Emergency Department - $100 Copayment; waved if admitted to hospital
- Urgent Care - $25 copayment

Non-covered services include:

- Dental care
- Cosmetic surgery, electrolysis, routine footcare
- Experimental services and treatments, unless approved by MetroPlusHealth or required by the decision of a New York State external appeal agent
- Long term custodial care in a facility
- Private duty nursing

XF MetroPlusHealth Outpatient & Inpatient Behavioral Health Benefit Tables

*MetroPlusHealth Inpatient Behavioral Health Benefit Table**

Line of Business	Benefit	Authorization Requirement
Medicaid Managed Care & HARP	Unlimited inpatient days	Authorization required for inpatient services
Medicaid Managed Care with SSI	Inpatient detox services are covered; mental health and substance use rehab services are covered by Medicaid Fee for Service (except SSI SNP members)	Inpatient Detox and Rehab require notification, not prior authorization
Child Health Plus	Unlimited inpatient days	Authorization required for inpatient services
HIV Special Needs Plan (SNP)	Unlimited inpatient days; mental health and substance use services for SSI SNP members are covered by HIV SNP	Authorization required for inpatient services
MetroPlusHealth Gold	Unlimited inpatient mental health; not to exceed 5 days per detox visit; not to exceed 30 days per calendar year for substance use rehab services	Authorization required for inpatient services

*MetroPlusHealth Outpatient Behavioral Health Benefit Table**

Line of Business	Benefit	Authorization Requirement
Medicaid Managed Care & HARP	Outpatient detox and behavioral health services – no visit limits	Authorization required after 60 outpatient visits per calendar year
Medicaid Managed Care with SSI	Outpatient detox – no visit limits; outpatient mental health and substance use services are covered by Medicaid Fee for Service	None
Child Health Plus	Outpatient behavioral health services – no visit limits	None
HIV Special Needs Plan (SNP)	Outpatient detox and behavioral health services – no visit limits	Authorization required after 60 outpatient visits per calendar year
MetroPlusHealth Gold	Outpatient detox – no limits; outpatient alcohol and substance use services – not to exceed 30 days per calendar year; long term outpatient mental health services are not covered	None

*Refer to Medicaid Managed Care Contract for more information.

For more detailed information on authorization requirements, please visit:
https://www.metroplus.org/provider/tools

https://www.metroplus.org/provider/authorization-request

XG MetroPlusHealth Medicare Advantage Plans (HMO-DSNP)

MetroPlus Advantage Plan (HMO-DSNP) is a Dual Eligible Special Needs Plan that coordinates your Medicare coverage with additional wrap around benefits and services you may be entitled to receive under New York State's Medicaid Program. Members who qualify for Medicare and Medicaid are known as dial eligible. As a dual eligible member, you are eligible for benefits under both the federal Medicare Program and the New York State Medicaid Program. Your Monthly premium and cost sharing depend on your level of Extra Help. If you are eligible for full Medicaid benefits, your deductible, copays and coinsurances could be as low as $0. The MetroPlus Advantage Plan (HMO-DSNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You can see our plan's Provider/Pharmacy Directory and Evidence of Coverage at metroplusmedicare.org. Or call us and we will send you a copy of the directory.

The following services are not covered by MetroPlus Advantage Plan (HMO-DSNP) but are available through Medicaid:

- Medicare Cost Sharing
- Adult Day Health Care
- AIDS Adult Day Health Care
- Assisted Living Program
- Behavioral Health Home and Community Based Services, including:
  - Psychosocial Rehabilitation (PSR)
  - Community Psychiatric Support and Treatment (CPST)
  - Habilitation Services
  - Family Support and Training
  - Short-term Crisis Respite
  - Intensive Crisis Respite
  - Education Support Services
  - Peer Supports
  - Pre-vocational Services
  - Transitional Employment
  - Intensive Supported Employment (ISE)
  - Ongoing Supported Employment
- Certain Behavioral Health Services, including:
  - Clinic: Continuing Day Treatment & Partial Hospitalization
  - Rehabilitation: Inpatient, Treatment & Residential Addiction Services
  - Outpatient Hospital & Personal Emergency Response Services
  - Crisis Residence 1115 Waiver Services
  - Personalized Recovery Oriented Services & Rehab: ACT Community Residence
- Certain Mental Health Services, including:
  - Intensive Psychiatric Rehabilitation Treatment Program
  - Day Treatment
  - Continuing Day Treatment
  - Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
  - Partial Hospitalizations (not covered by Medicare)
  - Assertive Community Treatment (ACT)
  - Personalized Recovery Oriented Services (PROS)

- Comprehensive Medicaid Case Management (CMCM)
- Court-Ordered Services
- Crisis Intervention Services
- Directly Observed Therapy for Tuberculosis Disease
- Home and Community Based Services (HCBS) Waiver Program Services
- Inpatient Mental Health Over 190-Day Lifetime Limit
- Medicaid Pharmacy Benefits
- Medical and Surgical Supplies, Parenteral Formula, Enteral Formula, and Hearing Aid Batteries
- Medical Social Services
- Methadone Maintenance Treatment Programs (MMTP)
- Non-Medicare Covered Care in Skilled Nursing Facility
- Non-Medicare Covered Durable Medical Equipment
- Non-Medicare Covered Home Health Services
- Nursing Home Care
- Nutrition
- Office for People with Developmental Disabilities (OPWDD) Services
- Out of Network Family Planning Services
- Personal Emergency Response Services
- Private Duty Nursing Services
- Prosthetics
- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs
- Substance Use Disorder (SUD) Services

XH Qualified Health Plan Benefit Summary

MetroPlusHealth offers Qualified Health Plans at all standard metal levels cost sharing options, both on the Individual and SHOP (Small Business Health Options) exchanges. For individuals, reduced cost sharing options are available for members with incomes under 250% of the FPL and for American Indians under 300% of the FPL. MetroPlusHealth also offers non-standard plans with adult vision and dental care, bronze level plans with HSA, and silver and gold plans with the first 3 PCP visits not subject to their deductible. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at 1.855.809.4073 with any questions regarding MetroPlusHealth benefits. The following services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services
- Inpatient and outpatient medical and surgical service
- Well baby/well child care
- Family planning and reproductive health care services, including abortions. For members who obtain SHOP coverage through religious employers, this may not be covered.
- Maternity care, including pre and postnatal visits, labor and delivery
- Smoking/vaping cessation drugs
- Diagnostic and laboratory tests and radiology services, including mammograms
- Pediatric vision services, including exams, eyeglasses and medically necessary contact lenses and polycarbonate lenses. One pair of glasses per 12 months.
- Short term inpatient and outpatient physical, occupational and speech therapy (60 visits per year, authorization required for all visits)
- Hearing (audiology) services, including hearing aids, ear molds, special fittings and replacement parts. Hearing aids are covered once every 3 years
- Durable medical equipment, including orthotics and prosthetics, from a contracted vendor
- Emergency room visits and emergency ambulance services, and non-urgent transport for medically necessary services
- Inpatient drug, alcohol and mental health treatment
- Radiation therapy and chemotherapy
- Dialysis
- Skilled nursing facility rehabilitative services
- Skilled home health services
- Pediatric dental services, including routine exams, x-rays, and preventive care
- Prescription drugs and enteral formulas
- Outpatient alcohol or substance use treatment services
- Hospice services
- Diabetic supplies and equipment
- Chiropractor services
- Basic infertility services, Comprehensive infertility services

Coverage is only provided if the member elects additional coverage for the following services:

- Adult vision care, including exams, eyeglasses, and contact lenses
- Adult dental care, including routine exams, x-rays, and preventive care
- 8 visits per plan-year for acupuncture services

Non-covered services include:

- Routine foot care
- Long-term custodial nursing care
- Personal care agency services
- IVF treatment

XJ Essential Plan Benefit Summary

MetroPlusHealth participates in the Essential Plan program which allows members access to a variety of plans based on specific eligibility criteria. Members eligible for EP 1 & 2 now have dental & vision coverage included in their benefits. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at 1.855.809.4073 with any questions regarding MetroPlusHealth benefits. The following services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services
- Inpatient and outpatient medical and surgical service
- Family planning and reproductive health care services, including abortions
- Diagnostic and laboratory tests and radiology services, including mammograms
- Short term inpatient and outpatient occupational therapy and physical therapy (60 visits per year, authorization required for all visits)
- Hearing (audiology) services, including hearing aids, earmolds, special fittings and replacement parts
- Durable medical equipment, including orthotics and prosthetics, from a contracted vendor
- Emergency room visits and emergency ambulance services, and non-urgent transport for medically necessary services
- Non-emergency transportation services are covered for members of the EP 3 and EP4 plans
- Inpatient drug, alcohol and mental health treatment
- Radiation therapy and chemotherapy
- Dialysis
- Skilled nursing facility rehabilitative services
- Skilled home health services Prescription drugs and enteral formulas.
- Non-prescription drugs are covered for members of the EP 3 and EP 4 plans.
- Outpatient alcohol or substance use treatment services
- Hospice services
- Diabetic supplies and equipment
- Chiropractor services
- Basic infertility services, Comprehensive infertility services

Non-covered services include:

- Routine foot care
- Long-term custodial nursing care
- IVF treatment

XK GoldCare Benefit Summary

MetroPlusHealth offers two GoldCare plans, which differ in cost sharing amounts and in breadth of network. Both plans offer a comprehensive benefits package. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at 1.877.475.3795 with any questions regarding MetroPlusHealth benefits. The following services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services
- Inpatient and outpatient medical and surgical service
- Well baby/well child care
- Family planning and reproductive health care services, including abortions
- Maternity care, including pre and postnatal visits, labor and delivery
- Smoking/vaping cessation drugs
- Diagnostic and laboratory tests and radiology services, including mammograms
- Speech therapy physical therapy and occupational therapy are covered up to 60 visits per condition per Plan Year
- Durable medical equipment, including orthotics, from a contracted vendor
- Emergency room visits and emergency ambulance services
- Inpatient drug, alcohol and mental health treatment
- Radiation therapy and chemotherapy
- Dialysis
- Skilled nursing facility rehabilitative services
- Skilled home health services
- Chiropractic care
- Prescription drugs and enteral formulas
- Outpatient alcohol or substance use treatment services
- Hospice services
- Diabetic supplies and equipment when obtained from a designated manufacturer
- Basic infertility services, Comprehensive infertility services, including 3 cycles per lifetime of IVF

Non-covered services include:

- Vision services
- Dental services
- Hearing aids
- Long-term custodial nursing care
- Personal care agency services
- Routine foot care

XL MetroPlusHealth Medicaid Advantage Plus

A comprehensive benefits package is provided to MetroPlusHealth Medicaid Advantage Plus, UltraCare members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Restrictions may apply. Please call member services at 866.986.0356 with any questions regarding MetroPlusHealth benefits. These services are covered by MetroPlusHealth:

Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Dual Eligibles covered services:

- Inpatient mental health
- Home health care (medically necessary)
- Inpatient hospital care, including substance use and rehabilitation services
- PCP office and specialist office visits
- Chiropractic
- Podiatry
- Outpatient surgery
- Emergency Department
- Urgent Care (in network only)
- Outpatient rehabilitation (Medicaid covered OT, PT, and ST)
- Medicare and Medicaid covered Durable Medical Equipment, including devices and equipment other than prosthetic or orthotic appliances
- Diabetes monitoring
- Diagnostic testing
- Colorectal screening
- Vaccines/Immunizations
- Medicare and Medicaid covered prosthetics, orthotics and orthopedic footwear
- Bone Mass measurement
- Mammograms
- Hearing aids and audiology services
- Vision care services
- Prostate cancer screening
- Outpatient drugs (no Part D)
- Preventive care services
- Private duty nursing (medically necessary)
- Dental services, including routine, preventive dental care. Ambulatory or inpatient surgical dental services subject to prior authorization.
- Personal Care services (medically necessary)
- Nutrition Medical Social Services
- Adult Day Health Care
- Social Day Care
- Home delivered and congregate meals
- Social and Environmental Supports
- Personal Emergency Response Services (PERS)

Starting 1/1/2023, Behavioral Health services to be covered Medicaid Advantage Plus, UltraCare, will include the following:

- Adult Outpatient Mental Health Care
  - Continuing Day Treatment (CDT)
  - Partial Hospitalization (PH)
- Adult Outpatient Rehabilitative Mental Health Care
  - Assertive Community Treatment (ACT)
  - Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)
  - Personalized Recovery Oriented Services (PROS)
- Adult Outpatient Rehabilitative Mental Health and addiction also known as Community Oriented Recovery and Empowerment (CORE) Services:
  - Psychosocial Rehabilitation (PSR)
  - Community Psychiatric Supports and Treatment (CPST)
  - Empowerment Services - Peer Supports
  - Family Support and Training (FST)
- Adult Mental Health Crisis Services
  - Comprehensive Psychiatric Emergency Program (CPEP)
  - Mobile Crisis and Telephonic Crisis Services
  - Crisis Residential Programs
- Adult Outpatient Addiction Services
  - Opioid Treatment Centers (OTP)
- Adult Residential Addiction Services
  - Residential Services
- Adult Inpatient Addiction Rehabilitation Services
  - State Operated Addiction Treatment Center's (ATC)
  - Inpatient Addiction Rehabilitation
- Inpatient Medically Supervised Detox

The following services are excluded from MetroPlusHealth's Medicare and Medicaid Benefit packages are covered in most instances by Medicare or Medicaid fee-for-services:

- Hospice Services
- Out of Network Family Planning Services
- Other Services deemed to be covered by original Medicare by CMS
- Pharmacy Benefits as Permitted by State Law (NYS Medicaid FFS provides coverage for certain drugs excluded). NYS Medicaid continues to provide coverage for certain drugs excluded from the Medicare Part D benefit such as barbiturates, benzodiazepines, and some prescription vitamins, and some non-prescription drugs.
- Methadone Maintenance Treatment Program (MMTP)

Non-Covered Medical Services include:

- Directly Observed Therapy for Tuberculosis Disease
- Assisted Living Program covered by Medicaid FFS

Non-Covered Mental Health Services include:

- Intensive Psychiatric Rehabilitation Treatment Programs (IPRT)
- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill Sponsored by State or Local Mental Health Units
- Home and Community Based Services (HCBS) Waiver Program Services
- Conversion or Reparative Therapy

XM MetroPlus Platinum Plan (HMO)

MetroPlus Platinum Plan (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B. The MetroPlus Platinum Plan (HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You can see our plan's Provider/Pharmacy Directory and "Evidence of Coverage" at metroplusmedicare.org. Or call us

and we will send you a copy of the Provider/Pharmacy Directory. You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, MetroPlus Platinum Plan (HMO). We are required to cover all Part A and Part B Services. However, cost sharing and provider access in this plan differ from Original Medicare.

