Primary Care & Specialist Provider Orientation

October 2024

PRV 24.091

Metro Plus Health

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METROPLUSHEALTH OVERVIEW

- MetroPlusHealth is a Prepaid Health Services Plan (PHSP) licensed to operate in all 5 NYC boroughs. Headquartered at 50 Water Street, in lower Manhattan.
- MetroPlusHealth, which began operations in 1985, is a wholly owned subsidiary of NYC Health + Hospitals.
- 2023 MetroPlusHealth Highlights:
  - We had over 713,000 members across all our lines of business
  - Nearly 1 in 5 New Yorkers who enrolled in EP, Medicaid, or Child Health were our members
  - Highest quality score ever in Medicare: 4-star rating from the Centers for Medicare & Medicaid
  - Highest Google review rating ever: Over 4.3 stars out of 5.
  - Highest QHP membership retention rate ever: Over 87% retention rate
- Ranked #1 in overall quality in the 2020 Medicaid Quality Incentive Program, according to the NYS Department of Health's 2020 Quality Incentive results.

Member Eligibility Verification

- Members' coverage and PCP must be verified before every encounter.
  - **Step 1:** Ask to see their MetroPlusHealth Member ID Card and a Photo ID
  - **Step 2:** Check member's eligibility using one of these methods:
    - MetroPlusHealth Provider Portal:
      - **http://providers.metroplus.org**
    - EMEVS web site: **www.emedny.org** for Medicaid, Medicaid HIV SNP and MetroPlus Medicare Advantage.
    - EMEVS verification line:
      - Call **800-997-1111**
      - Enter the MetroPlusHealth Provider Number 01529762 and the Plan Code 092
    - MetroPlusHealth Customer Services: **800-303-9626 (TTY: 771)**

METROPLUSHEALTH INSURANCE PRODUCT LINES

INDIVIDUAL & FAMILY PLANS	MEDICARE & DUAL-ELIGIBLE PLANS	SPECIAL NEEDS & LONG-TERM CARE	COMMERCIAL PLANS (NYC Employee Plans)
Medicaid Managed Care (MMC)	Medicare Advantage Plan (HMO D-SNP)	Enhanced (HARP) Plan	MetroPlusHealth Gold Plan
Child Health Plus (CHP)	Medicare Platinum Plan (HMO)	Managed Long-Term Care	MetroPlusHealth GoldCare Plans
Essential Plan (EP)	MetroPlus UltraCare (HMO D-SNP)	Partnership In Care (PIC) (HIV SNP)	
Qualified Health Plans (QHP) – Marketplace Plans			

Managed Care Benefits

Medicaid Managed Care Marketing

- **MetroPlusHealth MarketPlace Facilitated Enrollers (FEs) can assist with enrollment of uninsured people into their plans in person at an enrollment location, home visit or by contacting the NYSOH website: https://nystateofhealth.ny.gov/.**
- **Plan Facilitated Enrollers cannot enroll Fee for Service (FFS) Medicaid recipients; this is also true for MetroPlusHealth HIV SNP Facilitated Enrollers.**
  - If you have a patient who is in FFS Medicaid and wants to enroll in a Medicaid Managed Care Plan, please instruct them to call NY Medicaid CHOICE at 800-505-5678.
- **As a result of these changes, MetroPlusHealth HIV SNP Facilitated Enrollers (FEs) are no longer located in the NYC Health + Hospitals HIV clinics; they may be able to conduct workshops/educational activities.**
- **In addition to enrolling the uninsured, plans are expected to concentrate on retaining current members.**

NYS DOH Introduces A New Process for Personal Care Services (PCS)

NYS DOH will implement a new independent assessment process for adults aged 18 years and older newly seeking:

- Medicaid personal care services (PCS)
- Medicaid consumer-directed personal assistance services (CDPAS)
- MLTC plan eligibility

The independent assessment process started:

- May 16th, 2022 for individuals seeking PCS or CDPAS for the first time (“initial assessment”)
- This means a member has never received PCS either with MetroPlus or another Plan

NYS DOH contracted with Maximus Health Services, Inc. (Maximus) to implement the New York Independent Assessor (NYIA).

