# New York State
# Medicaid Managed Care

# METROPLUSHEALTH MEMBER HANDBOOK

**Revised November 2024**

# HERE'S WHERE TO FIND INFORMATION YOU WANT

## Welcome to MetroPlusHealth's Medicaid Managed Care Program

We are glad that you enrolled in MetroPlusHealth. This handbook will be your guide to the full range of health care services available to you. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at 800.303.9626.

### HOW MANAGED CARE PLANS WORK

### The Plan, Our Providers, and You

Managed care provides a central home for your care.

- We have a group of health care providers to meet your needs. These doctors and specialists, hospitals, labs, and other health care facilities make up our **provider network**. Our provider network is listed in our **provider directory**. To get a provider directory, call 800.303.9626 (TTY: 711) to get a copy or visit our website at **metroplus.org**.

- MetroPlusHealth has a contract with the State Department of Health to meet the health care needs of people with Medicaid. If you were getting behavioral health services using your Medicaid card, now those services may be available through MetroPlusHealth.

- When you join MetroPlusHealth, you will need to select a primary care provider (PCP) from our provider network. If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.

- Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page 10 for details.

Your PCP is available to you every day, day and night. If you need to speak to them after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible.

You may be restricted to certain plan providers if you have been identified as a restricted recipient. Below are examples of why you may be restricted:

- getting care from several doctors for the same problem
- getting medical care more often than needed

- using prescription medicine in a way that may be dangerous to your health
- allowing someone other than yourself to use your plan ID card.

**Confidentiality**

We respect your right to privacy. MetroPlusHealth recognizes the trust needed between you, your family, your doctors, and other care providers. MetroPlusHealth will never give out your medical or behavioral health history without your written approval. The only persons that will have your clinical information will be MetroPlusHealth, your Primary Care Provider, your authorized representative, and other providers who give you care. Referrals to such providers will always be discussed with you in advance by your Primary Care Provider or your Health Home Care Manager, if you have one. MetroPlusHealth staff have been trained in keeping strict member confidentiality.

## HOW TO USE THIS HANDBOOK

This handbook will help you when you join a managed care plan. It will tell you how your new health care system will work and how you can get the most from MetroPlusHealth. This handbook is your guide to health and wellness services. It tells you the steps to take to make the Plan work for you.

The first several pages will tell you what you need to know **right away**. Use this handbook for reference or check it out a bit at a time.

When you have a question, check this Handbook or call our Member Services unit. You can also call the managed care staff at your Local Department of Social Services (LDSS).

If you live in **Bronx, Kings, New York, Richmond, or Queens**, you can also call the New York Medicaid Choice Help Line at 800.505.5678.

## HELP FROM MEMBER SERVICES

There is someone to help you at Member Services:
Monday through Friday, 8am - 8pm, Saturday 9am - 5pm
Call us toll-free: 800.303.9626

If you are hearing impaired (have a hearing problem) and can get to a TDD/TTY machine, please call us toll-free at: **711**.

If you have a vision problem and would like to use a Braille handbook or a recorded (audio tape) handbook, call Member Services.

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| Member Services: | 800.303.9626 (TTY: 711) |
| For Behavioral Health Crisis, call our hotline toll-free: | 866.728.1885 |

If you need medical help after business hours, on weekends or holidays, call the MetroPlusHealth 24-Hour Health Care Hotline toll-free at **800.442.2560.**
**For Behavioral Health Crisis call our Hotline toll-free at 866.728.1885.**

- You can call Member Services to get help **anytime you have a question.** You may call us to choose or change your Primary Care Provider (PCP for short), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to let us know if you are pregnant or have a new baby, or ask about any change that might affect you or your family's benefits.

- If you are or become pregnant, your child will become part of MetroPlusHealth on the day they are born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your LDSS right away if you become pregnant and let us help you to choose a doctor for your **newborn baby** before they are born.

- We **offer free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that is best for you.

- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can serve you in your language.

- **For people with disabilities:** If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:

    - TTY machine (our TTY phone number is 711)
    - Information in large print
    - Case management
    - Help in making or getting to appointments
    - Names and addresses of providers who specialize in your disability

- **If you or your child are getting care in your home now,** your nurse or attendant may not know you have joined our plan. **Call us right away** to make sure your home care does not stop unexpectedly.

## YOUR HEALTH PLAN ID CARD

After you enroll, we will send you a Welcome Letter. Your MetroPlusHealth Member ID card should arrive within 14 days after your enrollment date. Your card has your PCP's (primary care provider's) name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong on your MetroPlusHealth ID card, call us right away. Your ID card does not show that you have Medicaid or that MetroPlusHealth is a special type of health plan.

Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need this card to get services that MetroPlusHealth does not cover.

# PART I: FIRST THINGS YOU SHOULD KNOW

## HOW TO CHOOSE YOUR PRIMARY CARE PROVIDER (PCP)

- You may have already picked your Primary Care Provider (PCP) to serve as your regular doctor. This person could be a doctor, nurse practitioner, or other health care provider. **If you have not chosen a PCP for you and your family, you should do so right away.** If you do not choose a doctor within 30 days from when you receive your welcome packet, we will choose one for you.

- Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. You may also choose to receive PCP services through a Behavioral Health clinic. Member Services (800.303.9626) can check to see if you already have a PCP or help you choose one.

- You can access your Provider Directory online at **metroplus.org**. The Provider Directory lists all of the doctors, clinics, hospitals, labs, and others who work with MetroPlusHealth. It lists the address, phone number, and special training of the doctors. The Provider Directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP. You can also request a copy of the Provider Directory for the county where you live or for the county where you want to see a provider on the MetroPlusHealth website, **metroplus.org**, or by calling Member Services at 800.303.9626.

  You may want to find a doctor that:

  - you have seen before,
  - understands your health problems,
  - is taking new patients,
  - can serve you in your language, or
  - is easy to get to.

- Women can also choose one of our OB/GYN doctors to deal with women's health care. Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if needed, and regular care during pregnancy.

- We also contract with Federally Qualified Health Centers (FQHCs). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs

because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory, or you can sign up with a primary care physician at one of the FQHCs that we work with, listed below. Just call Member Services at 800.303.9626 for help.

**A listing of available FQHCs can be found in your Provider Directory.**

- In almost all cases, your doctors will be MetroPlusHealth providers. **There are four instances when you can still see another provider that you had before you joined MetroPlusHealth**. In these cases, your provider must agree to work with MetroPlusHealth. You can continue to see your doctor if:

  - You are pregnant when you join MetroPlusHealth and you are getting prenatal care. In that case, you can keep your provider until after your delivery through post-partum care. This post-partum care continues up to 12 weeks after delivery.

  - At the time you join MetroPlusHealth, you have a life-threatening disease or condition that gets worse with time. In that case, you can ask to keep your provider for up to 60 days.

  - At the time you join MetroPlusHealth, regular Medicaid paid for your home care and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse, or attendant, and the same amount of home care, for at least 90 days.

  - At the time you join MetroPlusHealth, you are being treated for a Behavioral Health condition. In most cases, you can still go to the same provider. Some people may have to choose a provider that works with the health plan. Be sure to talk to your provider about this change. MetroPlusHealth will work with you and your provider to make sure you keep getting the care you need.

- If you have a long-lasting illness, like HIV/AIDS or other long term health problems, you may be able to **choose a specialist to act as your PCP.** You or your provider can call Member Services with this request, which will be reviewed and approved on a case-by-case basis.

- Members may also choose to have their PCP located in a behavioral health clinic.

- If you need to, you can **change your PCP** in the first 30 days after your first appointment with your PCP. After that, you can change once every six months without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to whom your PCP has referred you.

- If your **provider leaves MetroPlusHealth**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider if 1) you are pregnant when you join MetroPlusHealth and you are getting prenatal care, or 2) you are receiving ongoing treatment for a condition. In the first case, you can keep your provider until after your delivery through post-partum care. ,In the second case, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with MetroPlusHealth during this time.

- If any of these conditions apply to you, check with your PCP or call Member Services at 800.303.9626.

**HOW TO GET REGULAR HEALTH CARE**

- Regular health care means exams, regular checkups, shots or other treatments to keep you well, advice when you need it, and referral to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need.

- Day or night, your PCP is only a phone call away. Be sure to call your PCP whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

- Your care must be **medically necessary.** The services you get must be needed:
    1. to prevent, or diagnose and correct what could cause more suffering;
    2. to deal with a danger to your life;
    3. to deal with a problem that could cause illness; or
    4. to deal with something that could limit your normal activities.

- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can’t keep an appointment, call to let your PCP know.

- As soon as you choose a PCP, call to make a first appointment. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell them. Make a list of your medical background, any problems you have now, any medications you are taking, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.

- **If you need care before your first appointment**, call your PCP's office to explain your concern. He or she will give you an earlier appointment. You should still keep the first appointment to discuss your medical history and ask questions.