XI Statement on Fraud and Abuse

It is the policy of MetroPlusHealth to comply with all federal and state laws regarding fraud, waste and abuse, to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding claims submitted to federal and state healthcare programs, and to provide protection for those who report in good faith actual or suspected wrongdoing.

MetroPlusHealth is also required to refer potential fraud or misconduct related to its Federally Sponsored Programs (Medicare, Medicaid, HIV SNP, etc.) to the Health and Human Services Office of the Inspector General, Medicaid Fraud Control Unit (OIG MFCU) and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste and abuse related to the NY state funded programs are reported to the State Department of Health (SDOH), the Office of the Medicaid Inspector General (OMIG), Health + Hospitals Inspector General, and/or other appropriate law enforcement or regulatory agency.

The Compliance Policy

MetroPlusHealth maintains a strict policy of zero tolerance toward fraud and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member, or provider are subject to immediate disciplinary action up to and including termination.

As part of our commitment to this zero-tolerance policy, MetroPlusHealth provides this information to providers to achieve the following goals:

- Demonstrate its commitment to responsible corporate conduct
- Maintain an environment that encourages reporting of potential problems
- Ensure appropriate investigation of possible misconduct by the company

MetroPlusHealth has adopted organization-wide fraud prevention, detection, and investigation programs for the purpose of protecting the member, the government, and/or MetroPlusHealth from expending money where it should not be expended.

Specifically, MetroPlusHealth has an established Special Investigations Unit (SIU), which ensures that MetroPlusHealth and its providers are in compliance with all applicable state and federal regulations and managed care contract provisions. The SIU is chiefly responsible for accepting and investigating internal and external case referrals to determine if provider fraud or abuse has potentially occurred. MetroPlusHealth employees and contracted entities have a responsibility to report any inappropriate provider activities to the SIU.

All concerns about fraud or abuse, including those relating to member, contractor, provider or employee behavior, can be reported to the MetroPlusHealth Corporate Compliance department. MetroPlusHealth proactively investigates and resolves all complaints and other reports or findings that raise suspicion of fraud and/or abuse. Members, Providers, employees or the public can report suspected fraudulent or abusive behavior by:

- Calling the Compliance Hotline at 1.888.245.7247 or the Special Investigations Unit at 212.908.3138, or
- Emailing ComplianceOfficer@metroplus.org, or
- Writing **to MetroPlusHealth Compliance Department, MetroPlusHealth, 50 Water Street, 7th Floor, New York, NY 10004**.

The Member Services Department will also accept verbal or written reports and will ensure proper referral to the Compliance Department. You can contact the **Member Services Department** at **1.800.303.9626**.

Following receipt of the complaint/fraud and abuse referral, the Compliance Department conducts a preliminary investigation to assess the nature and scope of the issue. Based upon the findings of the preliminary investigation, a plan for further investigation and/or resolution of the matter is established.

Fraud, Waste & Abuse – General Information

Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

Fraud: An intentional, knowing, or willful deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste: The extravagant, careless or needless expenditure of funds resulting from deficient practices, systems, controls or decisions.

Relevant Statutes and Regulations

Stark Law

The Stark law, with several separate provisions, governs physician self-referral for Medicare and Medicaid patients. Physician self-referral is the practice of a physician referring a patient to a medical facility in which he or an immediate family member has a financial interest, be it ownership, investment, or a structured compensation agreement.

The Omnibus Budget Reconciliation Act of 1989 also bars self-referrals for clinical laboratory services under the Medicare program. The law included a series of exceptions to the ban in order to accommodate legitimate business arrangements. The Omnibus Budget Reconciliation Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. The Social Security Act prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship – unless an exception applies.

It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a health service furnished as a result of a prohibited referral.

Violations of Stark and Physician Self-Referral are to be reported to the Centers for Medicare and

Medicaid Services through an established self-disclosure process.

Anti-Kickback Statute

The Medicare and Medicaid Patient Protection Act of 1987, provides the basis for this statute. It provides for criminal penalties for certain acts which impact Medicare and Medicaid or any other Federal or State funded program. If you solic receive any remuneration in return for referring an individual to a person (doctor, hospital and provider) for a service for which payment may be made, it can be seen as a potential kickback. Remuneration includes payment, monies, or any other goods or services from any healthcare facilities, programs, and providers.

False Claims Act

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistle-blowers) can help reduce fraud against the government. The act allows everyday people to b suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (t act does not cover tax fraud).

For the purposes of this policy, “knowing and/or knowingly” means that a person has actual knowledge of the information acts in a deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity the information. No proof of specific intent to defraud is required.

Both federal and state False Claims Acts (FCA) apply when a company or person:

- Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment
- Knowingly makes, uses, or causes to be made or used a false record or statement to get a claim paid by the fed government
- Conspires with others to get a false or fraudulent claim paid by the federal government
- Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease obligation to pay or transmit money or property to the federal government

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting premium claims to the Medicaid program for members not actually served by MetroPlusHealth
- Knowingly failing to provide members with access to services for which MetroPlusHealth has received premium payments
- Knowingly submitting inaccurate, misleading or incomplete Medicaid cost reports

False Claims Act Penalties

Those who defraud the government can end up paying triple (or more than) the damage done to the government or a fine (up to $11,803) for every false claim, in addition to the claimant's cost and attorneys' fees. These monetary fines are in addition to potential incarceration, revocation of licensures, and/or becoming an "excluded" individual which prevents an individual from being employed in any job that receives monies from the Federal Government, the State Government, or both.

Protections for Whistle Blowers.

Whistle-blower protection is provided by federal acts and related State and federal laws, which shield employees from retaliation for reporting illegal acts of employers. An employer cannot retaliate in any way, such as discharging, demoting, suspending or harassing the whistle blower. If an employer retaliates in anyway, whistle-blower protection might entitle the employee to file a charge with a government agency, sue the employer or both.

To report information about fraud, waste or abuse involving Medicare or any other healthcare program involving federal funds, call the toll-free hotline established by the federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number **is 1.800.HHS.TIPS (1.800.447.8477**). For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to https://oig.hhs.gov/fraud/report-fraud/index.asp.

NYS Medicaid Prior Authorization Request Form For Prescriptions

Rationale for Exception Request or Prior Authorization - *All information must be complete and legible*

Patient Information

First Name:	Last Name:	MI:	☐ Male ☐ Female
Date of Birth: ___/___/___	Member ID:	Is patient transitioning from a facility? ☐ **Yes** ☐ **No** If yes, provide name of facility: _____	

Provider Information

First Name:	Last Name:		Address:	
NPI No:[1]	Phone No:	Fax No:	Office Contact:	Specialty:

Medication/Medical and Dispensing Information

Medication:	Strength:	Frequency:	Qty:	Refill(s):
Case Specific Diagnosis/ICD10:[2]	Route of Administration: ☐ Oral ☐ IM ☐ SC ☐ Transdermal ☐ IV ☐ Other For physician administered, will this provider be ordering & administering? ☐ **Yes** ☐ **No** If no, supply administering provider:			

Please check one of the following:

This is a new medication and/or new health plan for the patient. ☐ **If checked, *go to question 1***	This is continued therapy previously covered by the patient's current health plan. ☐ **If checked, approx. date initiated_____/_____. *Go to question 5***

1. Does the drug require a dose titration of either multiple strengths and/or multiple doses per day? ☐ **Yes** ☐ **No**
   If yes, provide titration schedule: _____
2. Is the drug being used for an FDA approved indication? ☐ **Yes** ☐ **No**
   2.(a) If the answer to 2 is **No**, is its use supported by Official Compendia (AHFS DI®, DRUGDEX ®)[3] ☐ **Yes** ☐ **No**
3. Has the patient experienced treatment failure with a preferred/formulary drug(s) or has the patient experienced an adverse reaction with a preferred/formulary drug(s) in the therapeutic class? If yes, complete the following: ☐ **Yes** ☐ **No**

Drug and Dose	Route	Frequency	Approx. date range therapy began & stopped	Outcome
			___/___ ___/___	
			___/___ ___/___	

4. Is there documented history of successful therapeutic control with a non-preferred/non-formulary drug and transition to a preferred/formulary drug is medically contraindicated? If yes, explain: ☐ **Yes** ☐ **No**
5. Is this a change in dosage/day for the above medication? ☐ **Yes** ☐ **No**
6. Does the request require an expedited review? ☐ **Yes** ☐ **No**
7. Attach relevant lab results, tests and diagnostic studies performed that support use of therapy. **Check if attached** ☐

Required clinical information: Please provide all relevant clinical information in the box below to support a medical necessity to determine coverage. Refer to health plan coverage requirements for the requested medication (see link above).
Please check here if documentation is attached. ☐

I attest that this information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a Medicaid MC claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Prescriber's Signature_____ Date___/___/___

Instructional Information for Prior Authorization

Upon our review of all required information, you will be contacted by the health plan.

When providing required clinical information, the following elements should be considered within the rationale to support your medical necessity request:

- *Height/Weight*
- *Compound ingredients*
- *Specific dosage form consideration*
- *Drug or Other Related Allergies*

Please consider providing the following information as applicable & when available:

- *Healthcare Common Procedure Coding System (HCPCS) 4*
- *Transition of Care Hospital and/or Residential Treatment Facilities Information (contact, phone number, length of stay)*
- *Life Situations Information such as foster care transition, homelessness, poly-substance abuse and history of poor medication adherence*
- *Patient information (address, phone number)*
- *Provider information (direct electronic contact information: e-mail, etc.)*

This form must be signed by the prescriber but can also be completed by the prescriber or his/her authorized agent. *An authorized agent is an employee of the prescribing practitioner and has access to the patient's medical records (i.e. nurse, medical assistant*). The completed fax form and any supporting documents must be faxed to the proper health plan.

Helpful Definitions

[1] **NPI:** A national provider identifier (NPI) is a unique ten-digit identification number required by HIPAA for all health care providers in the United States. https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/Downloads/AboutAdminSimpFactSheet20171017.pdf

[2] **ICD-10:** The International Classification of Diseases (ICD) is designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics http://www.cdc.gov/nchs/icd.htm

[3] **AHFS Drug Information® (AHFS DI®)** provides evidence-based evaluation of pertinent clinical data concerning drugs, with a focus on assessing the advantages and disadvantages of various therapies, including interpretation of various claims of drug efficacy. http://www.ahfsdruginformation.com/ **DRUGDEX ®** System within the Micomedex product which provides peer-reviewed, evidence-based drug information including investigational & non prescription drugs. http://www.micromedex.com/

[4] **The HCPCS** is divided into two principal subsystems, referred to as level I and level II of the HCPCS:

- Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.
- Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items. http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html

Disenrollment Forms for Excluded Populations

The following populations are ineligible for enrollment in any Medicaid Managed Care Plan. Please complete and fax this form to Customer Services at 1.212.908.8701 if you believe any of these circumstances apply to a MetroPlus member in your care.

Member Information:_____ Medicaid ID:_____

Provider Name:_____ Phone #:_____

Check the applicable box below and submit documentation to support the recommendation:

B. Disenrollment because of Exclusion Category

☐	Medicare/Medicaid Dually Eligible
☐	Individuals Who Become Eligible for Medicaid Only After Spending Down a Portion of Their Income
☐	Residents of State Psychiatric Facilities and Residential Treatment Facilities for Children and Youth
☐	Residents of Residential Health Care Facilities at Time of Enrollment and Persons who enter a Residential Health Care Facility subsequent to Enrollment Except for Short-Term Rehabilitative Stays Anticipated to be Less than Thirty (30 Days
☐	Medicaid-Eligible Infants Living with Incarcerated Mothers
☐	Comprehensive Private Health Insurance Consumers if Cost is Lower to the State
☐	Certified blind or disabled children living or expected to live separate and apart from their parents for 30 or more days.
☐	Individuals Expected to Be Medicaid Eligible for Less than Six Months (Except for Pregnant Women)
☐	Homeless Residing in Department of Homeless Services (DHS) Shelters Not Already Enrolled in a Plan at the Time They Enter a Shelter
☐	Individuals Receiving (at the Time of Enrollment) Institutional Long-Term Care Services through Long Term Home Health Care Programs, or Child Care Facilities (Except ICF services for the Developmentally Disabled)
☐	Individuals Eligible for Medical Assistance Benefits Only with Respect to Tuberculosis Related Services
☐	Individuals Place in OMH Licensed Family Care Homes
☐	Individuals Enrolled in the Restricted Recipient Program
☐	Individuals With a “County of Fiscal Responsibility Code 98 in MMIS”
☐	Individuals Receiving Hospice Services (At Time of Enrollment)

☐	Youths in the care and custody of the Commissioner of the New York State Office of Children and Family Services.
☐	Individuals temporarily residing out-of-district, i.e., college students, will be exempt until the last day of the month in which the purpose of the absence is accomplished
☐	Individuals placed in New York State Office of Mental Health licensed family care homes pursuant to New York State Mental Hygiene Law.

Health Care Proxy

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About the Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. “Health care” means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/ or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?
If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?
Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?
All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?
Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?
Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non- health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?
Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have
become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?
Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?
Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?
No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?
All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?
You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?
It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?
No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a Health Care Proxy the same as a living will?
No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you decide in advance decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?
Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation? Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. **Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.**

Can my health care agent make decisions for me about organ and/or tissue donation?
Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?
It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/ or tissue donation on your behalf. They are listed in order of priority: your health care agent; your decedent's agent; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; a guardian appointed by a court prior to the donor's death; or another person authorized to dispose of the body.