What is the Assessment Process

- RNs contracted by Maximus will conduct the assessment

- The initial assessment process includes:
  - The Community Health Assessment (CHA); and
  - A clinical exam, conducted by a clinician on an Independent Practitioner Panel (IPP)

- For high needs cases, e.g., more than 12 hours per day, on average, of PCS/CDPAS for the first time, an Independent Review Panel (IRP) evaluation will take place

How Does This Impact the Provider

HRA and Medicaid Managed Care Plans will no longer be responsible for scheduling the initial assessment for PCS and CDPAS.

- Note: Reassessments, both routine and non-routine, are not affected and will continue to need an M11Q.

PCPs will no longer be conducting exams/writing orders for PCS and CDPAS for patients who have never had these services previously.

- To schedule an appointment for individuals newly seeking Medicaid PCS or CDPAS, Members and/or Members Representative can call the NYIA at 855-222-8350.
- If a Member Representative is placing the call, the member must be on the line.

For more information:

- NYIA webpage at NYIA.

MetroPlusHealth Medicare

Beneficiaries must live in the MetroPlusHealth service area (5 NYC boroughs).

MetroPlusHealth Medicare Plans:

- Medicare Platinum Plan - MetroPlusHealth (HMO) for those eligible for Medicare Parts A and B.
- Medicare Advantage Plan - MetroPlusHealth (HMO D-SNP) for those eligible for Medicare Parts A and B and for NY State Medicaid.
- MetroPlus UltraCare Plan - MetroPlusHealth (HMO D-SNP) for those who are dual eligible for Medicare and full Medicaid and need long-term care services such as home care and personal care.

For more information, visit the MetroPlusHealth website www.MetroPlus.org/ and/or call our Medicare Customer Services Department at 866-986-0356 (TTY: 711). You can also log into our Provider Portal.

MEDICAID ADVANTAGE PLUS (MAP) ULTRACARE & ELIGIBILITY

Medicaid Advantage Plus (MAP) Plan is especially designed for people who have Medicare (Parts A and B) and FULL Medicaid.

They need health and community based long-term care services like home care and personal care, to stay in their homes and communities as long as possible.

Your patients are eligible to join MAP if they are enrolled in a Medicare Advantage plan (Part C) and:

- Are age 18 or older and have FULL Medicaid.
- Reside in the plan's service area, which is the Bronx, Brooklyn, Manhattan, Queens, and Staten Island.
- Must be eligible for nursing home level of care (as of time of enrollment) using the Uniform Assessment System (UAS).
- Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety.
- Have evidence of Medicare Part A & B coverage.
- Are expected to require at least one of the following Community Based Long Term Care Services (CBLTCS) covered for more than 120 days from the effective date of enrollment:

  - ✓ **Therapies in the home**
  - ✓ **Personal care services in the home**
  - ✓ **Nursing services in the home**
  - ✓ **Adult day health care**
  - ✓ **Home health aide services**
  - ✓ **Private duty nursing**
  - ✓ **Consumer Directed Personal Assistance Services**

MetroPlus Health Managed Long Term Care

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

Members are eligible if they are…

- 21 years old or older
- Eligible for Medicaid
- Living in the Bronx, Brooklyn, Manhattan, Staten Island or Queens
- In need of long-term care of nursing home-level care
- Able to remain in their home without jeopardizing their health or safety
- In need of long-term care services for at least four months – 120 days from the time of enrollment

MetroPlusHealth Managed Long Term Care will help members obtain the services we do not directly cover to make sure they receive the care needed.

To find out more about what is and isn't covered by MetroPlus Managed Long Term Care, please check our **Member Handbook,** call us at **855-355-MLTC (6582) (TYY: 711)** or visit our website MLTC Plan

✓MetroPlus**Health**

Provider Services is Here to Help You

- We are pleased to share that we have launched a new, dedicated, and improved **Provider Services Call Center** to support all provider and vendor inquiries and concerns.

- We will resolve all your queries and issues expeditiously and with minimal effort on your part.

- You can reach our **Provider Services Call Center at 1-800-303-9626, Monday-Friday, 8am-8pm,** for all contracting, billing, and credentialing inquiries.