- Use the following list as an **appointment guide for our limits on how long you may have to wait after your request for an appointment:**
  - adult baseline and routine physicals: within 12 weeks
  - urgent care: within 24 hours
  - non-urgent sick visits: within 3 days
  - routine, preventive care: within 4 weeks
  - follow-up visit after mental health/substance use emergency room (ER) or inpatient visit: 5 days
  - non-urgent mental health or substance use visit: 1 week.

- Use the following list as an **appointment guide for our limits on how long you may have to wait after your request for a perinatal appointment**:
  - first trimester: visit must occur within 3 weeks of the request for care
  - second trimester: visit must occur within 2 weeks of the request for care
  - third trimester: visit must occur within 1 week of the request for care
  - first newborn visit: within 2 weeks of hospital discharge
  - initial family planning visit must occur within 2 weeks of the request for care
  - for specialist referrals and urgent matters during pregnancy:
    - urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 72 hours
    - non-urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 2 to 4 weeks of when the request was made
    - for non-emergent, but urgent matters, pregnant persons must be seen within 24 hours of request for care

## HOW TO GET SPECIALTY CARE – REFERRAL

- If you need care that your PCP cannot give, they will REFER you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are MetroPlusHealth providers. Talk with your PCP to be sure you know how referrals work.

- If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.

- There are some treatments and services that your PCP must ask MetroPlusHealth to approve *before* you can get them. Your PCP will be able to tell you what they are.

- If you are having trouble getting a referral you think you need, contact Member Services at 800.303.9626.

- If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This is called an **out-of-network referral**. Your PCP or plan provider must ask MetroPlusHealth for approval *before* you can get an out-of-network referral. If your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except any copayments as described in this handbook.

- To get the referral, your doctor must give us some information. Once we get all this information, we will decide within 1 - 3 working days if you can see the out-of-network specialist. But, we will never take longer than 14 days from the date we got your request to make that decision. You or your doctor can ask for a fast-track review if your doctor feels that a delay will cause serious harm to your health. In that case, we will decide and get back to you in 1 - 3 working days. For information on the status of your request, please call Member Services at 800.303.9626.

    - Sometimes, we may not approve an out-of-network referral because we have a provider in MetroPlusHealth that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a **Plan Appeal**. See page 47 to find out how.

    - Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you

can get from MetroPlusHealth's provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a **Plan Appeal**. See page 47 to find out how.

- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.
- *If you have a long-term disease or a disabling illness that gets worse over time*, your PCP may be able to arrange for:
    - your specialist to act as your PCP; or
    - a referral to a specialty care center that deals with the treatment of your illness.

You can also call Member Services at 800.303.9626 for help in getting access to a specialty care center.

## GET THESE SERVICES FROM OUR PLAN WITHOUT A REFERRAL

### Women's Health Care

You do not need a referral from your PCP to see one of our providers if:

- you are pregnant,
- you need OB/GYN services,
- you need family planning services,
- you want to see a midwife,
- you need to have a breast or pelvic exam.

### Family Planning

- You can get the following family planning services: advice about birth control, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, and an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam, or a pelvic exam.

- You *do not need a referral* from your PCP to get these services. In fact, you can choose where to get these services. You can *use your MetroPlusHealth ID card* to see one of our family planning providers. Check the plan's Provider Directory or call Member Services for help in finding a provider.

- Or, you can *use your Medicaid card* if you want to go to a doctor or clinic outside our plan. Ask your PCP or call Member Services at 800.303.9626 for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (800.522.5006) for the names of family planning providers near you.

**HIV and Sexually Transmitted Infection (STI) Screening**

Everyone should know their HIV status. HIV and STI screenings are part of your regular health care.

- You can get an HIV or STI test any time you have an office or clinic visit.

- You can get an HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with any family planning provider. If you want an HIV or STI test, but *not as part of a family planning service,* your PCP can provide or arrange it for you.

- Or, if you'd rather not see one of our MetroPlusHealth providers, you can use your Medicaid card to see a family planning provider outside MetroPlusHealth. For help in finding either a Plan provider or a Medicaid provider for family planning services, call Member Services at 800.303.9626.

- Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call 800.541.AIDS (English) or 800.233.SIDA (Spanish).

Some tests are "rapid tests," and the results are ready while you wait. The provider who gives you the test will explain the results and arrange for follow-up care if needed. You will also learn how to protect your partner. If your test is negative, we can help you learn to stay that way.

**Eye Care**

The covered benefits include the needed services of an ophthalmologist, optometrist, and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period. You must choose one of our participating providers.

New eyeglasses, with Medicaid-approved frames, are usually provided once every two years. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses, or broken eyeglasses that can't be fixed, will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

**Behavioral Health – (Mental Health and Substance Use)**

We want to help you get the mental health and substance use services that you may need. If at any time you think you need help with mental health or substance use, you can see any behavioral health providers in our network to see what services you may need. This includes services like clinic and detox services. You do not need a referral from your PCP.

**Smoking Cessation**

You can get medication, supplies, and counseling if you want help to quit smoking. You do not need a referral from your PCP to get these services.

**Maternal Depression Screening**

If you are pregnant or recently had a baby and think you need help with depression, you can get a screening to see what services you may need. You do not need a referral from your PCP. You can get a screening for depression during pregnancy and for up to a year after your delivery.

To learn more about these services, call Member Services at 800.303.9626 (TTY: 711).

## EMERGENCIES

You are always covered for emergencies. An emergency means a medical or behavioral condition:

- that comes on all of a sudden, and
- has pain or other symptoms.

An emergency would make an average person fear that they, or someone, will suffer serious harm without care right away.

Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop
- a bad burn
- broken bones
- trouble breathing, convulsions, or loss of consciousness
- when you feel you might hurt yourself or others
- if you are pregnant and have signs like pain, bleeding, fever, or vomiting
- drug overdose

Examples of **non-emergencies** are:

- colds
- sore throat
- upset stomach
- minor cuts and bruises
- sprained muscles

Non-emergencies may also be family issues, a break-up, or wanting to use alcohol or other drugs. These may feel like an emergency, but they are not a reason to go to the emergency room.

**If you have an emergency, here's what to do**:

If you believe you have an **emergency**, call 911 or go to the emergency room. You do not need your Plan's or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

- **If you're not sure, call your PCP or MetroPlusHealth.**
  Tell the person you speak with what is happening. Your PCP or Member Services representative will:
    - tell you what to do at home,
    - tell you to come to the PCP's office, or
    - tell you to go to the nearest emergency room.

- If you are **out of the area** when you have an emergency:
    - Go to the nearest emergency room. If you are discharged from the emergency room with prescriptions, they must be filled at an NYRx Medicaid-enrolled pharmacy.

**Remember**

**You do not need prior approval for emergency services.**
**Use** the emergency room **only** if you have an **Emergency.**

**The Emergency Room should NOT be used for problems like the flu, sore throats, or ear infections.**

If you have questions, call your PCP or MetroPlusHealth at 800.303.9626.

## URGENT CARE

You may have an injury or an illness that is not an emergency but still needs prompt care.

- This could be a child with an earache who wakes up in the middle of the night and won't stop crying.
- This could be the flu or if you need stitches.
- It could be a sprained ankle, or a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 800.303.9626. Tell the person who answers what is happening. They will tell you what to do.

### Care Outside of the United States

If you travel outside of the United States, you can get urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

## WE WANT TO KEEP YOU HEALTHY

Besides the regular checkups and the shots you and your family need, here are some other ways to keep you in good health:

- Stop-smoking classes
- Prenatal care and nutrition
- Grief/loss support
- Chest feeding and baby care
- Stress management

- Weight control
- Cholesterol control
- Diabetes counseling and self-management training
- Asthma counseling and self-management training
- Sexually transmitted infection (STI) testing & protecting yourself from STIs
- Domestic violence services
- Other classes for you and your family

Call Member Services at 800.303.9626, or visit our website at **metroplus.org** to find out more and get a list of upcoming classes.

# PART II: YOUR BENEFITS AND PLAN PROCEDURES

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

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## BENEFITS

Medicaid Managed Care provides a number of services you get in addition to those you get with regular Medicaid. MetroPlusHealth will provide or arrange for most services that you will need. You can get a few services without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self-referral services, including those you can get from within MetroPlusHealth and some that you can choose to go to any Medicaid provider of the service. Please call our Member Services department at 800.303.9626 if you have any questions or need help with any of the services below.

## SERVICES COVERED BY METROPLUSHEALTH

**You must get these services from the providers who are in MetroPlusHealth.** All services must be medically or clinically necessary and provided or referred by your PCP (Primary Care Provider). Please call our Member Services department at 800.303.9626 if you have any questions or need help with any of the services below.