Health Care Proxy Form Instructions

Item (1)
Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

> *If I become terminally ill, I do/don't want to receive the following types of treatments....*
>
> *If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....*
>
> *If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....*
>
> *I have discussed with my agent my wishes about_____and I want my agent to make all decisions about these measures.*

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)
You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse , if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents,
a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) **I,** _____
Hereby appoint_____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) **Optional: Alternate Agent**
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint_____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

_____

_____

(4) **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name_____

Your Signature_____Date_____

Your Address_____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of: *(check any that apply)*

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues_____

_____

☐ Limitations_____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature_____Date_____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date_____

Name *(print)*_____

Signature_____

Address_____

_____

Witness 2

Date_____

Name *(print)*_____

Signature_____

Address_____

_____

Department of Health

NEW YORK STATE EXTERNAL APPEAL APPLICATION

Complete and send this application within 4 months of the plan's final adverse determination for health services if you are the patient or the patient's designee, or within 60 days if you are a provider appealing on your own behalf to DFS.
Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany, NY 12210 or Fax to: (800) 332-2729. For help, call (800) 400-8882 or email externalappealquestions@dfs.ny.gov.

1. Applicant Name:			
2. Patient Name:			
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Not designated/Other		
3. Patient Address:	Street:		
	City:	State:	Zip Code:
4. Patient Phone Number:	Primary: ( )	Secondary: ( )	
5. Patient Email Address:			
6. Patient Health Plan:		ID #:	
7. Patient's Physician/Prescriber:			
8. Physician/Prescriber Address:	Street:		
	City:	State:	Zip Code:
9. Physician/Prescriber Phone #:	( )	Fax:	( )
10. If the patient has a Medicaid Managed Care Plan, has patient requested a fair hearing through Medicaid or received a fair hearing determination?	☐ Yes	☐ No	☐ Don't know
11. To be completed if the applicant is the patient's designee			
Complete this section only if a designee is submitting this appeal on a patient's behalf. If the patient's provider is the designee complete section 14 instead of this section.			
Name of Designee:			
Relationship to Patient:			
Address:	Street:		
	City:	State:	Zip Code:
Phone Number:	( )	Fax:	( )
Designee Email Address:			

12. **Reason for Health Plan Denial** - check only one and **attach** a completed physician's attestation for all expedited appeals and all denial reasons except for Not Medically Necessary:

☐ Not medically necessary	☐ Experimental/investigational for a clinical trial
☐ Experimental/ investigational	☐ Experimental/investigational for a rare disease
☐ Out-of-network and the health plan proposed an alternate in-network service	☐ Out-of-network referral
☐ Formulary Exception (for individual and small group coverage, other than Medicaid or Child Health Plus)	

13. This appeal may be expedited. Expedited decisions are made within the timeframes described below, even if the patient, physician or prescriber does not provide needed medical information to the external appeal agent.		
If Expedited check one:	☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.	
	☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health, and patient's physician will complete the Physician Attestation and send it to the Department of Financial Services.	
	☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug, and patient's prescribing physician or other prescriber will complete the Physician Attestation and send it to the Department of Financial Services.	
If Standard check one:	☐ Standard Formulary Exception (72 hours)	☐ Standard Appeal for all other appeals (30 days)

***** If expedited you must call 888-990-3991 when the application is faxed*****

14. To be completed if applicant is patient's provider			
Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. This section should be completed by providers appealing on their own behalf or appealing as a patient's designee. The initial denial and final adverse determination from the first level of appeal must be attached.			
☐ Provider filing own behalf	☐ Provider filing as designee on behalf of patient		
Provider Name:			
Person or Firm Representing Provider (if applicable):			
Contact Person for Correspondence:			
Address for Correspondence:	Street:		
	City:	State:	Zip Code:
Phone Number:	( )	Fax:	( )
Email Address:			
I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.			
Provider Signature:			

EA 09/18

15. Description and date(s) of Service: (Attach any additional information you want considered):	
16. External Appeal Eligibility (Check one):	
	☐ Attached is final adverse determination from the health plan.
	☐ Attached is the health plan's letter waiving an internal appeal.
	☐ Patient requests expedited internal appeal at same time as the external appeal.
	☐ Health plan did not comply with internal appeal requirements for patient appeal.
17. External Appeal Fee	
You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you.	
Please check one:	☐ Enclosed is a check or money order made out to the health plan.
	☐ Application was faxed and fee will be mailed to the Department within 3 days.
	☐ Patient is covered under Medicaid or Child Health Plus.
	☐ Patient requests fee waiver for hardship and will provide documentation to the health plan.
	☐ Health plan does not charge a fee for an external appeal or fee is not required.

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans.

When an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance use treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, power of attorney, healthcare proxy or executor, a copy of the legal supporting document should be included.

Signature:			
Print Name:			
Relationship to patient, if applicable:			
Patient Name:		Age:	
Patient's Health Plan ID#:			
Date: (required)			

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental/investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal. The patient's prescriber may also request an expedited formulary exception appeal. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately.

Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany NY, 12210 or Fax to: (800) 332-2729.

Type of Review Requested:	☐ Standard Appeal (30 days), or for a non- formulary drug (72 hours)	☐ Expedited Appeal (72 hours), or for a non-formulary drug (24 hours)
If Expedited check one:	☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized. ☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health. ☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug.	
If Expedited complete both:	☐ I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours (or 24 hours for a non-formulary drug) of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.	
	During non-business days, I can be reached at: ( )	

- For an **expedited appeal**, the patient's physician, or for a non-formulary drug, the patient's prescribing physician or other prescriber, must complete the box below and item **14**. **You must send information to the agent immediately in order for it to be considered.**
- For an **experimental/investigational** denial (other than a clinical trial or rare disease treatment) the patient's physician must complete items **1-10 and 14**.
- For a **clinical trial** denial, the patient's physician must complete items **1-9, 11 and 14**.
- For an **out-of-network service** denial (the health plan offers an alternate in-network service that is not materially different from the out-of-network service), the patient's physician must complete items **1-10 and 14**.
- For an **out-of-network referral** denial (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient), the patient's physician must complete items **1 - 9, 13 and 14**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 12 and 14**.

1. Name of Physician (or Prescriber) completing this form:			
To appeal an experimental/investigational, clinical trial, out-of-network service, or out-of-network referral denial, the physician must be licensed and board-certified or board-eligible and qualified to practice in the area of practice appropriate to treat the patient. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.			
2. Physician (or Prescriber) Address:	Street:		
	City:	State:	Zip Code:
3. Contact Person:			
4. Phone Number:	( )	Fax:	( )
5. Physician (or Prescriber) Email:			
6. Name of Patient:			
7. Patient Address:			
8. Patient Phone Number:			
9. Patient Health Plan Name and ID Number:			
10. Experimental/Investigational Denial or Out-of-Network Service Denial (Complete this section for an experimental/investigational denial or an out-of-network service denial only. DO NOT complete this item for appeal of clinical trial participation, rare disease, or an out-of-network referral denial.)			
a. For an Experimental/Investigational Denial:			
As the patient's physician I attest that (select one without altering):			
OR	☐ Standard health services or procedures have been ineffective or would be medically inappropriate.		
	☐ There does not exist a more beneficial standard health service or procedure covered by the health plan.		
AND	☐ I recommended a health service or pharmaceutical product that, based on the following **two** documents of medical and scientific evidence **outlined in c and d below**, is likely to be more beneficial to the patient than any covered standard health service.		
b. For an Out-of-Network Service Denial			
☐ As the patient's physician I attest that the following out-of-network health service (identify service):			

is materially different from the alternate in-network health service recommended by the health plan and (based on the following **two** documents of medical and scientific evidence) is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.					
c. List the documents relied upon and attach a copy of the document					
Document #1 Title:					
Publication Name		Issue Number:		Date:	
Document #12Title:					
Publication Name		Issue Number:		Date:	

d. Supporting Documents		
The medical and scientific evidence listed above meets one of the following criteria (Note: peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.)		Check the applicable documents:
☐	Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;	☐ Document #1 ☐ Document #2
☐	Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;	☐ Document #1 ☐ Document #2
☐	Peer-reviewed abstracts accepted for presentation at major medical association meetings;	☐ Document #1 ☐ Document #2
☐	Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;	☐ Document #1 ☐ Document #2
☐	The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the National Comprehensive Cancer Network's Drugs and Biological Compendium; (iii) the American Dental Association Accepted Dental Therapeutics; (iv) Thomson Micromedex DrugDex; or (v) Elsevier Gold Standard's Clinical Pharmacology; or other compendia as identified by the Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal;	☐ Document #1 ☐ Document #2

☐	Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.	☐ Document #1 ☐ Document #2

11. Clinical Trial Denial

☐	There exists a clinical trial which is open and for which the patient is eligible and has been or will likely be accepted.

Although not required, it is recommended you enclose clinical trial protocols and related information. The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified non-governmental research entity as identified in guidelines issued by individual NIH Institutes for Center Support Grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

12. Rare Disease Treatment Denial

If provision of the service requires approval of an Institutional Review Board, include or attach the approval.

☐	As a physician, other than the patient's treating physician, I attest the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service. The requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service.

☐ I do ☐ I do not have a material financial or professional relationship with the provider of the service (check one).

Check one:	☐ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.
	☐ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

13. Out-of-Network Referral Denial

As the patient's attending physician, I certify that the in-network health care provider(s) recommended by the health plan do not have the appropriate training and experience to meet the particular health care needs of the patient. I recommend the out-of-network provider indicated below, who has the appropriate training and experience to meet the particular health care needs of the patient and is able to provide the requested health service.

Name of out-of-network provider:	
Address of out-of-network provider:	

Training and experience of out-of-network provider: (e.g., board certification, years treating the condition, # of procedures performed and outcome, any other pertinent information).			
14. Physician (or Prescriber) Signature			
I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.			
Signature of Physician (or Prescriber):		Date:	
Physician (or Prescriber) Name: (Print Clearly):			

HELPFUL HINTS FOR COMPLETING THE EXTERNAL APPEAL APPLICATION

Some sections of the application can be confusing. This will help explain what is expected for those sections.

Application

- **Number 11** is only required if the patient has designated someone other than the provider to act on their behalf.
- **Number 12** indicates the reason the health plan denied the service. This information is found on the Final Adverse Determination (denial letter) from the health plan.
- The Type of Review must be completed in **Number 13** if an expedited appeal is being requested. External appeals can only be expedited if the denial falls into one of these categories. If you already received the services, your appeal cannot be expedited. You must also indicate if this is for a Standard Formulary Exception or a Standard External Appeal.
- **Number 14** is required if the provider is submitting the application on their own behalf or behalf of the patient.
- **Number 15** is to be used to describe the services requested. You can attach a separate document with this information.
- **Number 17** relates to the fee that a health plan may charge for the external appeal. The Final Adverse Determination will indicate if the health plan charges a fee.

Patient Consent to the Release of Records for NYS External Appeal

- This document must be signed by the patient or their authorized representative. If the patient is a minor, the document must be signed their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Physician's Attestation for an External Appeal

- For medical necessity, experimental/investigational, and out-of-network appeals, the first section is required if the attending physician is requesting an expedited appeal because the standard 30- day timeframe would jeopardize the patient's life, health or agility to regain maximum function, or the delay would pose an imminent or serious threat to the patient's health. The attending physician must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination within 72 hours of receipt. The decision must be issued even in the event of incomplete medical information or unanswered questions due to the inability to reach the attending physician.
- For formulary exception appeals, the first section is required if the attending physician or prescriber is requesting an expedited appeal because the patient is suffering from a health condition that may seriously jeopardize his or her life, health or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug. The attending physician or prescriber must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination within 24 hours of receipt.
- The decision must be issued even in the event of incomplete medical information or unanswered questions due to the inability to reach the attending physician/prescriber.
- **Number 10** is required for experimental/investigational and out-of-network service denials (where the health plan offers an alternate in-network service that is not materially different from the out- of-network service). Subsections a, c and d are required when appealing an experimental/ investigational denial.
  - Subsection b, c and d are required for out-of-network service denials.
  - Subsection c must include information on the medical and scientific evidence (clinical peer reviewed literature) that supports the service requested for the patient's condition. Two articles are required. This section MUST be completed in full; "see attached" will not suffice. The

documents that are acceptable for submission are described in Subsection d. There is no requirement that the two documents be from different categories.

- **Number 11** is required for coverage in a clinical trial. Please note, the Affordable Care Act requires coverage of routine patient costs associated with approved clinical trials. This requirement does NOT apply to grandfathered health plans.
- **Number 12** is required for the experimental/investigational denials for treatment of rare disease. The physician signing the attestation for treatment of a rare disease cannot be the patient's attending physician. They must disclose any relationship with the patient's attending physician and indicate which definition of "rare disease" applies to the patient's condition.
- **Number 13** must be completed for out-of-network referral denials (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient). The name and address of the out-of-network provider must be included as well as their training and experience. The information provided will be used by the clinical peer reviewer when comparing the qualifications of the in-network provider(s) to the out-of-network provider. Information such as the out-of-network provider's curriculum vitae, Board Certification, number of years of experience treating the condition, the number of times the out-of-network provider has performed the requested procedure and the outcomes of those procedures, and any other relevant information should be provided. This information may be provided in an attachment to the application.
- **Number 14** must be signed by a physician. Physician is defined in NYS Education Law as an MD or DO. Attestations signed by any other provider will not be accepted. For formulary exception appeals, Number 14 may be signed by a physician or prescriber.

XVI DEPRESSION & DRUG USE SCREENING TOOLS

Depression Screening
PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____**DATE:**_____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself— or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite— being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:** _____

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at http://www.pfizer.com. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

ZT274388

Depression Screening
Fold back this page before administering this questionnaire
INSTRUCTIONS FOR USE
for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   - if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   - if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring — add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Step 1: ASK about drug use.

This screening instrument is appropriate for patients age 18 or older. You may deliver it as an interview and record patient responses, or read the Prescreen question aloud and have the patient complete the remaining questions (if applicable) as a written questionnaire. It is recommended that the person administering the screening review the sample script to introduce the screening process. The script offers helpful language for introducing what can be a sensitive topic for patients.

Step 1: ASK about drug use.