CREDENTIALING REQUIREMENTS & VERIFICATIONS

MetroPlusHealth Credentials and Re-Credentials:

- Providers in accordance with New York State Department of Health law.
- With any and other regulatory guidelines.
- Practitioners must meet the criteria for enrollment as outlined in MetroPlusHealth credentialing
- Credentialing staff verifies telehealth approvals for Adult BH HCBS and CORE providers by requesting State approval letters.
- The Credentialing Committee reviews the credentialing policy at least annually, updates the policy as needed to ensure that credentialing and re-credentialing processes meets regulatory guidelines.

MetroPlusHealth Recredentials organizational providers on a periodic basis (not less than once every three (3) years).

This includes, but is not limited to review of:

- Providers qualifications
- Performance
- Complaints
- Certifications required by contract.
- Exclusions and criminal activity checked from State and Federal Databases.
- Centers for Medicare & Medicaid Services

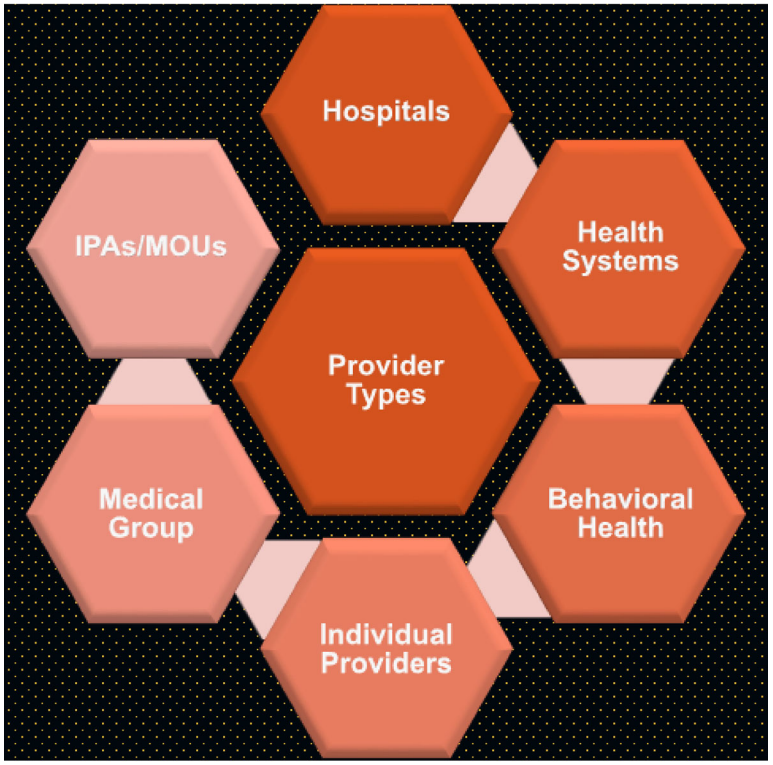
Credentialing Staff verifies OMH telehealth approval for Children and Family

PROVIDER CONTRACTING DEPARTMENT & PROVIDER TYPES

The Provider Contracting Department manages a robust network of more than 34,000 providers and 4,300 contracts in the New York City Region.

Our major network consists of:

- Hospital Systems
- Hospitals
- Independent Practitioner Associations (IPA)
- Memorandum of Understanding (MOU)
- Behavioral Health Providers
- Medical Groups
- Individual/Solo Practitioners
- Ancillary Providers

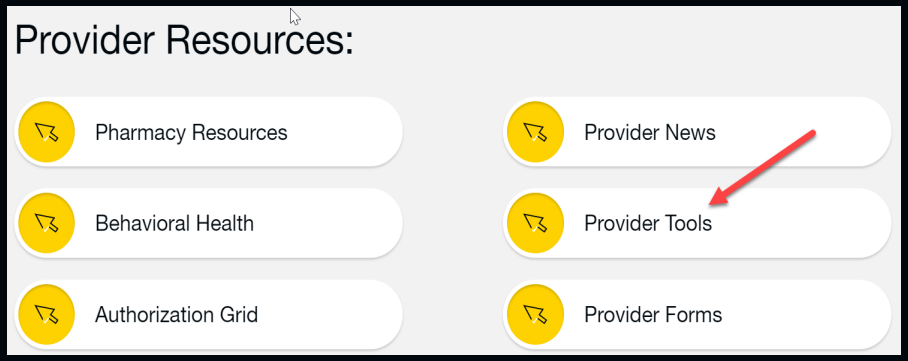


PROVIDER CONTRACTING

The Provider Contracting Department along with its legal and regulatory partners ensure that all regulatory requirements are fulfilled, and provider contracts comply with what is required by statute, regulatory requirements, and fair and appropriate policies and procedures set forth by MetroPlusHealth.