### Regular Medical Care

- office visits with your PCP
- referrals to specialists
- eye / hearing exams

### Preventive Care

- well-baby care
- well-child care
- regular checkups
- shots for children from birth through childhood
- access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth up to age 21 years
- smoking cessation counseling
- access to free needles and syringes
- HIV education and risk reduction

**Maternity Care**

- pregnancy care
- doctors/midwife and hospital services
- newborn nursery care
- screening for depression during pregnancy and up to a year after delivery

**Home Health Care**

- Must be medically needed and arranged by MetroPlusHealth
    - one medically needed post-partum home health visit; additional visits as medically needed for high-risk women
    - at least 2 visits for high-risk infants (newborns)
    - other home health care visits as needed and ordered by your PCP/specialist

**Personal Care/Home Attendant / Consumer Directed Personal Assistance Services (CDPAS)**

- Must be medically needed and arranged by MetroPlusHealth
    - Personal Care/Home Attendant – Help with bathing, dressing, and feeding and help with preparing meals and housekeeping.
    - CDPAS – Help with bathing, dressing, and feeding; help preparing meals and housekeeping, plus home health aide and nursing tasks. This is provided by an aide chosen and directed by you.
    - If you want more information, contact MetroPlusHealth at 800.303.9626.

**Personal Emergency Response System (PERS)**

- This is an item you wear in case you have an emergency.
- To qualify and get this service, you must be receiving personal care/home attendant or CDPAS services.

**Adult Day Health Care Services**

- Must be recommended by your Primary Care Provider (PCP).
- Provides health education, nutrition, nursing and social services, help with daily living, rehabilitative therapy, pharmacy services, plus referrals for dental and other specialty care.

**AIDS Adult Day Health Care Services**

- Must be recommended by your Primary Care Provider (PCP).
- Provides general medical and nursing care, substance use supportive services, mental health supportive services, nutritional services, plus socialization, recreational, and wellness/health promotion activities.

**Therapy for Tuberculosis (TB)**

- This is help taking your medication for TB and follow-up care.

**Hospice Care**

- Hospice helps patients and their families with their special needs that come during the final stages of illness and after death.
- Must be medically needed and arranged by MetroPlusHealth.
- Provides support services and some medical services to patients who are ill and expect to live for one year or less.
- You can get these services in your home or in a hospital or nursing home.

Children under age twenty-one (21) who are getting hospice services can also get medically needed curative services and palliative care.

If you have any questions about this benefit, you can call our Member Services Department at 800.303.9626.

**Dental Care**

MetroPlusHealth believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with DentaQuest, an expert in providing high-quality dental services; or we offer dental care through contracts with individual dentists who are experts in providing high-quality dental services. Covered services include regular and routine dental services such as:

- preventive dental checkups
- cleaning
- X-rays
- fillings
- other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you.

In certain circumstances, MetroPlusHealth may cover additional services, such as:

- dentures
- implants
- crowns
- root canals

*You do not need a referral from your PCP to see a dentist!*

**How to Get Dental Services**

You need to choose a primary care dentist. MetroPlusHealth uses DentaQuest to provide dental services. DentaQuest has participating dentists who specialize in general dentistry, pediatric dentistry, oral surgery, and gum disease. Call DentaQuest at 844.284.8819 to choose a primary care dentist. You can obtain a listing of participating dentists online at **metroplus.org**, or upon request by calling MetroPlusHealth Member Services at 800.303.9626. If you do not choose a dentist, one will be chosen for you. You can always change your dentist. Call your current dentist to ask if they participate with DentaQuest.

- If you need to find a dentist or change your dentist, please call DentaQuest at 844.284.8819, or please call MetroPlusHealth at 800.303.9626. Member Services representatives are there to help you. Many speak your language or have a contract with Language Line Services.

- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.

You can also go to a dental clinic that is run by an academic dental center, without a referral.

**Orthodontic Care**

**MetroPlusHealth** will cover braces for children up to age 21 who have a severe problem with their teeth, such as, can't chew food due to severely crooked teeth, cleft palate, or cleft lip.

**Vision Care**

- Services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or

replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider.

- Eye exams, generally every two years, unless medically needed more often
- Glasses (new pair of Medicaid-approved frames every two years, or more often if medically needed)
- Low-vision exam and vision aids ordered by your doctor
- Specialist referrals for eye diseases or defects
- Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period

**Hospital Care**

- Inpatient care
- Outpatient care
- Lab, X-ray, and other necessary tests

**Emergency Care**

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the Emergency Room, in an inpatient hospital room, or in another setting. This is called **Post Stabilization Services**.
- For more about emergency services, see Part I.

**Specialty Care**

Includes the services of other practitioners, including:

- physical therapist
- occupational and speech therapists
- audiologist
- midwives
- cardiac rehabilitation

**Residential Health Care Facility Care (Nursing Home)**

Includes short-term, or rehab, stays and long-term care;

- must be ordered by a physician and authorized by MetroPlusHealth;
- covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy, and speech-language pathology.

**Rehabilitation:**

MetroPlusHealth covers short-term, or rehabilitation (also known as “rehab”) stays, in a skilled nursing home facility.

**Long-Term Placement:**

MetroPlusHealth covers long-term placement in a nursing home facility for members 21 years of age and older.

**Long-term placement means you will live in a nursing home.**

When you are eligible for long-term placement, you may select one of the nursing homes that are in the MetroPlusHealth network that meets your needs. Call 800.303.9626 for help finding a nursing home in our network.

If you want to live in a nursing home that is not part of the MetroPlusHealth network, you must transfer to another plan that has your chosen nursing home in its network. Call New York Medicaid Choice at 800.505.5678 for help with questions about nursing home providers and plan networks.

**Eligible Veterans, Spouses of Eligible Veterans, or eligible Gold Star Parent of Eligible Veterans may choose to stay in a Veterans’ nursing home.**

If you are an eligible veteran, spouse of an eligible veteran, or an eligible Gold Star parent of an eligible veteran, and you want to live in a veterans’ home, we will help arrange your admission in a veteran’s home in our operating network. If MetroPlusHealth does not have a veteran’s home in our operating network, you may transfer to another Medicaid Managed Care Plan that has a veteran’s home in its network.

**Determining Your Medicaid Eligibility for Long-Term Nursing Home Services**

You must apply to your Local Department of Social Services (LDSS) to have Medicaid and/or MetroPlusHealth pay for long-term nursing home services. The LDSS will review your income and assets to determine your eligibility for long-term nursing home services. The LDSS will let you know about any costs you may have to contribute toward your long-term nursing home care.

**Additional Resources**

If you have concerns about long-term nursing home care, choosing a nursing home, or the effect on your finances, there are additional resources to help.

- Independent Consumer Advocacy Network (ICAN) provides free and confidential

assistance. Call 844.614.8800, or visit **icannys.org**.

- New York State Office for the Aging
  - Health Insurance Information, Counseling and Assistance (HIICAP) provides free counseling and advocacy on health insurance questions. Call 800.701.0501.
  - NY CONNECTS is a link to long-term service and supports. Call 800.342.9871 or visit **nyconnects.ny.gov**.
- Nursing Home Bill of Rights (NHBOR) describes your rights and responsibilities as a nursing home resident. To learn more about NHBOR, visit **health.ny.gov/facilities/nursing/rights/**.

**Behavioral Health Care**

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to behavioral health services, which include:

**Adult Mental Health Care**

- Psychiatric services
- Psychological services
- Inpatient and outpatient mental health treatment
- Injections for behavioral health-related conditions
- Rehab services if you are in a community home or in family-based treatment
- Individual and group counseling through Office of Mental Health (OMH) clinics

**Adult Outpatient Mental Health Care**

- Continuing Day Treatment (CDT)
- Partial Hospitalization (PH)

**Adult Outpatient Rehabilitative Mental Health Care**

- Assertive Community Treatment (ACT)

Personalized Recovery Oriented Services (PROS)**Adult Mental Health Crisis Services**

- Comprehensive Psychiatric Emergency Program (CPEP), including extended observation bed

- Crisis intervention services
    - Mobile Crisis and Telephonic Crisis Services
- Crisis Residential Programs:
    - Residential Crisis Support: This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.
    - Intensive Crisis Residence: This is a treatment program for people who are age 18 or older who are having severe emotional distress.

**Substance Use Disorder Services for Adults age 21+**

- Crisis Services/Detoxification
    - Medically Managed Withdrawal and Stabilization Services
    - Medically Supervised Inpatient Withdrawal and Stabilization Services
    - Medically Supervised Outpatient Withdrawal and Stabilization Services
- Inpatient Rehabilitation Services
- Residential Addiction Treatment Services
    - Stabilization
    - Rehabilitation
    - Reintegration
- Outpatient Addiction Treatment Services
    - Outpatient Clinic
        - Intensive Outpatient Treatment
        - Ancillary Withdrawal Services
        - Medication Assisted Treatment
    - Outpatient Rehabilitation Services
    - Opioid Treatment Programs (OTP)
- Gambling Disorder Treatment Provided by Office of Addiction Services and Supports (OASAS) Certified Programs
    - MetroPlusHealth covers Gambling Disorder Treatment provided by Office of Addiction Services and Supports (OASAS) certified programs.
    - You can get Gambling Disorder Treatment:
        - face-to-face; or
        - through telehealth.
    - If you need Gambling Disorder Treatment, you can get it from an OASAS outpatient program or if necessary, an OASAS inpatient or residential program.
    - You do not need a referral from your primary care provider (PCP) to get these services. If you need help finding a provider, please call MetroPlusHealth Member Services at 800.303.9626.