A. Introduce yourself and establish rapport.
B. Ask about lifetime drug use.
C. Begin the NIDA-Modified WHO ASSIST.
D. Score the ASSIST and identify patient's risk level.

A. Introduce yourself and establish rapport.

Before you begin the interview, please read the following to the patient:

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But am interested in those only if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

- If the patient declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of drug use.

B. Ask patients about lifetime drug use using the Prescreen Question of the NIDA-Modified ASSIST.

- Without being judgmental or confrontational, ask the patient if he or she has "ever used" any of the substances listed—see the Prescreen question on the NIDA-Modified ASSIST (http://www.drugabuse.gov/nidamed/screening/nmassist.pdf) for a list. **Note:** If the patient mentions a drug not on the list (e.g., steroids), please enter it in the "other" category.

Reminder:

Patients should be advised of the limits of confidentiality and insurance coverage for conditions occurring under the influence of alcohol or illicit drugs (these vary by State and provider).

- Be prepared to gently probe certain questions. For example, if the patient answers "No" to every substance, ask a probing question such as "Not even when you were younger, perhaps in high school or college?"

- If the patient says "No" for all drugs in Prescreen, reinforce abstinence. For example, you may say "It is really good to hear you aren't using drugs. That is a very smart health choice." **Screening is complete.**

- If the patient says "Yes" to any of the drugs, **go to C.**

Drug Screening

Begin the NIDA-Modified ASSIST (Link to PDF of tool).

- For patients who answer **"never"** to Question 1 (In the past three months, how often have you used the substances you mentioned?): Skip to Questions 5–7 to determine if they have symptoms of a prior substance use problem. Provide feedback (see Step 2) and reinforce abstinence.

- For patients who report use of **tobacco:** *Any* tobacco use in the past three months places a patient at risk.
  - **Advise** all tobacco users to quit. For more information on smoking cessation, please see *Helping Smokers Quit: A Guide for Clinicians* at http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm

- For patients who report use of **alcohol:** Question the patient in more detail about frequency and quantity of use:

If the answer is:

☐ None: **Advise** patient to stay within these limits.
For healthy men under the age of 65: No more than 4 drinks per day AND no more than 14 drinks per week.
For healthy women under the age of 65 and not pregnant (and healthy men over the age of 65) No more than 3 drinks per day AND no more than 7 drinks per week.
Recommend lower limits or abstinence as medically indicated for patients who:
- Take medications that interact with alcohol
- Have a health condition exacerbated by alcohol
- Are pregnant (advise abstinence).

Encourage patients to talk openly about alcohol and any concerns that may arise, rescreen annually.

Reminder:

Many people don't know what counts as a standard drink (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor).

For information, please see http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide_13_p_mats.htm

☐ One or more times of heavy drinking (≥ 5 for men; ≥ 4 for women): Patient is an at-risk drinker.

Drug Screening

Please see the National Institute on Alcohol Abuse and Alcoholism **(NIAAA)** Web site "Helping patients who drink too much: A clinician's guide" at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm for additional information to **Ask, Assess, Advise, Assist, and Arrange** help for at-risk drinkers or patients with alcohol use disorders.

- For patients who report **any illicit or nonmedical prescription drug use,** go to Questions 2 through 7. **Note:** Ask Question 7 if the patient reports the use of any drug that might be injected, including those that might be listed in the "other" category (e.g., steroids).

- For patients who report **alcohol *as well as* any illicit or nonmedical prescription drug use**, ask alcohol follow-up questions and then go to Questions 2–7.

D. Score the full NIDA-Modified *ASSIST* for illicit and nonmedical prescription drug use.

- For each substance, add up the scores received for Questions 1–6. This is the Substance Involvement (SI) score. Do not include the results from either Step 1 (Prescreen) or Question 7 in your SI score. The patient will receive an SI score for ***each*** substance endorsed, not a cumulative score. Therefore, the patient's risk level may differ from drug to drug.

Use the resultant SI score to identify patient's risk level. If more than one substance is reported, focus intervention on the substance with the highest score.

Reminder:

Use clinical judgment if the patient reports use of multiple drugs but does not score highly on any of them (i.e., consider an intervention).

XVII CORRECT CODING EQUALS ACCURATE RISK SCORES AND MEDICAID/MEDICARE/AFFORDABLE CARE ACT COMPLIANCE

In order to comply with Federal and State reporting requirements. MetroPlus relies on our provider partners to submit complete and accurate diagnosis code information on the claim associated with each clinical encounter. Clinical specificity of a disease/condition can be expressed through the fourth (4th), fifth (5th), sixth (6th), and/ or seventh (7th) digit of some ICD- 10-CM diagnostic codes. Documentation in the medical record of an encounter with a Medicare, Medicaid, Essential Plan or Marketplace (Qualified Health Plan) member must include all conditions and comorbidities being treated and managed. Telehealth visits must be noted as such in the medical record, and must specify whether the visit is audio-only or audio/video. Specificity of coding is based on the accuracy of information written in the medical records.

What you need to do to ensure compliance with these requirements:

- ✓ Code all claims for Medicare and Medicaid members to the highest level of specificity using the fourth (4th), fifth (5th), sixth (6th), and/or seventh (7th) digit of codes when applicable.
- ✓ Ensure medical record documentation is clear, concise, consistent, complete, and legible.
- ✓ Submit a claim for every patient encounter regardless if the encounter is covered under a capitated or fee-for-service arrangement.
- ✓ Include the member's identification on each page of the medical record, the date of service, the signature(s) of the person(s) doing the treatment, reason for the visit, care rendered, conclusion and diagnosis, and follow-up care plan in all medical records.
- ✓ Include the provider's credentials on the medical record, either written next to his/her signature or using a pre-printed stamp with the provider's name on the practice's stationery.
- ✓ Report and submit on a Claim all diagnoses that impact the patient's evaluation, care, and treatment; reason for the visit; coexisting acute conditions; chronic conditions; or relevant past conditions.
- ✓ Respond to request for an onsite appointment by MetroPlusHealth within seven (7) business days.

XVIII CULTURAL COMPETENCY

As part of MetroPlusHealth's continuing mission to provide quality care to all of our members, we encourage our network providers to take advantage of the many resources available on Cultural Competency. Cultural Competency is the ability to work effectively with your patients, regardless of their culture, religion, ethnicity, or socio-economic status. Gaining Cultural Competency Skills will benefit your patients and your practice.

The New York State Department of Health has approved cultural competency training offered by the United States Department of Health and Human Services (HHS), Office of Minority Health education program, Think Cultural Health. This free, e-learning program can be found here https://thinkculturaljealth.hhs.gov/education. Providers participating in our Medicaid, HIV SNP, HARP, and MLTC lines of business are required to complete this training annually and submit a certification attesting to its completion. This certification, along with links to the training, can be found in the MetroPlusHealth Provider Portal.

Beyond the required training, the Think Cultural Health Program (https://thinkculturalhealth.hhs.gov/education) provided by HHS features a host of information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. It additionally offers the opportunity to earn free CME credits.

Other Continuing Education Programs:

- **A Physician's Practical Guide to Culturally Competent Care** (*https://cccm.thinkculturalhealth.hhs.gov/*) – This e-learning program will equip health care providers with competencies that will enable them to better treat the increasingly diverse U.S. population. This is a self-directed training course designed for physicians, physician assistants, and nurse practitioners. Up to 9 CME credits for physicians, physician assistants and nurse practitioners.

For Additional Information About Cultural Competency:

- **American Academy of Family Physicians** gives links to other resources with guidelines on cultural competency. Assessment tools, brochures/manuals and videos are included on these sites, as well access to CME courses provided by AAFP.
- The **American Medical Association** (AMA) offers information in regard to the health problems that arise because of cultural incompetence. AMA also offers a program to increase the awareness of the imbalance of care that patients from different backgrounds receive. For AMA members the kit costs $10 and $15 for non-members.
- **Diversity and Cultural Competency** is American Health Insurance Plan's (AHIP) web portal that has activities, research findings, and training courses as well as published communicative information that is catered to teaching and reducing health care inequality due to diverse cultures.
- **Critical Measures** is a training and management consulting company. Their website provides a guide that defines cultural competence, explains its importance, and describes how health care professionals can gain training in the cultural competency field. Critical Measures also provides access to CME courses from their site.
- **Ask Me 3** is a tool catered to health care practitioners and patients that improves the communication between doctors and patients.
- The **Substance Abuse and Mental Health Services Administration** (SAMSHSA) has many publications that aid practitioners and clinicians with giving efficient health services to people of different cultural backgrounds. To find more information, visit SAMHSA's site and enter "cultural competence" in the search box.

XIX SOCIAL SERVICES FOR SENIORS: QUICK REFERENCE GUIDE (QRG)

Social Security

Monthly payments to insured workers and their dependents or survivors.

Apply to: Social Security Administration (800) 772-1213.

Retirement Benefits

- You may start receiving benefits as early as age 62. You do not need to be retired.
- Other family members of retiree may be eligible:
- Spouse, if age 62 or older
- Spouse at any age if caring for a child under 16
- Unmarried children under 18
- Divorced spouses if currently unmarried; were married at least 10 years to retiree; age 62 or older
- Survivor Beneficiaries:
- Widowed spouse 60 or older
- Widowed spouse 50 or older and disabled
- Widowed at any age if caring for a child under 16 or disabled
- Unmarried children under 18
- Dependent parents
- Ask about children and grandchildren.

Note: However, if you are under full retirement age when you start getting your Social Security payments, $1.00 in benefits will be deducted for each $2.00 you earn above the limit. For 2009 that limit is $14,160. When you reach full retirement age, you will get your Social Security payments with no deduction or your earnings.

Direct Deposit Available

Supplemental Security Income (SSI)

A monthly payment to people with low-income who are 65 or older or blind or disabled. Payments supplement Social Security and/or other income. With some exceptions, citizenship is required.

Apply to: Social Security Administration (800) 772-1213.

Note: Applicants eligible for SSI may also qualify for Medicaid and Food Stamps.

Eligibility Requirements: 65 years of age or older or a disability, income, and assets.

Income: The more income you have, the lower your SSI benefit. Payments not counted by SSI as income include the first $20.00 of unearned income received in a month; the first $65.00 of earned income and half the amount over $65.00.

Allowable Assets: $2,000 (one person), $3,000 (couple) plus burial fund, $1,500 per person.

Maximum Monthly Benefits: For an individual living alone: $761. A couple: $1,115. The amount may differ if the recipient is living with others: for one person $697, for a couple $1,057. Inquire about benefits levels for family care and residential care.

Food Stamps

Allowances issued on a monthly basis that are used in place of cash to purchase food items at participating stores and supermarkets. With some exceptions, citizenship is required.

Call 311 for more information.

You may qualify if you:

- work for low wages
- work part-time
- are unemployed
- receive Public Assistance, SSI or other assistance payments
- are elderly or disabled and live on low income

Eligibility Requirements: *Assets and Income*

Assets: Although there is an assets limit for persons under age 60, applicants who are 60 or older or disabled and meet Food Stamps income guidelines might be considered "categorically eligible" and exempt from the assets limit

Income: Monthly limit for one person $1,127.00; couples $1,517.00. If a household member is 60 or older or disabled, net income must be 100% of current poverty level. *Seniors are encouraged to apply because allowable income is calculated individually based on living arrangements and out of pocket, medically related expenses.*

Note: Eligibility is determined only after completing a full Food Stamp budget form, using all applicable income deductions. Different income deductions apply in specific situations such as having no cooking facility, living in a shelter, or only one spouse applying.

Commodity Supplemental Food Program (CSFP)

The New York State Department of Health's Commodity Supplemental Food Program (CSFP) offers free, nutritious foods to seniors aged 60 years of age and older, and to some women and children that are not eligible for the Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program.

Call the center nearest you for application information:

Catholic Charities Neighborhood Services
89-56 162nd Street
Jamaica, NY 11432
(718) 674.1000

Kings County Hospital Center
840 Alabama Avenue
Brooklyn, NY 11207
(718) 498-9208

Other Food-related websites for Seniors are:

- Meals on Wheels - getmeals@citymeals.org
- Diabetic Meals - www.magickitchen.com
  Free Meal Locations - www1.nyc.gov

Transportation Services

MTA Reduced Fare

Individuals 65 and older or have a disability may apply for a Reduced Fare card:

MTA Customer Service Center
3 Stone Street,
New York, NY 10004
Or call 212-METROCARD

Documentation is needed when applying for Reduced Fare Metrocard or Photo Identification Metrocard.

Eligibility Requirements: *65 years of age or older or a disability.*

AMTRAK Passenger Discount for Seniors

Seniors Save 15%

Amtrak travelers 62 years of age and over are eligible to receive a 15% discount on the lowest available rail fare on most Amtrak trains. On cross-border services operated jointly by Amtrak and VIA Rail Canada, a 10% Senior discount is applicable to travelers aged 60 and over.

Eligibility Requirements: *62 years of age or older.*

Accessible Dispatch Program

Call 311 for more information.

This system links passengers that use wheelchairs with accessible vehicles through a central dispatcher. 311 connects the passenger to the dispatcher. The dispatcher collects the passenger's pick-up location and communicates electronically with participating drivers. The closest available driver accepts the dispatch and picks up the passenger. Fares charged for Accessible Service are the same as the metered rate of all NYC yellow cabs.

Eligibility Requirements: *Passengers that use Wheelchairs.*

Access-A-Ride

Call 311 for more information.

MTA New York City Transit operates Access-A-Ride (AAA), the City's paratransit system. AAR provides transportation for people with disabilities who are unable to use public bus or subway service for some or all of their trips. Service is available 24 hours a day, seven days a week, including holidays.

Eligibility Requirements: *Passengers with Disability who are unable to use Public Bus or Subway Service.*

XIX SOCIAL SERVICES FOR SENIORS: QUICK REFERENCE GUIDE (QRG)

Home/Apartment Related Services

Senior Citizen Rent Increase Exemption (SCRIE)

Call 311 for more information.

SCRIE provides elderly renters with exemptions from most future rent increases. SCRIE covers increases for renewal leases, Maximum Base Rent (MBR) increases, fuel, landlord hardship, and major capital improvements. SCRIE does not cover increases for direct services or new equipment. Rent must be at least 1/3 of net monthly income. For rent-stabilized apartments, tenants must have a valid one or two-year lease.

Eligibility Requirements: Head of household 62 years of age or older; $29,000 annual household income limit.

Senior Citizen Homeowners Exemption (SCHE)

Call 311 for more information.

Savings of up to 50% to qualified property owners of 1 to 3 units dwelling, condominiums or cooperative apartments. Applicants must be age 65 or older, have held title to the property for at least 12 consecutive months and the property must be applicant's legal residence, used exclusively for residential purposes.

Eligibility Requirements: 65 years of age or older; $36,400 income limit for the last calendar year.

Real Property Tax Credit (IT-214) and/or City of New York School Tax Credit (NYC-210)

Call for more information or apply to:

Taxpayers Assistance Bureau
New York State Department
for Taxation and Finance
1-800-225-5829

Provides tax credit or cash payment of up to $375 to homeowners or renters for part of previous year's rent or real property taxes. To qualify, current market value (home, garage, land, etc.) must be $85,000 or less; or average monthly rent must be $450 or less, not including heat, gas or electricity.
Eligibility Requirements: $18,000 income limit.

Weatherization Referral and Packaging Program (WRAP)

Call 311 for more information.

Provides low-income elderly with free weatherization services to lower their energy bills and increase the comfort of their homes. Services include insulation, replacement of doors and windows and repairs furnaces and roofs.
Eligibility Requirements: 60 years of age or older; Monthly Income Limit $1,963.00 (one person); $2,567.00 (couple)

Repair and Safety Services

Call 212-962-7559 or e-mail: nyfscinc@aol.com

New York Foundation for Senior Citizens, Inc.
11 Park Place, 14th Floor
New York, NY 10007-2801

Through this Program, senior homeowners and renters with limited finances benefit from free home maintenance and repair services. Services include minor plumbing, gutter- cleaning, masonry, electrical, carpentry, caulking, weather- stripping, and the installation of crime prevention devices, as well as some emergency services.

Lifeline for Verizon Customers in New York

For more information call Verizon 1.800.837.4966 or visit: verizon.com/lifeline

Lifeline is a government program that offers qualified low income households a discount on their monthly local telephone bill. Each state has its own guidelines to qualify. The application and qualification process differs by state and sometimes by individual phone company.

Eligibility Requirements: Program Based (Food Stamps; Medicaid; Low Income Home Energy Assistance Program (LIHEAP); Supplemental Security Income (SSI); Temporary Assistance for Needy Families (TANF); Persons with a non-service related disability and receiving Veterans Disability Pension or Veterans Surviving Spouse Pension; Additional eligibility criteria may apply to residents of federally recognized tribal lands) and Income Based (Tax Return required to determine eligibility)

Home Energy Assistance Program (HEAP)

Call 311 for more information.

A one-time grant per year to help low-income homeowners and renters pay fuel and utility cost. Available to both households that pay directly for heat and households where heat is included in rent. Benefit amounts range from $40.00 - $585.00. Eligible households that pay directly for heat with their main source of heat being oil, kerosene or propane may receive a benefit up to $800.00.
Eligibility Requirements: Monthly Income Limit $1,963.00 (one person); $2,567.00 (couple).

Health Related Services

Medicare Savings Program

Call 311 for more information or write to:

Medicare Savings Program Applications
PO BOX 3011 Jamaica, NY 11431

1. ***Qualified Medicare Beneficiaries (QMB)***
   Those covered by Part A and Part B may be able to have Medicaid cover the monthly premium ($96.40) in addition to deductibles and co-insurance.
   Eligibility Requirements: 65 years of age or older or disabled receiving Medicare after being on Social Security Disability for two years; Monthly Income Limit $903.00 (one person); $1,215.00 (couple)
2. ***Specified Low-Income Medicare Beneficiaries (SLIMB)***
   Those covered by Part A and Part B may be able to have Medicaid pay the Medicare Part B medical premium ($96.40).
   Eligibility Requirements: 65 years of age or older or disabled receiving Medicare after being on Social Security Disability for two years; Monthly Income Limit $1,083.00 (one person); $1,457.00 (couple)
3. ***Qualified Individual 1 (QI-1)***
   Those covered by Part A and Part B may be able to have Medicaid pay the Medicare Part B medical premium ($96.40).
   Eligibility Requirements: 65 years of age or older or disabled receiving Medicare after being on Social Security Disability for two years; Monthly Income Limit $1,219.00 (one person); $1,640.00 (couple)

New York Prescription Saver Card

A free pharmacy discount card for New York State residents; use this card at participating pharmacies to save as much as 60% on generics and 30% on brand name drugs.

Call New York Prescription Saver at 1-800-788-6917 or visit https://nyprescriptionsaver.fhsc.com/

Eligibility Requirements: Age 50 to 65 not receiving Medicaid; Income $35,000.00 (single); $50,000.00 (Married)

Elder Pharmaceutical Insurance Coverage (EPIC)

For information call EPIC 1-800-332-3742

Two coverage plans to choose from: Annual Fee Plan and Deductible Plan; saves more than half the cost of most prescription drugs.
Eligibility Requirements: 65 years of age or older; Annual Income Limit $35,000.00 (one person); $50,000.00 (couple); Pharmacy must be EPIC participants.

Miscellaneous

America The Beautiful - The National Parks and Federal Recreational Lands Annual Pass

The pass is a lifetime entrance pass to national parks, monuments, historic sites, recreation areas, and national wildlife refuges that charge an entrance fee.

A Golden Age Passport must be obtained in person at a federal area where an entrance fee is charged. There is a one-time $10 processing charge to obtain the Golden Age Passport.
Eligibility Requirements: 62 years of age or older OR medically determined to be blind or permanently disabled; Citizens or Permanent Residents of the US.

Big Apple Senior Strollers
For more information call 311 or visit: www1.nyc.gov

Other websites for Seniors:

- *www.BenefitsCheckUp.org*
- *www.nycservice.org*
- *cscs-ny.org*
- *www.nyfsc.org*

XX METROPLUSHEALTH: NOTICE TO PROVIDERS REGARDING PROTECTED HEALTH INFORMATION AND PRIVACY PRACTICES

Effective June 1, 2017
By law, MetroPlusHealth must protect the privacy of our member's health information. A MetroPlusHealth provider this requirement extends to you. To ensure your practice is aware of and adheres to applicable rules and regulations, as well as MetroPlusHealth's standards, we are providing you this notice outlining permissible use and disclosure practices for protected health information ("PHI"). This document also provides you with MetroPlusHealth's expectations for handling member PHI.

A member's protected health information (PHI) is protected through various mechanisms, including your contractual relationship with MetroPlusHealth. As PHI can be found in multiple documents and data points maintained by your office in the course of providing health services, you must take steps to ensure this information is safeguarded and held in strict confidence to comply with state and federal privacy laws. *Please see the notes section as the end of this appendix for a listing of applicable rules and regulations.*

MetroPlusHealth follows the practices described on our website. By enrolling, members authorize MetroPlusHealth to disclose and request their respective PHI as necessary to administer their benefits and manage their care. As a covered entity, MetroPlusHealth shares its Privacy Notice detailing the steps taken by the Plan to safeguard our member's information. You as a provider are required to develop your own privacy notices and practices to ensure our member's PHI is always protected. As a provider, you must maintain a member's written acknowledgment to receiving the Privacy Notice shared by your office

To see how MetroPlusHealth complies with Privacy Notice requirements outline below, please visit the MetroPlusHealth website at *https://www.metroplus.org/privacy-policies*.
MetroPlusHealth Privacy Notice (As required by NYS Insurance Law Reg. 169)

- MetroPlusHealth Notice of Health Information Privacy Practices (As required by HIPAA)
- MetroPlusHealth Privacy Policies around website usage, *www.metroplus.org*

In addition, each of the above privacy notices contains a Multi-Language Interpreter Services and Non-Discrimination notice as required by Section 1557 of the Affordable Care Act

Additional resources and guidance regarding what information has to be included in your notice of privacy practices is available at the U.S. Department of Health & Human Services website here: *http//www.hhs.gov/hipaa*

Providers should take all reasonable steps to protect the privacy and confidentiality of its member's personally identifiable information and PHI to prevent unauthorized use or disclosure by a third party. While the HIPAA Privacy Rules governs the use and disclosure of PHI, PHI related to behavioral health, substance use disorder, and/or HIV receive an additional layer of protection.

Without specific authorization, these records and data sets can only be released to the member, except in a limited number of circumstances. To ensure compliance with these specific confidentiality requirements, providers should develop policies and procedures that include:

- Education and training for staff and contractors accessing this data:
- Access limitations including:
  - How access is limited
  - Who should be able to access information
- How is information secured and stored; and
- How staff should handle requests for this subset of data

If a provider is a Part 2 program, as defined in 42 CFR Part 2, the provider must ensure that:

1. You obtain and maintain a member's written consent authorizing the disclosure of substance abuse information covered by this regulation for all data disclosed to MetroPlusHealth; and
2. All consent forms authorizing disclosure of Part 2 data to MetroPlusHealth allow MetroPlusHealth to use this data for the purposes of payment and healthcare operations.

HIPAA Privacy Rule Summary

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The Privacy Rule standards address the use and disclosure of individuals' health information – called "protected health information" by organizations subject to the Privacy Rule – called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used.

Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

This is a summary of key elements of the Privacy Rule and not a complete or comprehensive guide to compliance. Entities regulated by the Rule are obligated to comply with all of its applicable requirements.

To view the entire Rule, and for other additional helpful information about how it applies, see the OCR website: *http://www.hhs.gov/hipaa.* In the event of a conflict between this summary and the Rule, the Rule governs. To review the entire Rule itself, and for other additional helpful information about how it applies, see the OCR website: *http://www.hhs.gov/hipaa*.

NOTES

1. Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR § 160 & 164, and 42 USC1320d, known collectively as the Privacy Rule.
2. The Health and Information Technology for Economic & Clinical Health Act, 42 USC § 17901 – 17953, known collectively as HITECH.
3. Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2
4. Privacy of Consumer Financial and Health Information, N.Y. Comp. Codes R. & Regs. title 11 Part 420, known as regulation 169
5. New York State Code, including:
   - Public Health Law § 17, Release of Medical Records
   - Public Health Law § 18, Access to Patient Information
   - Public Health Law § 206, Disclosure for Research Purposes
   - Public Health Law §§ 2305 (2), 2306, and 2504 (1), Sexually Transmitted Diseases
   - Public Heath Law §§ 2708-2787 (also referred to as Article 27-f), Protection of HIV/AIDS Information

- Mental Hygiene Law § 22.05 (b), Patient Chemical Dependence Service Records
- Mental Hygiene Law § 22.11 (c), Treatment of Minors
- Mental Hygiene Law § 33.13, Confidentiality of Clinical Records
- Mental Hygiene Law § 33.16, Access to Clinical Records
- General Business Law § 399-ddd, Confidentiality of Social Security Account Number
- General Business Law § 399-h (1)(d), Definition of Personal Information
- General Business Law § 399-h (2), Protected Health Information (PHI)/Protected Information (PI) Disposal Requirements
- General Business Law § 899-aa, Breach Notification Requirements
- Department of Social Services 18 NYCRR § 360-8, Confidentiality of HIV and AIDS-Related Information
- Civil Rights Law § 79, Confidentiality of Genetic Test Records

XXI PROVIDER GUIDE TO HIV TESTING

as Recommended by New York State Department of Health AIDS Institute

Who Should be Tested for HIV?

What does the NYSDOH AIDS Institute guideline recommend for HIV screening in the general population? Healthcare providers should offer *HIV testing* to all individuals aged >13 years as part of routine healthcare.

What does NYS public health law require with regard to HIV testing? *New York State public health law* requires that all individuals aged >13 years receiving care in a primary care setting, an emergency room, or a hospital are offered an HIV test at least once and mandates that care providers offer an HIV test to any person, regardless of age, if there is evidence of activity that puts an individual at risk of HIV acquisition.

Who should be offered *ongoing* testing for HIV? Healthcare providers should offer an HIV test at least annually to all individuals whose behavior increases their risk for exposure to HIV (such behavior includes condomless anal sex, sex with multiple or anonymous partners, needle-sharing, or sex with partners who share needles). Since many people choose not to disclose risk behaviors, care providers should consider adopting a low threshold for recommending HIV testing.

Also, any individual who has been diagnosed with a sexually transmitted infection (STI) should be offered HIV testing.

How often should HIV screening be performed in individuals who engage in high-risk behavior? Healthcare providers should screen patients who engage in high-risk behavior as often as every 3 to 6 months and should provide or refer these individuals for ongoing medical care, risk- reduction counseling and services, and HIV prevention, such as pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP). Access to care and prevention are important to maintain the health of individuals at risk and to prevent transmission by those who acquire HIV.

How often should HIV screening be performed in individuals who would not fall into a high- risk behavior category? CDC recommends that everyone between the ages of 13 and 64 get test for HIV at least once as part of routine health care. In a 2019 recommendation about HIV testing, the U.S. Preventative Health Task Force found insufficient evidence to determine appropriate or optimal time intervals or strategies for repeat HIV screening. Routine rescreening may not be necessary for persons who have not been at increased risk since they last tested negative for HIV. Members screened during a previous pregnancy should be rescreened in subsequent pregnancies. For patients who test negative for HIV early in pregnancy, clinicians should perform repeat testing in the third trimester preferably before 36 weeks' gestation

Consent

Is written consent required before an HIV test is ordered? As of May 17, 2017, neither written nor oral consent is needed before ordering an HIV test; however, patients must be informed that an HIV test will be performed and they may opt out.

Recommended HIV Test

What is the best test to use for HIV screening? The optimal test for screening is a 4th-generation HIV 1/2 antigen/antibody (Ag/Ab) immunoassay, which is a test that uses serum or plasma.

Can a rapid point-of-care test be used for HIV screening? Yes, although it will detect antibodies later in the course of HIV infection and may miss early infection in many cases. There are also newer

point-of-care tests that detect antigen and, therefore, earlier infection. It is worth clarifying with your facility which rapid test is used.