## Harm Reduction Services

If you are in need of help related to a substance use disorder, Harm Reduction Services can offer a complete patient-oriented approach to your health and well-being. MetroPlusHealth covers services that may help reduce substance use and other related harms. These services include:

- A plan of care developed by a person experienced in working with substance users.
- Individual supportive counseling that assists in achieving your goals.
- Group supportive counseling in a safe space to talk with others about issues that affect your health and well-being.
- Counseling to help you with taking your prescribed medication and continuing treatment.
- Support groups to help you better understand substance use and identify coping techniques and skills that will work for you.

To learn more about these services, call Member Services at 800.303.9626 (TTY:711).

## Children's Behavioral Health Services

MetroPlusHealth covers more behavioral health services for children and youth. You can get these services by using your health plan card.

Some of these services may already be covered by MetroPlusHealth for certain eligible children under age 21.

Members under age 21 are able to get these Substance Use Disorder Services (provided by the Office of Addiction Services and Supports):

- Crisis Services
  - Medically Managed Withdrawal and Stabilization Services
  - Medically Supervised Inpatient Withdrawal and Stabilization Services
  - Medically Supervised Outpatient Withdrawal and Stabilization Services
- Inpatient Rehabilitation Services
- Residential Addiction Treatment Services
  - Stabilization
  - Rehabilitation
  - Reintegration
- Outpatient Addiction Treatment Services
  - Outpatient Clinic
    - Intensive Outpatient Treatment

        - Ancillary Withdrawal Services
        - Medication Assisted Treatment
    - Outpatient Rehabilitation Services
    - Opioid Treatment Programs (OTP)

MetroPlusHealth will cover these services for all eligible children and youth under age 21, including those:

- with Supplemental Security Income (SSI);
- who have federal Social Security Disability Insurance (SSDI) status; or
- who have been determined certified disabled by a New York State Medical Disability Review.

**Mental Health Care for Individuals Under Age 21**

All eligible children under age 21:

- Comprehensive Psychiatric Emergency Program (CPEP), including Extended Observation bed
- Partial hospitalization (PH)
- Inpatient psychiatric services
- Individual and group counseling through OMH clinics
- Children and Family Treatment and Support Services (CFTSS), including:
    - Other Licensed Practitioner (OLP)
    - Psychosocial Rehabilitation (PSR)
    - Community Psychiatric Supports and Treatment (CPST)
    - Family Peer Support Services (FPSS)
    - Crisis Intervention (CI)
    - Youth Peer Support (YPS)
- Psychiatric services
- Psychological services
- Injections for behavioral-health-related conditions
- Children's Crisis Residence. This is a support and treatment program for people under age 21. These services help people cope with an emotional crisis and return to their home and community.

**Mental Health Services for Eligible Children under Age 21 (ages 18-20):**

- Assertive Community Treatment (ACT)
- Continuing Day Treatment (CDT)
- Personalized Recovery Oriented Services (PROS)
- Crisis Residential Programs:
  - Residential Crisis Support. This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.
  - Intensive Crisis Residence. This is a treatment program for people who are age 18 or older who are having severe emotional distress.

**Substance Use Disorder Care for Individuals Under Age 21**

- Crisis Services/Detoxification
  - Medically Managed Withdrawal and Stabilization Services
  - Medically Supervised Inpatient Withdrawal and Stabilization Services
  - Medically Supervised Outpatient Withdrawal and Stabilization Services
- Inpatient Rehabilitation Services
- Residential Addiction Treatment Services
  - Stabilization
  - Rehabilitation
  - Reintegration
- Outpatient Addiction Treatment Services
  - Outpatient Clinic
    - Intensive Outpatient Treatment
    - Ancillary Withdrawal Services
    - Medication-Assisted Treatment
  - Outpatient Rehabilitation Services
  - Opioid Treatment Programs (OTP)

**Children's Home and Community Based Services (HCBS)**

New York State covers Children's Home and Community Based Services (HCBS) under the children's waiver. MetroPlusHealth covers children's HCBS for members participating in the children's waiver and provides care management for these services.

Children's HCBS offer personal, flexible services to meet the needs of each child/youth. HCBS are provided where children/youth and families are most comfortable and supports them as they work towards goals and achievements.

| | |
|---|---|
| Member Services: | 800.303.9626 (TTY: 711) |
| For Behavioral Health Crisis, call our hotline toll-free: | 866.728.1885 |

**Who can get Children's HCBS?**

Children's HCBS are for children and youth who:

- Need extra care and support to remain at home/in the community
- Have complex health, developmental, and/or behavioral health needs
- Want to avoid going to the hospital or a long-term care facility
- Are eligible for HCBS and participate in the children's waiver

Members under age 21 will be able to get these services from their health plan:

- Community habilitation
- Day habilitation
- Caregiver/Family Advocacy and Support Services
- Prevocational services – *must be age 14 and older*
- Supported employment – *must be age 14 and older*
- Respite services (planned respite and crisis respite)
- Palliative care
    - Expressive Therapy
    - Massage Therapy
    - Bereavement Service
    - Pain and Symptom Management
    - Non-medical Transportation

Members under age 21 will access the following services through designated health homes using your Medicaid card:

- Environmental modifications
- Vehicle modifications
- Adaptive and Assistive Technology

Children/youth participating in the Children's Waiver must receive care management. Care management provides a person who can help you find and get the services that are right for you.

- If you are getting care management from a Health Home Care Management Agency (CMA), you can stay with your CMA. MetroPlusHealth will work with your CMA to help you get the services you need.
- If you are getting care management from the Children and Youth Evaluation Service (C-YES), MetroPlusHealth will work with C-YES and provide your care management.

**Article 29-I Voluntary Foster Care Agency (VFCA) Health Facility Services**

| | |
|---|---|
| Member Services: | 800.303.9626 (TTY: 711) |
| For Behavioral Health Crisis, call our hotline toll-free: | 866.728.1885 |

MetroPlusHealth covers Article 29-I VFCA Health Facility services for children and youth under age 21.

29-I VFCA Health Facilities work with families to promote well-being and positive outcomes for children in their care. 29-I VFCA Health Facilities use trauma-informed practices to meet the unique needs of each child.

29-I VFCA Health Facilities may only serve children and youth referred by the local district of social services.

The 29-I VFCA Health Facility services include:

**Core Limited Health-Related Services**

1. Skill Building
2. Nursing Supports and Medication Management
3. Medicaid Treatment Planning and Discharge Planning
4. Clinical Consultation and Supervision
5. Managed Care Liaison/Administration

and

**Other Limited Health-Related Services**

1. Screening, diagnosis, and treatment services related to physical health
2. Screening, diagnosis, and treatment services related to developmental and behavioral health
3. Children and Family Treatment and Support Services (CFTSS)
4. Children's Home and Community Based Services (HCBS)

To learn more about these services, call Member Services at 800.303.9626 (TTY: 711).

**Health Home Care Management**

MetroPlusHealth wants to meet all of your health needs. If you have multiple health issues, you may benefit from Health Home Care Management to help coordinate all of your health services.

A Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your health care;
- Work with the people you trust, like family members or friends, to help you plan and get your care;
- Help with appointments with your PCP and other providers; and

- Help manage ongoing medical issues like diabetes, asthma, and high blood pressure.

To learn more about Health Homes, contact Member Services at 800.303.9626.

**Infertility Services**

If you are unable to get pregnant, MetroPlusHealth covers services that may help.

MetroPlusHealth will cover some drugs for infertility. This benefit will be limited to coverage for 3 cycles of treatment per lifetime.

MetroPlusHealth will cover the coordination of care related to limited infertility drugs covered by the Medicaid pharmacy program. The infertility benefit includes:

- Office visits
- X-ray of the uterus and fallopian tubes
- Pelvic ultrasound
- Blood testing

**Eligibility**

You may be eligible for infertility services if you meet the following criteria:

- You are 21 - 34 years old and are unable to get pregnant after 12 months of regular, unprotected sex.
- You are 35 - 44 years old and are unable to get pregnant after 6 months of regular, unprotected sex.

To learn more about these services, call Member Services at 800.303.9626 (TTY: 711).

**National Diabetes Prevention Program (NDPP) Services**

If you are at risk for developing Type 2 diabetes, MetroPlusHealth covers services that may help.

MetroPlusHealth will cover diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit will cover 22 NDPP group training sessions over the course of 12 months.

The **National Diabetes Prevention Program** is an educational and support program designed to assist at-risk people from developing Type 2 diabetes. The program consists of group training sessions that focus on the long-term, positive effects of healthy eating and exercise. The goals for these lifestyle changes include modest weight loss and increased physical activity. NDPP sessions are taught using a trained lifestyle coach.

**Eligibility**
You may be eligible for diabetes prevention services if you 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.

And, you meet one of the following criteria:

- You have had a blood test result in the prediabetes range within the past year, **or**
- You have been previously diagnosed with gestational diabetes, **or**
- You score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test.

Talk to your doctor to see if you qualify to take part in the NDPP.

To learn more about these services, call Member Services at 800.303.9626 (TTY: 711).

**Transportation**

Emergency and/or non-emergency medical transportation will be covered by regular Medicaid. To get non-emergency transportation, you or your provider must call Medical Answering Services (MAS) at 844.666.6270. If possible, you or your provider should call MAS at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing. Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette, and public transportation. If you require an attendant to go with you to your doctor's appointment or if your child is the member of MetroPlusHealth, transportation is also covered for the attendant or parent or guardian.

If you have an emergency and need an ambulance, you must call 911.

**<u>Note</u>: For undocumented non-citizens age 65 and over, non-emergency transportation is not covered.**

**Applied Behavior Analysis (ABA) Services**

MetroPlusHealth covers Applied Behavior Analysis (ABA) therapy provided by a:

- Licensed Behavioral Analyst (LBA), or
- Certified Behavioral Analyst Assistant (CBAA) under the supervision of an LBA.

**Who can get ABA?**
Children/youth under the age of 21 with a diagnosis of autism spectrum disorder and/or Rett Syndrome. If you think you are eligible to get ABA services, talk to your provider about this service. MetroPlusHealth will work with you and your provider to make sure you get the service you need.

**The 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.

To learn more about these services, call Member Services at 800.303.9626 (TTY: 711).

**Gender Dysphoria Related Care and Services**

MetroPlusHealth covers the following gender dysphoria related care and services:

- Gender Reassignment (sex change) Surgeries, Services, and Procedures,
- Puberty Suppressants (medications used to delay the effects of puberty), and
- Cross-Sex Hormone Therapy (hormone medications used to help with sex change).

**What is Gender Dysphoria?**
Gender Dysphoria is the feeling of discomfort or distress that might occur when there is a conflict between the sex you were assigned at birth and the gender you identify with.

**Gender Reassignment Surgery**
Prior to surgery for the treatment of gender dysphoria, you must:

- receive a medical necessity determination from a qualified medical professional,
- be 18 years of age or older. Members under 18 years of age will be reviewed on a case-by-case basis for medical necessity and must receive prior approval from MetroPlusHealth, as applicable.
- have lived in a gender role consistent with your gender identity for 12 months. During this time, you must have received behavioral health counseling, as deemed necessary by your treating qualified medical professional, and
- have two letters from qualified New York State licensed health professionals recommending surgery based upon their own assessment.

**Puberty Suppressants and Cross-Sex Hormones**
MetroPlusHealth will provide medically necessary hormone therapy for treatment of gender dysphoria.

Treatment with puberty suppressants, must be:

- based upon a determination from a qualified medical professional.

Treatment with cross-sex hormones, must meet the following age specific criteria:

- members 16 years of age or older must receive a determination of medical necessity made by a qualified professional.
- members 16 and 17 years of age must also receive a determination from a qualified medical professional that you are eligible and ready for treatment.
- members under 16 years of age, must meet the above criteria and receive prior approval from MetroPlusHealth, as applicable.

Talk to your health care provider to see if you qualify for gender dysphoria related care and services. To learn more about these services, call Member Services at 800.303.9626.

**In Lieu of Services (ILS)**

ILS are services or settings that are not covered by Medicaid but are medically appropriate substitutes for covered services or settings.

**Medically Tailored Meals (MTM)**

MetroPlusHealth offers the Medically Tailored Meals Program that provides healthy meals straight to your home. This is an alternative service in lieu of Personal Care Aide (PCA) service hours. It is used for meal preparation, food shopping, or hospital inpatient stays and/or emergency department visits.

Through this program, you and members who qualify can get:

- Help from a registered dietitian and nutritionist. This person is a food and nutrition expert and will help give guidance and support in choosing healthy foods.
- **Up to two meals per day** delivered to your home for six months at a time. You may be able to continue receiving meals as long as you are eligible for this program. These meals are tailored for your specific health needs and can help you gain access to healthy, nutritious foods.

This program is offered to Medicaid members who are 18 years of age and older. Members must have a secure place to store and heat meals, and:

- Receive personal care services. Members must choose to replace some of their meal preparation and food shopping hours while getting a medically tailored meal. The hours reduced will depend on the number of meals you receive, **or**

- Have cancer, diabetes, heart failure, or HIV/AIDS, and a certain number of inpatient hospital stays and/or emergency room (ER) visits within the last 12 months related to these conditions.

Joining this program is up to you. If you decide not to join, it will not affect your Medicaid eligibility or benefits. To learn more about these services, call Member Services at 800.303.9626 (TTY: 711).

**Inpatient Psychiatric Hospitalization in an Institution for Mental Disease (IMD)**

Short-term intensive stay in a private IMD licensed by the Office of Mental Health (OMH) is an alternative setting in lieu of the State Plan Inpatient Psychiatric services available in OMH-licensed inpatient units of Article 28 hospitals.

MetroPlusHealth offers coverage of this benefit to Adult Medicaid Members who are 21-64 years of age, and in need of medicallly necessary care in an acute inpatient psychiatric unit.

- The IMD ILS benefit is limited to up to 15 days per calendar month in one of the six IMD facilities licensed by the Office of Mental Health, if such facility is available in our plan service area.
- Your Medicaid benefit package covers inpatient psychiatric admission to these six OMH-licensed facilities up to 30 days per calendar month, or up to 60 days per year, which may be authorized as medically necessary **after** reaching the IMD ILS benefit limit.

**Other Covered Services**

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics /Orthotics
- Court Ordered Services
- Case Management
- Help getting social support services
- Federally Qualified Health Centers (FQHC)
- Services of a podiatrist as medically needed

## BENEFITS YOU CAN GET FROM METROPLUSHEALTH *OR* WITH YOUR MEDICAID CARD

For some services, you can choose where to get the care. You can get these services by using your MetroPlusHealth membership card. You can also go to providers who will take your Medicaid Benefit card. You do not need a referral from your PCP to get these services. Call us if you have questions at 800.303.9626.

### Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can visit one of our family planning providers as well. Either way, you do not need a referral from your PCP.

You can get birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

If you are in need of contraceptives, MetroPlusHealth covers some drugs, devices, and products.

You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at one time. Contraceptive drugs, devices, or products are available to you at no cost.

To learn more about this, call Member Services at 800.303.9626 (TTY: 711).

### HIV and STI Screening (when receiving this service as part of a family planning visit)

Everyone should know their HIV status. HIV and sexually transmitted infection screenings are part of your regular health care.

- You can get an HIV or STI test any time you have an office or clinic visit.

- You can get an HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with any family planning provider. If you want an HIV or STI test, but *not as part of a family planning service*, your PCP can provide or arrange it for you.

- If you'd rather not see one of our MetroPlusHealth providers, you can use your Medicaid card to see a family planning provider outside MetroPlusHealth. For help in finding either a Plan provider or a Medicaid provider for family planning services, call Member Services at 800.303.9626 (TTY: 711).

- Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call 800.541.AIDS (English) or 800.233.SIDA (Spanish).

Some tests are "rapid tests," and the results are ready while you wait. The provider who gives you the test will explain the results and arrange for follow-up care if needed. You will also learn how to protect your partner. If your test is negative, we can help you learn to stay that way.

You can ask your PCP for a list of places to get these services, or call Member Services at 800.303.9626 (TTY: 711). You can also call the New York State Growing Up Healthy Hotline (800.522.5006) for nearby places to get these services.

### Tuberculosis (TB) Diagnosis and Treatment

You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

## BENEFITS USING YOUR MEDICAID CARD ONLY

There are some services MetroPlusHealth does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid Benefit card.

### Pharmacy

You can get prescriptions, over-the-counter medicines, enteral formulas, and some medical supplies from any pharmacy that takes Medicaid. A copayment may be required for some people, for some medications and pharmacy items.

Certain medications may require that your doctor get prior authorization from Medicaid before the pharmacy can dispense your medication. Getting prior authorization is a simple process for your doctor and does not prevent you from getting medications that you need.

Do you have questions or need help? The Medicaid Helpline can assist you. They can talk to you in your preferred language. They can be reached at 800.541.2831 (TTY: 800.662.1220).

They can answer your call:

- Monday to Friday, 8am – 8pm
- Saturday, 9am – 1pm

**Transportation**

Emergency and/or non-emergency medical transportation will be covered by regular Medicaid. To get non-emergency transportation, you or your provider must call Medical Answering Services (MAS) at 844.666.6270. If possible, you or your provider should call MAS at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing. Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette, and public transportation.

For more information about how to access your transportation services, call MAS at 844.666.6270, or visit their website at **medanswering.com**.

If you have an emergency and need an ambulance, you must call 911.