Which HIV test should be performed in an individual who has been diagnosed with an STI?
The optimal HIV test is always a 4th-generation HIV Ag/Ab blood test.

Should a 4th-generation Ag/Ab HIV test be used to screen for HIV in individuals who are taking PrEP? Yes, that is the optimal test. A rapid point-of-care test can be performed at the same time so patients have an immediate test result, but the rapid test should not replace the 4th-generation Ag/Ab test. If exposure is recent (within past 10 days) or patient has signs or symptoms of acute HIV, an HIV RNA test should be ordered.

HIV Testing Follow-Up

What follow-up is recommended if the 4th-generation HIV Ag/Ab test is reactive but the confirmatory HIV-1/2 differentiation assay is indeterminate or negative? An HIV-1 viral load test will differentiate a diagnosis of acute HIV infection from a false positive screening result.

What follow-up is recommended if an individual has a reactive point-of-care rapid test (such as OraQuick)? As follow-up, the healthcare provider should:

- Perform a 4th-generation HIV Ag/Ab test and counsel the patient that the result of the rapid test is preliminary pending the result of the confirmatory HIV test and follow-up differentiation assay.
- Discuss the patient's option of starting antiretroviral therapy (ART) while awaiting confirmatory test results.
- Screen for suicidality and domestic violence and make sure the patient is safe.
- Make sure a return appointment is scheduled so test results can be delivered in person.

What follow-up is recommended when a patient's 4th-generation HIV Ag/Ab test is reactive?
In this scenario, the healthcare provider should:

- Have the patient's specimens tested for HIV-1 and HIV-2 antibodies. Order HIV 1/ 2 Ag/Ab assay with reflex. Always include "with reflex" so if indicated, additional recommended tests are conducted on the same specimen.
- If the results are negative or indeterminate, then perform an HIV-1 RNA test.
- Interpret the final result based on a combination of test results. The *NYSDOH Testing Toolkit* provides more information about HIV diagnostic tests and the CDC's *Recommended Laboratory HIV Testing Algorithm for Serum or Plasma Specimens*. The NYSDOH AIDS Institute guideline *HIV Testing* may be consulted as well.
- Discuss *ART initiation* at the time of a positive result with the first rapid test. Initiation of ART during acute infection may have a number of beneficial clinical outcomes.
- When a diagnosis of *acute HIV infection* is made, discuss the importance of notifying all recent contacts and refer patients to partner notification services, as mandated by *New York State Law.* The Department of Health can provide assistance if necessary.

What follow-up is recommended if an individual's HIV test is negative but they remain at high risk of acquiring HIV? In this scenario, the healthcare provider should discuss and/or recommend PrEP and ensure that the patient has access to PrEP services. The healthcare provider should also provide risk-reduction counseling (e.g., safer sex practices, needle exchange, post-exposure prophylaxis [PEP]) and advise retesting for HIV every
3 months for as long as the individual is at risk.

XXII SAMPLE MEMBER ID CARD: *ESSENTIAL PLAN/ESSENTIAL PLAN REISSUE*

✓MetroPlusHealth

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:
13265	004336	MEDDADV	RX8541

Primary Care Physician (PCP)	PCP Phone #
YOUR PCP NAME	(212) 123-4567

What You Pay	PCP Copay	Specialist Copay	ER Amount	Urgent Care Copay	Deductible Copay	Max Out of Pocket
	$0	$0	$0	$0	$100	$7,150

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 830480
Birmingham, AL 35283-0480

Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplus.org

Customer Service	Rx Customer Services	Mental Health Crisis (24/7)	Dental Health Services
1 (800) 303-9626	1 (855) 383-9426	1 (866) 728-1885	1 (844) 831-9097
TTY for the hearing impaired: 711		SMS capable for the hearing impaired	TTY: 1 (800) 466-7566 DentaQuest

Except for emergencies, pre-approval from MetroPlusHealth is needed before hospital stays and some treatments. Call 1 (800) 303-9626 to obtain approval.

XXIII SAMPLE MEMBER ID CARD: *MARKETPLACE*

✓MetroPlusHealth

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:	Rx 30-Day
13265	004336	MEDDADV	RX8541	$10 / $20 / $50

Primary Care Physician (PCP)	PCP Phone #
YOUR PCP NAME	(212) 123-4567

What You Pay	PCP Copay	Specialist Copay	Deductible Amount	Urgent Care Copay	ER Copay	Max. Out of Pocket
	$0	$0	$0	$0	$100	$7,150

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 830480
Birmingham, AL 35283-0480

FULLY INSURED COVERAGE

Email MetroPlusHealth

help.memberexperience@metroplus.org

Visit the Website

metroplus.org

Customer Service	Rx Customer Services	Mental Health Crisis (24/7)	Dental Health Services
1 (800) 303-9626	1 (855) 383-9426	1 (866) 728-1885	1 (844) 831-9097
TTY for the hearing impaired: 711		SMS capable for the hearing impaired	TTY: 1 (800) 466-7566 DentaQuest

Except for emergencies, pre-approval from MetroPlusHealth is needed before hospital stays and some treatments. Call 1 (800) 303-9626 to obtain approval.

XXIV SAMPLE MEMBER ID CARD: *MEDICAID/MEDICAID REISSUE*

✓MetroPlusHealth

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:
13265	004336	ADV	RXMPHP

Primary Care Physician (PCP)	PCP Phone #
YOUR PCP NAME	(212) 123-4567

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 830480
Birmingham, AL 35283-0480

Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplus.org

Customer Service	Rx Customer Services	Mental Health Crisis (24/7)	Dental Health Services
1 (800) 303-9626	**1 (855) 656-0361**	**1 (866) 728-1885**	**1 (844) 284-8819**
TTY for the hearing impaired: 711		SMS capable for the hearing impaired	TTY: 1 (800) 466-7586 DentaQuest

SAMPLE MEMBER ID CARD: PARTNERSHIP IN CARE/PARTNERSHIP IN CARE REISSUE

✓MetroPlusHealth

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:
13265	004336	ADV	RXMPHP

Primary Care Physician (PCP)	PCP Phone #
YOUR PCP NAME	(212) 123-4567

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 830480
Birmingham, AL 35283-0480

Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplus.org

Customer Service	Rx Customer Services	Mental Health Crisis (24/7)	Dental Health Services
1 (800) 303-9626	**1 (855) 656-0361**	**1 (866) 728-1885**	**1 (844) 284-8819**
TTY for the hearing impaired: 711		SMS capable for the hearing impaired	TTY: 1 (800) 466-7586 DentaQuest

SAMPLE MEMBER ID CARD ENHANCED (HARP)/ENHANCED (HARP) REISSUE

✓MetroPlusHealth

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:
13265	004336	ADV	RXMPHP

Primary Care Physician (PCP)	PCP Phone #
YOUR PCP NAME	(212) 123-4567

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 830480
Birmingham, AL 35283-0480

Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplus.org

Customer Service	Rx Customer Services	Mental Health Crisis (24/7)	Dental Health Services
1 (800) 303-9626	**1 (855) 656-0361**	**1 (866) 728-1885**	**1 (844) 284-8819**
TTY for the hearing impaired: 711		SMS capable for the hearing impaired	TTY: 1 (800) 466-7586 DentaQuest

SAMPLE MEMBER ID CARD: CHILD HEALTH PLUS/CHILD HEALTH PLUS REISSUE

✓MetroPlusHealth

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:
13265	004336	ADV	RXMPHP

Primary Care Physician (PCP)	PCP Phone #
YOUR PCP NAME	(212) 123-4567

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 830480
Birmingham, AL 35283-0480

Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplus.org

Customer Service	Rx Customer Services	Mental Health Crisis (24/7)	Dental Health Services
1 (800) 303-9626	**1 (855) 656-0361**	**1 (866) 728-1885**	**1 (844) 284-8819**
TTY for the hearing impaired: 711		SMS capable for the hearing impaired	TTY: 1 (800) 466-7586 DentaQuest

XXV SAMPLE MEMBER ID CARD: *MEDICARE ADVANTAGE/MEDICARE ADVANTAGE REISSUE*

✓MetroPlusHealth

MedicareRx
Prescription Drug Coverage

Medicare Advantage
H0423-001

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

PayerID #	RxBIN:	RxPCN:	RxGROUP:
13235	004336	MEDDADV	RX8541

Primary Care Physician (PCP)	PCP Phone #
YOUR PCP NAME	(212) 123-4567

Send behavioral health and medical claims to:

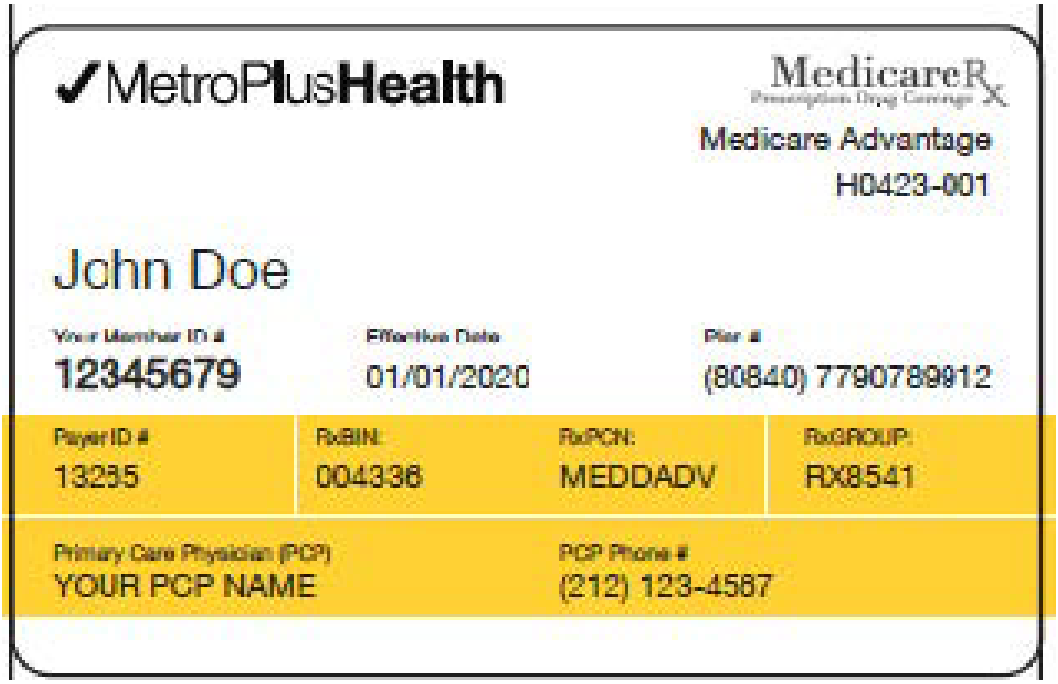
MetroPlusHealth
PO Box 381509
Birmingham, AL 35283-0480

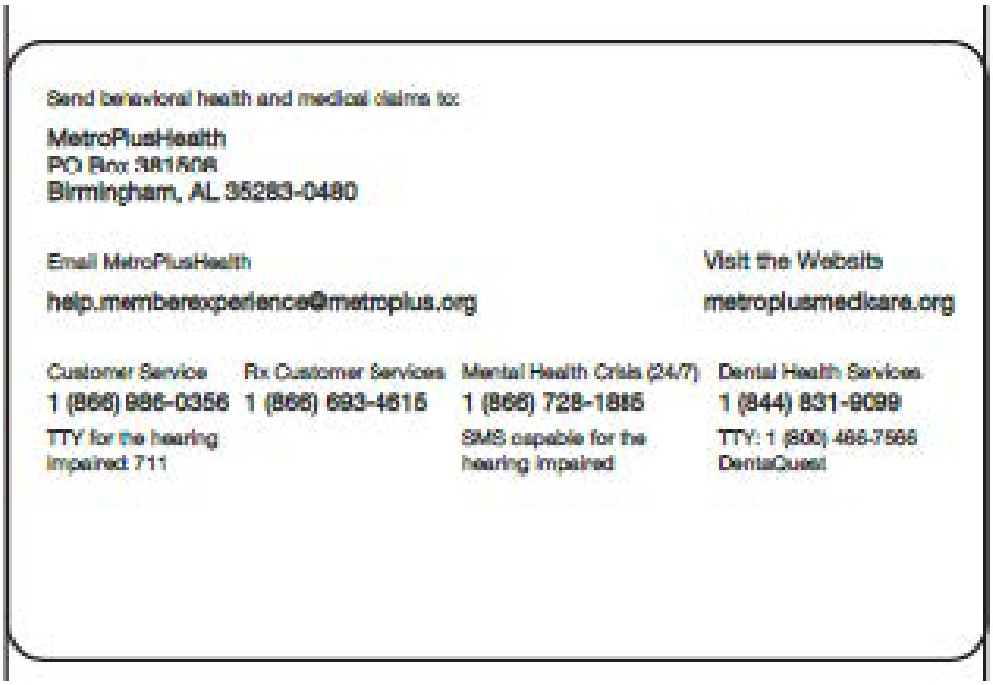
Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplusmedicare.org

Customer Service	Rx Customer Services	Mental Health Crisis (24/7)	Dental Health Services
1 (866) 986-0356	1 (866) 693-4615	1 (866) 728-1886	1 (844) 831-9099
TTY for the hearing impaired 711		SMS capable for the hearing impaired	TTY: 1 (800) 466-7566 DentaQuest

SAMPLE ID CARDS: MEDICARE PLATINUM/MEDICARE PLATINUM REISSUE





SAMPLE MEMBER ID CARD: ULTRACARE/ULTRACARE REISSUE

✓MetroPlusHealth

MedicareRx
Prescription Drug Coverage

Medicare Advantage
H0423-001

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:
13235	004336	MEDDADV	RX8541

Primary Care Physician (PCP)	PCP Phone #
YOUR PCP NAME	(212) 123-4567

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 38150A
Birmingham, AL 35283-0480

Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplusmedicare.org

Customer Service	Rx Customer Services	Mental Health Crisis (24/7)	Dental Health Services
1 (866) 986-0356	1 (866) 693-4615	1 (866) 728-1886	1 (844) 831-9099
TTY for the hearing impaired: 711		SMS capable for the hearing impaired	TTY: 1 (800) 466-7566 DentaQuest

XXVI SAMPLE MEMBER ID CARD: MANAGED LONG-TERM CARE/MANAGED LONG-TERM CARE REISSUE

✓MetroPlusHealth

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:
13265	004336	ADV	RX7542

Primary Care Physician (PCP)	PCP Phone #
YOUR PCP NAME	(212) 123-4567

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 830480
Birmingham, AL 35283-0480

Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplus.org

Customer Service	Rx Customer Services	Mental Health Crisis (24/7)	Dental Health Services
1 (800) 303-9626	1 (855) 656-0361	1 (866) 728-1885	1 (844) 284-8819
TTY for the hearing impaired: 711		SMS capable for the hearing impaired	TTY: 1 (800) 466-7566 DentaQuest

XXVII SAMPLE MEMBER ID CARD: *METROPLUS GOLD*

✓MetroPlus**Health** Gold

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:	Rx 30-Day
13265	004336	ADV	RX7542	$10 / $20 / $50

Primary Care Physician (PCP)	PCP Phone #
CALL PLAN TO SELECT	(212) 123-4567

What You Pay	PCP Copay	Specialist Copay	Deductible Amount	Urgent Care Copay	ER Copay	Max. Out of Pocket
	$0	$0	$0	$25	$100	$7,150

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 830480
Birmingham, AL 35283-0480

FULLY INSURED COVERAGE

Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplus.org

Concierge Line
1 (877) 475-3795
TTY for the hearing impaired
711

Prescription Customer Service
1 (855) 656-0361

Mental Health Crisis (24/7)
1 (866) 728-1885
SMS capable for the hearing impaired

Except for emergencies, pre-approval from MetroPlusHealth is needed before hospital stays and some treatments. Call 1 (800) 303-9626 to obtain approval.