**Note: For undocumented non-citizens age 65 and over, non-emergency transportation is not covered.**

**Developmental Disabilities**

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program

**SERVICES NOT COVERED:**

*These services are **not available** from MetroPlusHealth **or** Medicaid*. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Personal and comfort items

- Services from a provider that is not part of MetroPlusHealth, unless it is a provider you are allowed to see as described elsewhere in this handbook, or MetroPlusHealth or your PCP send you to that provider
- Services for which you need a referral (approval) in advance, and you did not get it
- Drugs when used to treat erectile dysfunction or sexual dysfunction

You may have to pay for any service that your PCP does not approve. Or, if before you get a service, you agree to be a "private pay" or "self-pay" patient, you will have to pay for the service. This includes:

- non-covered services (listed above),
- unauthorized services, and
- services provided by providers not part of MetroPlusHealth.

**If You Get a Bill**

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call MetroPlusHealth at 800.303.9626 right away. MetroPlusHealth can help you understand why you may have gotten a bill. If you are not responsible for payment, MetroPlusHealth will contact the provider and help fix the problem for you.

You have the right to ask for a plan appeal if you think you are being asked to pay for something Medicaid or MetroPlusHealth should cover. See the Plan Appeal section later in this handbook.

If you have any questions, call Member Services at 800.303.9626 (TYY: 711).

**SERVICE AUTHORIZATION**

**Prior Authorization**

There are some treatments and services that you need to get approval for before you receive them, or in order to be able to continue receiving them. This is called **prior authorization**. You, your provider, or someone you trust can ask for this. The following treatments and services must be approved before you get them.

Your PCP can approve referrals to **Participating Providers** for:

- Specialty care
- Laboratory services

You or your PCP must get an OK from MetroPlusHealth if you:

- Are referred to a provider who is not in the MetroPlusHealth network, unless you require care in an emergency room
- Are given a standing referral to a specialist
- Are admitted to a hospital, unless it is an emergency or to deliver a baby
- Are having outpatient surgery at any hospital except an HHC hospital
- Are having potentially cosmetic procedures at any facility
- Receive treatments for erectile dysfunction disorders
- Receive chiropractic care
- Receive prenatal or genetic testing
- Participation in clinical trials
- Receive infusion therapy in the home
- Receive a transplant
- Receive airborne emergent transportation
- Receive non-emergent transportation
- Receiving anesthesia for oral surgery
- Are needing contact lenses
- Requiring transgender services
- Requiring Treatment Adherence services
- Are assigned a private-duty nurse in the hospital
- Are admitted to a skilled nursing facility or an acute rehabilitation facility, including all physician services provided during an admission to a skilled nursing facility
- Are admitted to a hospital for Directly Observed Therapy for Tuberculosis Disease
- Receive home care services
- Receive hospice services
- Receive Personal Care Services or Consumer-Directed Personal Assistance Program Services
- Request PERS (Personal Emergency Response System)
- Receive adult day health care or AIDS adult day health care
- Receive long-term nursing home care
- Obtain durable medical equipment (DME) including orthotics, prosthetics, enteral formula and supplies (formula is obtained through the State), autism spectrum disorders-related DME
- Receive more than 20 visits of physical, occupational, or speech therapy.

**Note:** Prior authorization **is not** required for medically necessary SUD inpatient services including detoxification, rehabilitation, or OASAS-authorized residential treatment.

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services, you need to:

Call Member Services at 800.303.9626, or send your request by fax to 212.908.8521. A Member Services representative will answer any questions you have about the process and will transfer your call to the Utilization Review (UR) Department, if needed. Utilization review is what we do to decide whether treatment is medically necessary and will be approved or paid for by MetroPlusHealth. Doctors and nurses make the decisions. They do this by checking your treatment plan against medically acceptable standards. Our UR staff is available 8:30am to 5:00pm, Monday through Friday. We have a 24-Hour Health Care Hotline number (**800.442.2560**) to use if you need assistance with a medical problem. UR staff will respond to your message on the next business day.

You or your doctor may also submit a service authorization request in writing by sending it to:

MetroPlusHealth
50 Water Street
New York, NY 10004
Attention: Prior Authorization

You will also need to get prior authorization if you are getting one of these services now but need to continue or get more of the care. This is called **concurrent review**.

**What happens after we get your service authorization request**

MetroPlusHealth has a review team to be sure you get the services you need. We check that the service you are asking for is covered under your health plan. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, we use to make decisions about medical necessity.

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| Member Services: | 800.303.9626 (TTY: 711) |
| For Behavioral Health Crisis, call our hotline toll-free: | 866.728.1885 |

After we get your request, we will review it under a **standard** or **fast-track** process. You or your doctor can ask for a fast-track review if it is believed that a delay will cause serious harm to your health. If your request for a fast-track review is denied, we will tell you and your case will be handled under the standard review process.

We will fast track your review if:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the review must be faster:
- You are asking for more of a service you are getting right now;

In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision. (See also the Plan Appeals and Fair Hearing sections later in this handbook.)

**Timeframes for prior authorization requests:**

- **Standard review**. We will make a decision about your request within 3 working days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

- **Fast-track review**. We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

**Timeframes for concurrent review requests:**

- **Standard review**. We will make a decision within 1 working day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.

- **Fast track review**. We will make a decision within 1 working day of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within 1 working day if we need more information.

**Special timeframes for other requests**

- If you are in the hospital or have just left the hospital and you are asking for home health care, we will make a decision within 72 hours of your request.
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your request.
- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.

If we need more information to make either a standard or fast-track decision about your service request, we will:

- Write and tell you what information is needed. If your request is in a fast-track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give us to help decide your case. This can be done by calling 800.303.9626 or writing to:

MetroPlusHealth
50 Water Street
New York, NY 10004
Attention: Prior Authorization

You or your representative can file a complaint with MetroPlusHealth if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 800.206.8125.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If we do not respond to a request to override a step therapy protocol on time, your request will be approved.

If you think our decision to deny your service authorization request is wrong, you have the right to file a Plan Appeal with us. *See the Plan Appeal section later in this*

*handbook.*

**Other Decisions About Your Care**

Sometimes we will do a concurrent review on the care you are receiving, to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we make these decisions.

**Timeframes for notice of other actions**

- In most cases, if we make a decision to reduce, suspend, or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- We must tell you at least 10 days before we make any decision about long-term services and supports, such as home health care, personal care, CDPAS, adult day health care, and nursing home care.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving all information we need for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by MetroPlusHealth or by Medicaid, even if we later deny payment to the provider.**

## HOW OUR PROVIDERS ARE PAID

You have the right to ask us whether we have any special financial arrangement with our providers that might affect your use of health care services. You can call Member Services at 800.303.9626 if you have specific concerns. Most of our providers are paid in one or more of the following ways.

- Most PCPs who work in a clinic or health center get a **salary.** The number of patients they see does not affect their salary.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same regardless of the number of times the patient visits the PCP. This is called **capitation**.
- Providers may get a set fee for each person on their patient list, but some money may be held back for an **incentive** fund. At the end of the year, PCPs who have met the incentive standards set by MetroPlusHealth receive additional payments.
- Providers may also receive **fee-for-service payment.** This means they get a set fee for each service they provide.

## YOU CAN HELP WITH PLAN POLICIES

You can help us develop policies that best serve our members. If you have ideas, please tell us about them. Please let us know if you would like to work with one of our member advisory boards or committees. Call Member Services at 800.303.9626 to find out how you can help.

### Additional Information From Member Services

Here is information you can get by calling Member Services at 800.303.9626:

- A list of names, addresses, and titles of MetroPlusHealth's Board of Directors, Officers, Controlling Parties, Owners, and Partners
- A copy of the most recent financial statements/balance sheets, summaries of income, and expenses
- A copy of the most recent individual direct-pay subscriber contract
- Information from the Department of Financial Services about consumer complaints about MetroPlusHealth
- How we keep your medical records and member information private
- In writing, we will tell you how MetroPlusHealth checks on the quality of care to our members.
- We will tell you which hospitals our health providers we work with.

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| Member Services: | 800.303.9626 (TTY: 711) |
| For Behavioral Health Crisis, call our hotline toll-free: | 866.728.1885 |

- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by MetroPlusHealth.
- If you ask in writing, we will tell you the qualifications needed and how health care providers can apply to be part of MetroPlusHealth.
- If you ask, we will tell you:
    1. whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so,
    2. information on the type of incentive arrangements used; and
    3. whether stop-loss protection is provided for physician and physician groups.
- Information about how our company is organized and how it works.

**KEEP US INFORMED**

Call Member Services at 800.303.9626 whenever these changes happen in your life:

- You change your name, address, or telephone number
- You have a change in Medicaid eligibility
- You are pregnant
- You give birth
- There is a change in insurance for you or your children.

**If you no longer get Medicaid**, you *may* be able to enroll in another program. Contact your local Department of Social Services, or NY State of Health, The Official Health Plan Marketplace, at 855.355.5777, or **nystateofhealth.ny.gov**.

**DISENROLLMENT AND TRANSFERS**

**1. If YOU want to leave MetroPlusHealth**

You can try us out for 90 days. You may leave MetroPlusHealth and join another health plan at any time during that time. If you do not leave in the first 90 days, however, you must stay in MetroPlusHealth for nine more months, *unless* you have a good reason (good cause) to leave our Plan.