XXVIII SAMPLE MEMBER ID CARD: *METROPLUS GOLDCARE*

✓MetroPlusHealth Gold

John Doe

Your Member ID #	Effective Date	Plan #
12345679	01/01/2020	(80840) 7790789912

Payer ID #	RxBIN:	RxPCN:	RxGROUP:	Rx 30-Day
13265	004336	ADV	RX7542	$10 / $20 / $50

Primary Care Physician (PCP)	PCP Phone #
CALL PLAN TO SELECT	(212) 123-4567

What You Pay	PCP Copay	Specialist Copay	Deductible Amount	Urgent Care Copay	ER Copay	Max. Out of Pocket
	$0	$0	$0	$25	$100	$7,150

Send behavioral health and medical claims to:

MetroPlusHealth
PO Box 830480
Birmingham, AL 35283-0480

FULLY INSURED COVERAGE

Email MetroPlusHealth
help.memberexperience@metroplus.org

Visit the Website
metroplus.org

Concierge Line
1 (877) 475-3795
TTY for the hearing impaired
711

Prescription Customer Service
1 (855) 656-0361

Mental Health Crisis (24/7)
1 (866) 728-1885
SMS capable for the hearing impaired

Except for emergencies, pre-approval from MetroPlusHealth is needed before hospital stays and some treatments. Call 1 (800) 303-9626 to obtain approval.

LDSS-3134 (2/01)

STERILIZATION CONSENT FORM

PATIENT NAME	CHART NO.	RECIPIENT ID NO.
HOSPITAL/CLINIC		

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (doctor or clinic). When I asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation know as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I,_____, hereby consent of my own free will to be sterilized by _____ (Doctor) by a method called_____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date: _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

☐1 American Indian or Alaska Native ☐ 4 Hispanic

☐2 Asian or Pacific Islander ☐ 5 White (not of Hispanic origin)

☐3 Black (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT■

Before_____ (Name of Individual) signed the consent form, I explained to him/her the nature of the sterilization operation_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowlingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization) _____ (Operation), I explained to him/her the nature of the sterilization operation_____ (Specify type of operation), the fact that it is intended to be a final irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date sterilization was performed.

(2) This sterilization was preformed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable and fill in information requested):

☐ 1. Premature delivery
Individual's expected date of delivery: _____

☐ 2. Emergency abdominal surgery: _____
(describe circumstances): _____

_____ _____
Physician *Date*

THE FOLLOWING MUST BE COMPLETED FOR STERILIZATIONS PERFORMED IN NEW YORK CITY -- WITNESS CERTIFICATION

I,_____ do certify that on_____ I was present while the counselor read and explained the consent form to_____ (patient's name) and saw the patient sign the consent form in his/her handwriting.

SIGNATURE OF WITNESS	TITLE	DATE
X		

REAFFIRMATION (to be signed by the patient on admission for Sterilization)

I certify that I have carefully considered all the information, advice and explanations given to me at the time I originally signed the consent form.
I have decided that I still want to be sterilized by the procedure noted in the original consent form, and I hereby affirm that decision.

SIGNATURE OF PATIENT	DATE	SIGNATURE OF WITNESS	DATE
X		X	

DISTRIBUTION: 1 – Medical Record File 2 – Hospital Claim 3- Surgeon Claim 4 – Anesthesiologist Claim 5 – Patient

LDSS-3113 (4/84)

ACKNOWLEDGEMENT OF HYSTERECTOMY INFORMATION

(NYS MEDICAID PROGRAM) *EITHER PART I OR PART II MUST BE COMPLETED*	RECIPIET ID NO | | | | | | | | | |	SURGEON'S NAME

PART 1: RECIPIENT'S ACKNOWLEDGEMENT STATEMENT AND SURGEON'S CERTIFICATION

RECIPIENT'S ACKNOWLEDGEMENT STATEMENT

It has been explained to me, _____, that the hysterectomy to be performed on me
(RECIPIENT NAME)
Will make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me and all my questions have been answered to my satisfaction prior to the surgery.

RECIPIENT OR REPRESENTATIVE SIGNATURE X	DATE	INTERPRETER'S SIGNATURE (if required) X	DATE

SURGEON'S CERTIFICATION

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

SURGEON'S SIGNATURE X	DATE

PART II: WAIVER OF ACKNOWLEDGMENT AND SURGEION'S CERTIFICATION

The hysterectomy performed on _____ was solely for medical indications.
(RECIPIENT NAME)
The hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement of Receipt of Hysterectomy information from her and have her complete Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

☐ 1. She was sterile prior to the hysterectomy
(briefly describe the cause of sterility) _____
_____

☐ 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgment was not possible. (briefly describe the nature of the emergency)
_____
_____

☐ 3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

SURGEON'S SIGNATURE X	DATE

DISTRIBUTION: File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit with claims for payment; patient.

<Date>

<ProviderFirstName> <ProviderLastName>
<ProviderAddress1> <ProviderAddress2>
<ProvderCity>, <ProviderState> <ProviderZip>

Re: Informed Consent Procedures for Hysterectomy and Sterilization

Dear Provider,

MetroPlusHealth Plan providers will comply with New York City Department of Health and Mental Hygiene (NYCDOHMH) informed consent guidelines in 42 CFR, Part 441, Sub Part F and 18 NYCRR Section 505.13. A member undergoing a hysterectomy must be notified verbally and in writing that the procedure will render her permanently sterile. She or her authorized representative must sign the required consent form.

This requirement is only waived if the hysterectomy was performed in a life threatening (emergency) situation or when the evidence exists that the member was sterile prior to the procedure. If either situation occurs, then the surgeon's attestation must be completed stating that one of these circumstances existed.

Specific Disclosures:
The physician performing the sterilization procedure must be available to answer questions and provide all requested information and advice in addition to providing the form and informed consent. The following issues must be discussed with the member seeking sterilization at least thirty (30) days before the procedure is performed.

- Member's right to withdraw consent at any time prior to the procedure without jeopardizing any future treatment or federally subsidized benefit.
- Alternative methods of family planning and birth control.
- Irreversibility of the sterilization procedure.
- Detailed and thorough explanation of the procedure to be performed.
- Full description of the associated risks, side effects, and discomforts (including those associated with any anesthesia to be used)
- Full explanation of the benefits or advantages to be expected after undergoing the procedure.
- Explanation that the procedure will not be performed for at least thirty (30) days except in cases of premature delivery or emergency abdominal surgery.

MetroPlusHealth will monitor compliance with the informed consent procedures for hysterectomy and sterilization as specified in 42 CFR, Part 441, Sub Part F and 18 NYCRR Section 505.13. Our records indicate the member(s) listed in this letter had a sterilization procedure (see attached list).

Please fax us a copy of the member's signed consent form to our Quality Improvement Specialist at 212-908-5188, or mail to Attn: Miguel Negron, MetroPlusHealth, Quality Management Department, 50 Water St., 8 Floor, New York, NY 10004.
PRV 21.018

If you have any question, please feel free to contact me at 212-908-8553

Catherine Lopez
Director, Quality Improvement

Provider Name: <ProviderFirstName> <ProviderLastName>

MEMBER NAME	DOB	DATE OF SERVICE
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
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<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>
<MemberFirstName> <MemberLastName>	<MemberDOB>	<ServiceDate>

Senior Associate Director Quality Management

Note: If standards are not met Networks Relations will outreach to individual providers to discuss the importance of complying with the informed consent procedures for hysterectomy and sterilization. Providers who are found to be non-compliant with regulatory requirements will be re-evaluated after a period of 6 months and if still non-compliant will be presented to the Credentialing Committee for further action.

XXXII CONTRACEPTIVE SERVICES

$0 Cost-Share Services, Products & Drugs covered by MetroPlusHealth

QHP/Essential Plan

Family Planning and Reproductive Health Services

MetroPlusHealth covers family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise covered under the Prescription Drug Coverage section of this Contract, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. MetroPlusHealth also covers vasectomies subject to Copayments, Deductibles or Coinsurance. MetroPlusHealth does not cover services related to the reversal of elective sterilizations.

Covered Prescription Drugs include but are not limited to contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA, which can be filled up to a 12-month supply in one fill.

Interruption of Pregnancy

MetroPlusHealth covers therapeutic abortions including abortions in cases of rape, incest or fetal malformation (i.e., medically necessary abortions). We cover elective abortions for one (1) procedure per Member, per Plan Year.

Designated Pharmacies

If your patients require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, MetroPlusHealth may direct them to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports. If your patients are directed to a Designated Pharmacy and they choose not to obtain the Prescription Drug from a Designated Pharmacy, your patient will not have Coverage for that Prescription Drug. Contraceptives are included in the therapeutic class of Prescription Drugs or conditions.

See the full QHP and Essential formulary at *https://www.metroplus.org/member- services/formularies.*

XXXIII CONTRACTED UTILIZATION REVIEWAGENTS' PHONE NUMBERS

CVS Caremark is contracted with MetroPlusHealth to provide Pharmacy Benefit Management services, including utilization management for non-specialty medications. Contact Caremark for non- specialty medication prior authorization at **1.877.433.7643**.

Prior authorization for specialty medications is reviewed by the pharmacy department at MetroPlusHealth. Please contact them at **1.800.303.9626**.

Integra Partners is contracted with MetroPlusHealth to provide Durable Medical Equipment (DME) benefit management services. Contact Integra Partners for prior authorizations at **1.866.679.1647** or via fax at **1.212.908.5185**.

Healthplex is contracted with MetroPlusHealth to provide Dental Benefit Management services, including utilization management for dental. Contact Healthplex at **1.888.468.2183**.

Effective 1/1/2023, DentaQuest is contracted with MetroPlusHealth to provide Dental Benefit Management services, including utilization management for dental. Contact DentaQuest at **1.888.308.2508**.

XXXIV MEDICAL MANAGEMENT: MEDICARE CARE MANAGEMENT TRAINING PROGRAM

Welcome

- Welcome: 2021/2022 MetroPlus MAP Model of Care for providers
- Chapter 42 of the Code of Federal Regulations (42 CFR 42..101 (f)(2)(ii)) mandates that Special Needs Plans (SNPs) conduct SNP Model of Care (MOC) training for all employees and contracted providers
  - All providers must complete this training annually
- The SNP MOC is the evidence-based process MetroPlus uses to integrate benefits and coordinates care for members enrolled in our SNPs

Terms

- Let's review some basic terms and introduce you to the Medicare Special Needs Plan (SNP)
- What is a Special Needs Plan? Congress created Special Needs Plans (SNP) in the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed care plan focused on certain vulnerable groups of Medicare beneficiaries. These members are
  - Individuals dually eligible for Managed Medicare with FFS Medicaid (D-SNP)
  - Individuals who are institutionalized or eligible for nursing home care
  - Individuals with specific severe or disabling chronic conditions
- Dual Eligible Members ("duals")- Individuals who are dually eligible for Medicare and Medicaid. There are two major types of dual eligible members:
  - Full duals: these individuals have full Medicare benefits but also receive full Medicaid benefits (which includes long-term services and supports
  - Partial duals: these individuals have full Medicare benefits, but don't qualify for full Medicaid because their income and/or resources are too high to qualify for full Medicaid. Depending on their income, Medicaid may pay for their Medicare premiums and for some (Qualified Medicare Beneficiaries whose income is less 100% of the Federal Poverty Limit), Medicaid may also pay for deductibles, co-insurance and co- payments.
- Partial duals are eligible for Medicare Advantage but not integrated plans like Medicaid Advantage

Lines of Business (LOB)

MetroPlus currently offers several Medicare plans, two of which are Special Needs Plans

- MetroPlus Platinum (HMO)- This plan does not have an additional membership requirement. This plans is a Managed Care Plan for Medicare (only members). This is not a special needs plans.
- MetroPlus Advantage (HMO/SNP)- This plan is for members that have both Medicare and Full or Partial Medicaid. This why you see both an HMO and SNP designation. Partial Duals for Medicare Plus means people who don't have Medicaid, but get assistance either from LIS (low income subsidy or MSP (Medicare Savings Program). The costs of the plan are determined by the level of the assistance.
  - This plan is often referred to as "D-SNP"
- Medicaid Advantage Plan- MAP (Medicaid Advantage Plan)- Starting November 1, 2021, MetroPlus will offer a MAP plan to Full Dual beneficiaries who are eligible for Medicare and long-term care services. This plan combines services covered by Medicare with comprehensive Medicaid services including long-term care, in effect combining a Medicare Advantage plan and a Medicaid MTLC plan in a single package
  - This plan is referred to as "MAP" or "Ultracare"

Medicare Advantage SNP

- MetroPlus Advantage Plan (HMO/SNP)- A dual-eligible Special Needs Plan for Medicare beneficiaries that reside in MetroPlus' coverage area are eligible for Medicare parts A and B, and receive assistance from NYS Medicaid and other programs such as LIS (Low Income Subsidy) and MSP (Medicare Savings Program)
    - MetroPlus Medicare Advantage members receive a variety of services in addition to a wide range of benefits
- Care Management- a program that works with MetroPlus Medicare members identified as having significant health care needs, and their PCPs, to effectively manage all the services and referrals that the member needs
- Skilled Nursing Facility Services- institutions licensed or approved under state of local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended are facility, or nursing care facility
- Social Services- members benefit from access to social services which include: supplemental Security income, elderly pharmaceutical insurance coverage, and the Medicare Savings Program
- HIV/AIDS support services- assists members with referrals and coordination of services through partner agencies and other community-based AIDS service organizations. These services include: HIV case management, treatment education. For example, the support and promotion of adherence to treatment regimens
- Inpatient Care- services performed within a hospital or care facility
- Pharmacy- prescription drugs and information on Pharmacy coverage
- Outpatient Care- services that are performed in the outpatient department of a facility or in a health care professional's office

What is the MAP or Ultracare?