Some examples of good cause include:

- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.

- You, MetroPlusHealth, and the Local Department of Social Services all agree that disenrollment is best for you.
- You are or become exempt or excluded from managed care.
- We have not been able to provide services to you as we are required to under our contract with the State.

To change plans:

If you've enrolled through your Local Department of Social Services (LDSS):

- Call the Managed Care staff at your LDSS.
- If you live in Bronx, Kings, New York, Richmond, or Queens, call New York Medicaid Choice at 800.505.5678. The New York Medicaid Choice counselors can help you change health plans.

If you've enrolled through NY State of Heath:

- Log on to your NY State of Health account at **nystateofhealth.ny.gov**, or
- Meet with an enrollment assistor to receive assistance with updating your account, or
- Call the NY State of Health Customer Service Center at 855.355.5777 (TTY: 800.662.1220).

You may be able to transfer to another plan over the phone. If you have to be in managed care, you will have to choose another health plan.

It may take between two and six weeks to process, depending on when your request is received. You will get a notice that the change will take place by a certain date. MetroPlusHealth will provide the care you need until then.

You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Call your Local Department of Social Services or New York Medicaid Choice.

**2. You Could Become Ineligible for MetroPlusHealth Medicaid Managed Care**

- You or your child may have to leave MetroPlusHealth if you or the child:
    - move out of the county or service area
    - change to another managed care plan,
    - have access to an HMO or other insurance plan through work,
    - go to prison, or

    - otherwise lose Medicaid eligibility.

- Your child may have to leave MetroPlusHealth or change plans if they:
    - join a Physically Handicapped Children's Program, or

- **If you have to leave MetroPlusHealth or become ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home**. Call New York Medicaid Choice at 800.505.5678 right away if this happens.

**3. We Can Ask You to Leave MetroPlusHealth**

You can also lose your MetroPlusHealth membership, if you often:

- refuse to work with your PCP regarding your care,
- don't follow MetroPlusHealth's rules,
- do not fill out forms honestly or do not give true information (commit fraud),
- cause abuse or harm to plan members, providers or staff, or
- act in ways that make it hard for us to do our best for you and other members, even after we have tried to fix the problems.

**PLAN APPEALS**

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **Initial Adverse Determination**.

If you are not satisfied with our decision about your care, there are steps you can take.

**Your provider can ask for reconsideration:**

If we made a decision that your service authorization request was not medically necessary, or was experimental or investigational, and we did not talk to your doctor about it, your doctor may ask to speak with our Medical Director. The Medical Director will talk to your doctor within one work day.

**You can file a Plan Appeal:**

If you think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a **Plan Appeal**.

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services at 800.303.9626 if you need help asking for a Plan Appeal or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor, or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

**Aid to continue while appealing a decision about your care:**

If we decided to reduce, suspend, or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. You must ask for your Plan Appeal:

- **Within 10 days from being told that your care is changing; or**
- **By the date the change in services is scheduled to occur, whichever is later.**

If your Plan Appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

You can call or write to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters, or other information that explains why you need the service.
- Any specific information we said we needed in the *Initial Adverse Determination* notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records, and other documents we used to make the Initial Adverse

Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling 800.303.9626.

Give us your information and materials by phone, fax, or mail:

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| Phone..... | 800.303.9626 |
| Fax..... | 212.908.8824 |
| Mail..... | Appeals Coordinator<br>50 Water Street<br>New York, NY 10004 |

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing.

If you ask for a standard Plan Appeal orally, you will also need to ask for it in writing. (You won't have to do this for an expedited Plan Appeal.) When you file a standard Plan Appeal orally, we have to tell you that you need to ask us in writing too. We may choose to send you a summary of the Plan Appeal. You will need to sign and return the summary.

If we get an appeal request from you orally, we will send you a letter with a summary of the appeal. The letter will also give you the option to review and change your request.

If you are asking for an out-of-network service or provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:

    1. a statement in writing from your doctor that the out-of-network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board-certified or board-eligible specialist who treats people who need the service you are asking for.
    2. two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

    If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. *See the External Appeal section later in this handbook*.

- If you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out-of-network provider. You will need to ask your doctor to send this information with your appeal:

    1. a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
    2. a recommendation to an out-of-network provider with the correct training and experience who is able to provide the service.

    Your doctor must be a board-certified or board-eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. *See the External Appeal section later in this handbook.*

**What happens after we get your Plan Appeal:**

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call MetroPlusHealth at 800.303.9626 if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination**.
- **If you think our Final Adverse Determination is wrong:**
    - you can ask for a Fair Hearing. *See the Fair Hearing section of this handbook.*
    - for some decisions, you may be able to ask for an External Appeal. *See the External Appeal section of this handbook.*

- you may file a complaint with the New York State Department of Health at 800.206.8125.

**Timeframes for Plan Appeals:**

- **Standard Plan Appeals:** If we have all the information we need, we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.

- **Fast-track Plan Appeals:** If we have all the information we need, fast-track Plan Appeal decisions will be made in 2 working days from your Plan Appeal, but not more than 72 hours from when you asked for your Plan Appeal.
  - We will tell you within 72 hours if we need more information.
  - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
  - We will tell you our decision by phone and send a written notice later.

**Your Plan Appeal will be reviewed under the fast-track process if:**

- you or your doctor asks to have your Plan Appeal reviewed under the fast-track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your Plan Appeal will be reviewed under the standard process; **or**
- your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- your request was denied when you asked for home health care after you were in the hospital; or
- your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

If we need more information to make either a standard or fast-track decision about your Plan Appeal, we will:

- Write you and tell you what information is needed. If your request is in a fast-track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest; and
- Make a decision no later than 14 days from the day we asked for more information.

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give MetroPlusHealth to help decide

your case. This can be done by calling 800.303.9626, or by writing.

You or your representative can file a complaint with MetroPlusHealth if you don't agree with our decision to take more time to review your Plan Appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 800.206.8125.

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. *See the Fair Hearing section of this handbook.*

The original denial will be reversed and your service authorization request will be approved if we do not decide your Plan Appeal on time, and we said the service you are asking for is:

1. not medically necessary, or
2. experimental or investigational, or
3. not different from care you can get in the plan's network, or
4. available from a participating provider who has the correct training and experience to meet your needs.

**External Appeals**

You have other appeal rights if the service you are asking for was:

1. not medically necessary
2. experimental or investigational
3. not different from care you can get in the plan's network
4. available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State (NYS) for an independent **External Appeal**. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or NYS. These reviewers are qualified people approved by NYS. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; **or**

- If you have not gotten the service, and you ask for a fast-track Plan Appeal, you may ask for an expedited External Appeal at the same time. Your doctor will have to say an expedited External Appeal is necessary; **or**
- You and MetroPlusHealth may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove MetroPlusHealth did not follow the rules correctly when processing your Plan Appeal.

You have **4 months** after you receive MetroPlusHealth's Final Adverse Determination to ask for an External Appeal. If you and MetroPlusHealth agreed to skip our appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at 800.303.9626 if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services at 800.400.8882.
- Go to the Department of Financial Services' website at **dfs.ny.gov/**.
- Contact the health plan at 800.303.9626.

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and MetroPlusHealth will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health; or
- You are in the hospital after an emergency room visit and the hospital care is denied by your plan.

This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- you ask for a fast-track Plan Appeal within 24 hours, **AND**
- you ask for a fast-track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast-track Plan Appeal in 24 hours. The fast-track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends, or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

**Fair Hearings**

You may ask for a Fair Hearing from New York State if:

- You are not happy with a decision your Local Department of Social Services or the State Department of Health made about your staying with or leaving MetroPlusHealth.

- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the *Notice of Intent to Restrict* to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the *Notice of Intent to Restrict*, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.

- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with MetroPlusHealth. If we agree with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.

- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
    - reduce, suspend, or stop care you were getting; or
    - deny care you wanted;

- deny payment for care you received; or
- did not let you dispute a copay amount, other amount you owe, or payment you made for your health care.

You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will then have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

**If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you are getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination, or by the time the action takes effect, whichever is later.** However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.

The decision you receive from the fair hearing officer will be final.

You can use one of the following ways to request a Fair Hearing:

1. By phone call toll-free 800.342.3334
2. By fax 518.473.6735
3. By internet **otda.state.ny.us/oah/forms.asp**
4. By mail New York State Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   Managed Care Hearing Unit
   P.O. Box 22023
   Albany, NY 12201-2023

When you ask for a Fair Hearing about a decision MetroPlusHealth made, we must send you a copy of the **evidence packet.** This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 800.303.9626 to ask for it.

Member Services: 800.303.9626 (TTY: 711)
For Behavioral Health Crisis, call our hotline toll-free: 866.728.1885

Remember, you may complain anytime to the New York State Department of Health by calling 800.206.8125.

## COMPLAINT PROCESS

### Complaints

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services, you can file a complaint with MetroPlusHealth. Problems that are not solved right away over the phone, and any complaint that comes in the mail, will be handled according to our complaint procedure, as described below.