- MetroPlusHealth Ultracare is a Managed Long-Term plan for people with Medicare and Medicaid who need long term care services such as home care and personal care.
- Ultracare providers members with all the benefits of Medicare and Medicaid, plus over-the-counter benefits, prescriptions drug coverage, MetroPlusHealth Member Rewards as well as vision, dental, and hearing coverage.

What is Care Management?

- MetroPlus Care Management coordinates services to meet the medical, behavioral, psychosocial, and functional needs of the dual eligible membership.
- MetroPlus follows a series of steps to offer the best possible care to our members
    - Health Risk Assessment (HRA)
    - Development of Person Centered Service Plan (PCSP)
    - Interdisciplinary Care Team (ICT)
    - Transitions of Care (TOC)

Roles and Responsibilities of Care Managers

The MetroPlus Care Manager is the central point person who coordinates the care and services of members across the continuum of illness. He/She:

- Promotes effective utilization and monitoring of health care resources; and participates in the ICT to achieve optimal clinical and resource outcomes
- Communicates with the participant, family, PCP, specialists and other members of the health care team to gather information pertinent to the identification of the member's health care needs
- Develops a person-centered service plan (care plan) based upon patient-centered goals; updates the plan as needed to reflect the member's current health status and needs by coordinating and communicating with the PCP and other providers of care
- Advocates, informs and educates members
- Ensures members obtain timely, cost-effective quality care in the appropriate setting; identifies and facilitates access to community resources
- Ensures the coordination of Medicare and Medicaid services, including mental health, substance use and rehabilitation services.
- Conducts inpatient admission review, coordination of continuing stay, discharge planning, care transitions and review of requests for pre-authorization of elective admissions and procedures
- Collaborates with the ICT and the Primary Care Physician to ensure continuity and appropriateness of care

Health Risk Assessment

- The Health Risk Assessment is a comprehensive assessment of a person's medical health, behavioral health, long-term services, and supports (LTSS) and social needs
  - The Medicare HRA is completed by an RN on staff, or under contract with, MetroPlus. For Managed Long Term Care Plans, including UltraCAre, it is usually conducted in person, but in some circumstances, it can be conducted via video as well. For Managed Medicare (Platinum) and for the Medicare DSNP (Advantage), the HRA is conducted telephonically by MetroPlus' Quality Management Department.
  - The initial HRA must be completed within 90 days of effective enrollment.
  - Annual reassessment must be completed within 365 days of the last HRA
  - Used to stratify members into risk categories for care management

Person Centered Service Plan

- In conjunction with the member and/or the member's caregiver, the Medicare care manager develops an individualized care plan (referred to as a PCSP)
- PCSP identified member-specific health care goals, planning for care, and addresses the member's needs. It contains:
  - Member's health care preference
  - Member's demographics, health conditions and medications
  - Short & Long term goals, including self-management goals and targets
  - Detailed tasks and interventions (for the care manager, provider and/or member)
  - Services the members needs and uses
  - Service providers the members uses, including PCP, specialists, home care agencies, etc…
- The PCSP is shared with the provider and member

Interdisciplinary care team

- The ICT functions as a multidisciplinary team to support the member to improve the member's health outcomes. The member is the central focus of the Interdisciplinary Care Team
- The purpose of the (ICT) team is to:
  - Assist the member with the coordination of care
  - Assist the member with managing transitions of care
  - Mediate identified barriers in care
  - Facilitate and coordinate the course of treatment prescribed by the primary care physician
- The ICT consists of various professionals, including the member's providers, that have insight into the member's care plan and can recommend changes. These include the member or care giver, MetroPlus care management staff, providers, Member's PCP, Mental Health and/or behavioral health experts, social workers etc.

Transitions of Care

- Care transitions occur when a member moves from one health care provider or setting to another e.g.,
  - Discharged from, or admission to, hospital, acute rehab or skilled nursing facility
- MetroPlus care manager will assist members during transitions to ensure needs are met
  - Medications are reconciled and accessible, e.g. Medical equipment is ready
  - Services are started or resumed

Provider responsibilities

- Providers support the integrated care delivery system through
  - Communicate with MetroPlus care managers, care givers and members
  - Participate in the ICT process
  - Using evidence-based care guidelines
  - Review patient medications
  - Take part in quality improvement activities
  - Submitting documentation in a timey manner
  - Communicate with MetroPlus care managers when needs arise
  - Empower the member to continue the treatment established in the PCSP

Summary

- The MetroPlus MOC and our various care management departments are designed to ensure our members, your patients, get the best care possible
- We value your partnership in delivering quality healthcare
- We are here to answer any questions you may have

XXXV NATIONALDIABETESPREVENTIONPROGRAM

Effective February 1, 2020, the National Diabetes Prevention Program (NDPP) is included in the Medicaid managed care (MMC) benefit package. This applies to mainstream MMC plans, HIV Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs).

Overview

The National Diabetes Prevention Program (NDPP) is an evidence-based educational and support program, taught by trained Lifestyle Coaches, that is designed to prevent or delay the onset of type 2 diabetes. This benefit will cover 22 NDPP group training sessions over the course of a calendar year and is taught using a trained lifestyle coach.

Eligibility

Members may be eligible for diabetes prevention services if they have a recommendation by a physician or other licensed practitioner and are:

- At least 18 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

Also, they must meet *one* of the following criteria:

- They have had a blood test result in the prediabetes range within the past year, or
- They have been previously diagnosed with gestational diabetes, or
- They score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes RiskTest: http://www.diabetes.org/are-you-at-risk/diabetes-risk-test/

Program Structure

- Does not limit NDPP services to once per lifetime,
- Consists of only in-person group training sessions,
- Requires sessions be taught using a CDC-approved curriculum,
- Requires sessions be taught by trained Lifestyle Coaches, who can be health professionals or non- licensed personnel,
- Requires sessions be approximately one-hour in length,
- Requires sessions include recording of the member's body weight.
- Year-long program
  - At least 16 weekly sessions in months 1 – 6
  - At least 6 monthly sessions in months 7 – 12

NDPP Provider information

- Providers should bill on an 837P
- Provider enrollment and maintenance information can be found at the following link: https://www.emedny.org/info/ProviderEnrollment/ndpp/index.aspx
- The Medicaid enrolled provider listing can be found here: https://health.data.ny.gov/Health/Medicaid-Enrolled-Provider-Listing/keti-qx5t

Service Description	Units	MEDS Category of Services (COS)	HCPCS Procedure Code	Provider Specialty Code
In-person NDPP group counseling sessions	Per member, per session	01	0403T	105
Incentive Payment	Once over the course of 22 sessions, when member first achieves the 5% weight-loss baseline	01	G9880	105

Early Hearing Detection and Intervention (EHDI), Newborn Hearing Screening (NHS), and Early Intervention Program (EIP)

New York State Public Health Law, Section 2500-g, enacted in 1999, requires the Commissioner of Health to establish a program to screen newborn infants for hearing problems. To identify newborns with significant hearing loss, the New York State Department of Health has implemented a statewide comprehensive Newborn Hearing Screening Program. The Department, in collaboration with health care providers, hospital representatives, parent representatives and audiologists has developed a new Subpart 69-8 of Title 10 (Health) of the New York Codes, Rules and Regulations (NYCRR) to implement the Newborn Hearing Screening Program. This regulation was adopted on August 22, 2001, became effective on October 20, 2001, and requires all facilities caring for newborn infants to administer a newborn hearing screening program as of that date.

All infants should be screened for hearing loss no later than 1 month of age. Hearing screening should be completed as part of the newborn screening done at the birth hospital prior to discharge. If an infant does not pass the initial hearing screening, the birth hospital is required to schedule a follow- up hearing screening or refer to an outpatient audiologist. The birth hospital is also required to ensure that the follow-up hearing screening was completed.

If an infant does not pass the follow-up hearing screening, then a pediatric audiologic evaluation should be conducted no later than 3 months of age. For infants who do not pass the pediatric audiologic evaluation, referral to Early Intervention Program should be made no later than 6 months of age.

Please refer to the below guidance for more information.

Early Hearing Detection and Intervention (EHDI)/Newborn Hearing Screening (NHS)and Early Intervention Program (EIP)

EHDI 1-3-6 Guidelines:

Initial Hearing Screening no later than 1-month of age Diagnosis of Hearing Loss no later than 3 months of age Enrollment into EI or other services no later than 6-months of age

Newborn Screening – Birth Hospital (Prior to Discharge)

Hospital-Based Inpatient Screening

- Hospital administers hearing screening for newborn.
  - Otoacoustic Emissions (OAE)
  - Auditory Brainstem Response (ABR)
- Birth Hospital updates infant records via birth register.
- Birth Hospital staff ensures information is documented correctly in EHDI-Information System (EHDI-IS).
- Birth Hospital staff/Newborn Hearing Screening Program Manager is responsible to ensure documentation and follow-up screening is completed, regardless of whether the screening was completed by hospital staff or a contractor.

Every infant younger than 28 days who fails their initial screening is required to be tested for Cytomegalovirus (CMV)

Pass

Ongoing Care of All Infants: Coordinated by the Medical Home Provider

Did Not Pass

Re-Screening Complete – Before 1 Month

Outpatient Re-Screening

- Birth Hospitals are required to schedule infant for follow-up screening or refer to an outpatient audiologist.
- Birth Hospital is required to follow the infant for 75 days, post discharge, to confirm follow- up hearing screening was completed.
- Birth Hospitals are allowed to document re- screening results.
- If there is no documentation of follow-up, the Birth Hospital must refer the infant At Risk to the Early Intervention official in the county of residence unless the parent has objected to such a referral.
- **Follow-up screening results or At Risk referral to EI should be documented in EHDI-IS, in the appropriate fields, not in**

Pass

Ongoing Care of All Infants: Coordinated by the Medical Home Provider

Did Not Pass

Diagnostic Evaluation – Before 3 Months

Pediatric Audiologic Evaluation

- Audiologist reports to NY EHDI Program
  - Results for every child seen must be documented in EHDI-IS, regardless of Hearing Loss Status, in the appropriate fields, not in Comments.

Pass

Ongoing Care of All Infants: Coordinated by the Medical Home Provider

Did Not Pass

Intervention Services – Before 6 Months

- Refer to The Early Intervention Program (EIP) https://www.health.ny.gov/community/infants_children/early_intervention/index.htm
- Referral to EIP should be documented in EHDI-IS, inthe appropriate Refer to EI field, not in comments.
- Refer to other Intervention Services as discussed between Parents, Audiologist, and other Healthcare Providers

Early Hearing Detection and Intervention (EHDI)/ Newborn Hearing Screening (NHS) and EarlyIntervention Program (EIP)

Best Practices for MCOs to Assist Providers with EHDI/NHS to Early Intervention Program (EIP) Process

- The Early Intervention Program (EIP) is administered locally by Local Health Department (LHDs). Keep Early Intervention (EI) contact information for the county(ies) under your coordination handy. Refer to the contact resources in the box belowfor where EI county level contact information can be found.

- Advise Primary Care Practitioners (PCPs) to obtain parental written informed consent for release of informationat first contact with the EIP, in order for information to be shared between the EIP and the PCP.

- Patient Identifying Information (PII) should only be shared via in person, mail, or secure fax.

- Referral sources should use County Specific Referral Forms, if available, when referring to the EIP and ensure theforms are completed in their entirety, and legible. Include complete referral source contact information in case theEIP needs to contact the referral source.

- Referrals should be made to the County EI office in the **county of residence**, not the county of birth.

- When referring to the EIP be sure to include:
  - Child's Name and Date of birth
  - Complete address
  - Dominant language or mode of communication of child and parent/legal guardian
  - Parent/legal guardian names and address, if different from child, and phone number(s) (multiple numbersif possible)
  - Race/Ethnicity
  - Reason for Referral
  - Developmental concerns, hearing status, testing results completed
  - Insurance information

- "A Parent's Guide" is available through the NYSBEI website. This is a useful guide that provides parentsanoverview of the Early Intervention Program. https://www.health.ny.gov/publications/0532.pdf

Early Hearing Detection and Intervention (EHDI) Contact Resources

- Need assistance from EHDI? We can help! Email us at nyehdi@health.ny.gov. Please do not include any Personally Identifying Information in the message.

- Learn more about the Early Hearing Detection and Intervention Program https://www.health.ny.gov/community/infants_children/early_intervention/newborn_hearing_screening/

Early Intervention Program Contact Resources:

- Learn more about the Early Intervention Program https://www.health.ny.gov/community/infants_children/early_intervention/index.htm

- Contact information for Early Intervention Officials in your NYS Municipal/County https://www.health.ny.gov/community/infants_children/early_intervention/county_eip.htm

- Need assistance from the EIP? We can help! Email us at beipub@health.ny.gov. Please do not includeany Personal Identifying Information in the message.