You can call Member Services at 800.303.9626 if you need help filing a complaint or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 800.206.8125, or write to: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, NY 12237.

If you have a complaint against a BH provider or OMH facility, you can instead contact the New York State Office of Mental Health phone number for Complaints at 800.597.8481.

You may also contact your Local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at 800.342.3736 if your complaint involves a billing problem.

### How to File a Complaint

You can file a complaint, or you can have someone else, like a family member, friend, doctor, or lawyer, file the complaint for you. You and that person will need to sign and date a statement saying you want that person to represent you.

To file by phone, call Member Services at 800.303.9626, Monday to Friday, 8am - 8pm, and Saturday 9am - 5pm. If you call us after hours, leave a message. We will call you

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| Member Services: | 800.303.9626 (TTY: 711) |
| For Behavioral Health Crisis, call our hotline toll-free: | 866.728.1885 |

back the next work day. If we need more information to make a decision, we will tell you.
You can write us with your complaint to:

MetroPlusHealth
50 Water Street
New York, NY 10004
Attention: Complaints Manager

Or, call the Member Services number and request a complaint form. It should be mailed to:

MetroPlusHealth
50 Water Street
New York, NY 10004

**What Happens Next**

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

You can also provide information to be used reviewing your complaint in person or in writing. Call MetroPlusHealth at 800.303.9626 if you are not sure what information to give us.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified health care professionals.

**After we review your complaint:**

- We will let you know our decision within 45 days from when we have all the information we need to answer your complaint. You will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision within 48 hours from when we have all the information we need to answer your complaint. You will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied, and we will include any forms you may need to complete.

- If we are unable to make a decision about your complaint because we don't have enough information, we will send a letter and let you know.

**Complaint Appeals**

If you disagree with a decision we made about your complaint, you can file a **complaint appeal** with MetroPlusHealth.

**How to make a complaint appeal:**

- If you are not satisfied with what we decide, you have at least 60 working days after hearing from us to file a complaint appeal.
- You can do this yourself or ask someone you trust to file the complaint appeal for you.
- The complaint appeal must be made in writing. If you make a complaint appeal by phone, it must be followed up in writing to:

MetroPlusHealth
50 Water Street
New York, NY 10004
Attention: Complaints Manager

- After your call, we will send you a form, which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

**What happens after we get your complaint appeal:**

After we get your complaint appeal, we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint appeal
- how to contact this person
- if we need more information

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

If we have all the information we need, you will know our decision in 30 working days. If

a delay would risk your health, you will get our decision in 2 working days from when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 800.206.8125.

## MEMBER RIGHTS AND RESPONSIBILITIES

### Your Rights

As a member of MetroPlusHealth, you have a right to:

- Be cared for with respect, without regard for health status, gender, race, color, religion, national origin, age, marital status, or sexual orientation.
- Be told where, when, and how to get the services you need from MetroPlusHealth.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use the MetroPlusHealth complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the NYS State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

### Your Responsibilities

As a member of MetroPlusHealth, you agree to:

- Work with your PCP to guard and improve your health.
- Find out how your health care system works.

- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect to receive yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel an appointment, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after hours.

## ADVANCE DIRECTIVES

There may come a time when you are not able to decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out.

- First, let family, friends, and your doctor know what kinds of treatment you do or don't want.
- Second, you can appoint an adult you trust to make decisions for you.
- Third, it is best if you put your thoughts in writing.

### Health Care Proxy

A health care proxy form allows you to name another adult that you trust (usually a family member or a friend) to make decisions about your medical care if you are not able to make your own decisions. You should talk with the person you choose so they know about your wishes. To get Health Care Proxy forms, talk to your provider or go to **health.ny.gov/forms**.

### Do Not Resuscitate (DNR)

You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

**Organ Donor Card**

This wallet-sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

**IMPORTANT PHONE NUMBERS**

Your PCP:_____

Your nearest emergency room: _____

MetroPlusHealth

Member Services: 800.303.9626
Member Services TTY/TDD: 711

Other Units (e.g., Nurse Hotline, Utilization Review, etc.):

_____

_____

New York State Department of Health (complaints)..... 800.206.8125
New York State Office of Mental Health (OMH) Complaints ..... 800.597.8481
New York State Office of Addiction Services and
Supports (OASAS) Complaints..... 518.473.3460

Ombudsman: CHAMP..... 888.614.5400
Mailbox (Ombuds@oasas.ny.gov)

County Department of Social Services..... 718.557.1399

New York Medicaid Choice ..... 800.505.5678

New York State HIV/AIDS Hotline..... 800.541.AIDS (2437)
Spanish..... 800.233.SIDA (7432)
TDD ..... 800.369.AIDS (2437)

New York City HIV/AIDS Hotline (English & Spanish).....800.TALK.HIV (8255-448)

HIV Uninsured Care Programs..... 800.542.AIDS (2437)
TDD ..... Relay, then 518.459.0121

Child Health Plus..... 800.698.4543
- Free or low-cost health insurance for children (TTY: 877.898.5849)

Independent Consumer Advocacy Network (ICAN) ..... 844.614.8800
- Provides free and confidential assistance

Member Services: 800.303.9626 (TTY: 711)
For Behavioral Health Crisis, call our hotline toll-free: 866.728.1885

Partner Assistance Program ..... 800.541.AIDS (2437)
- In New York City (CNAP)..... 212.693.1419

Social Security Administration..... 800.772.1213

New York State Domestic Violence Hotline..... 800.942.6906
Spanish..... 800.942.6908
Hearing Impaired ..... 800.810.7444

Americans with Disabilities Act (ADA) Information Line... ..... 800.514.0301
TDD ..... 800.514.0383

Local Pharmacy ..... _____

Other Health Providers:

_____

_____

**IMPORTANT WEBSITES**

MetroPlusHealth
**metroplus.org**

New York State Department of Health (DOH):
**health.ny.gov**

New York State Office of Mental Health (OMH):
**omh.ny.gov**

New York State Office of Addiction Services and Supports (OASAS):
**oasas.ny.gov**

New York State DOH HIV/AIDS Information:
**health.ny.gov/diseases/aids/**

New York State HIV Uninsured Care Programs:
**health.state.ny.us/diseases/aids/resources/adap/index.htm**

HIV Testing Resource Directory:
**health.ny.gov/diseases/aids/consumers/testing/index.htm**

New York City Department of Health & Mental Hygiene (DOHMH):
**nyc.gov/site/doh/index.page**

Member Services: 800.303.9626 (TTY: 711)
For Behavioral Health Crisis, call our hotline toll-free: 866.728.1885

New York City DOHMH HIV/AIDS Information:
**nyc.gov/site/doh/health/health-topics/aids-hiv.page**

✓MetroPlusHealth

**NOTICE OF NON-DISCRIMINATION**

**MetroPlus Health Plan** complies with Federal civil rights laws. **MetroPlus Health Plan** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

## **MetroPlus Health Plan** provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

## If you need these services, call **MetroPlus Health Plan** at 1-800-303-9626. For TTY/TDD services, call 711.

If you believe that **MetroPlus Health Plan** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **MetroPlus Health Plan** by:

| | |
|---|---|
| Mail: | 50 Water Street, 7th Floor, New York, NY 10004 |
| Phone: | 1-800-303-9626 (for TTY/TDD services, call 711) |
| Fax: | 1-212-908-8705 |
| In person: | 50 Water Street, 7th Floor, New York, NY 10004 |
| Email: | Grievancecoordinator@metroplus.org |

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

| | |
|---|---|
| Web: | Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf |
| Mail: | U.S. Department of Health and Human Services<br>200 Independence Avenue SW., Room 509F, HHH Building<br>Washington, DC 20201<br>Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html |
| Phone: | 1-800-368-1019 (TTY/TDD 800-537-7697) |

**Language Assistance**

| | |
|---|---|
| ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-303-9626 (TTY: 711). | English |
| ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-303-9626 (TTY: 711). | Spanish |
| 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-303-9626 (TTY: 711). | Chinese |
| ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-303-9626(TTY:711 رقم هاتف الصم والبكم) | Arabic |
| 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-800-303-9626 (TTY: 711) 번으로 전화해 주십시오. | Korean |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-303-9626 (телетайп: TTY: 711). | Russian |
| ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-303-9626 (TTY: 711). | Italian |
| ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-303-9626 (TTY: 711). | French |
| ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-303-9626 (TTY: 711). | French Creole |
| אויפמערקזאם: אויב איר רעדט אידיש, זענען פאראהאן פאר אייך שפראך הילף סערוויסעס פרײַ פון אפצאל. רופט 1-800-303-9626 (TTY: 711). | Yiddish |
| UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-303-9626 (TTY: 711) | Polish |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-303-9626 (TTY: 711). | Tagalog |
| লক্ষ করুনঃ যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-800-303-9626 (TTY: 711) | Benga |
| KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-303-9626 (TTY: 711). | Albanian |
| ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-303-9626 (TTY: 711). | Greek |
| خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-800-303-9626 (TTY: 711) | Urdu |

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