Provider Contracting Webpage

MetroPlusHealth website has a section dedicated to the provider Community. Please visit Providers – MetroPlusHealth and familiarize yourself with the Provider Tools. Here you will find the Provider Manual, forms, and other operating tools to assist in navigating and contacting MetroPlusHealth's Provider Contracting Department.



Provider Responsibilities

Participating Providers assume responsibility for the care of members agreeing to adhere to administrative procedures, reporting requirements, medical records maintenance, quality assurance and utilization review policies, and regulatory standards.

Key responsibilities include, but are not limited to, the following:

- Providing appropriate and cost-effective care in accordance with utilization management plan, protocols and clinical guidelines.
- Ensuring that members (or a designee, when appropriate) give informed consent for any procedure or treatment.
- Complying with all Public Health Guidelines, including statutory reporting requirements for communicable diseases.
- Complying with standards for appointment access.

Clinical Practice Guidelines

MetroPlusHealth has Guidelines available for providers within but not limited to the following specialties:

- Adolescent Medicine
- Adult Medicine
- Behavioral Health
- Cardiology
- Infectious Disease
- Oncology
- Ophthalmology
- Obstetrics/Gynecology
- Pediatrics
- Prevention/Screening
- Pulmonology
- Rheumatology
- Urology

MetroPlusHealth uses several strategies to ensure provider compliance with Clinical Practice Guidelines. MetroPlusHealth provides education and tools to the provider regarding the specifics of the Guidelines. Education can be provided face-to-face, through webinars, provider newsletters, provider portal and the MetroPlusHealth.

Notification of Changes In Your Practice

- **Always notify MetroPlusHealth immediately about the following changes**:
  - Change of address
  - Change in Tax ID Number
  - Change of providers in group practice
  - New sites or closed sites
  - Change in practice name/ownership
  - Extended leave of absence
- **Submit changes to Provider Services**:
  - By phone: **800-303-9626**
  - By fax: **212-908-3691**
  - By email: **Providerupdate@metroplus.org**
  - In writing to:

    MetroPlusHealth Plan Provider Services
    50 Water Street, 8th Floor New York, NY 10004

HIV Testing

HIV testing must be offered to all people between the ages of 13 and 64 receiving one of the following:

- Primary care services from a physician, physician assistant, nurse practitioner or midwife
- Care in the emergency room
- Care as an inpatient in a hospital

Prenatal care providers should provide HIV counseling to all pregnant women as early as possible in their pregnancy.

- A repeat third trimester test, preferably at 34 - 36 weeks, should be recommended to all pregnant women who tested negative early in prenatal care.

Informed Consent Guidelines

- Providers are required to obtain an informed consent form for all MetroPlusHealth Plan members undergoing a hysterectomy or sterilization procedure.
- Providers must notify a member undergoing a hysterectomy or sterilization procedure verbally and in writing that the procedure will render them permanently sterilized and not reversible.
- The member or an authorized representative must sign a consent form before the procedure is performed (see provider manual for a copy of forms).

Advanced Directives

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

Communicable Disease Public Health Reporting

MetroPlusHealth requires compliance with public health reporting requirements of communicable diseases and conditions by participating providers mandated in Article 21 of the NYS Public Health Law and for Contractors operating in New York City, the New York City Health Code (24 RCNY §§11.03-11.07)

Preventative Health Care Guidelines

- MetroPlusHealth adopts and disseminates to its practitioners and members guidelines for the prevention and early detection of illness and disease.
- Preventive Health Care Guidelines are intended to encourage the appropriate provision and utilization of preventive health services at appropriate intervals.
- The implementation of these guidelines has the potential to reduce undesirable variation in the process and outcome of care. The preventive health care guidelines that MetroPlusHealth adopts are specific to the age, sex and risk status of our members.
- All preventive health care guidelines are scientifically based and/or are based on a nationally recognized medical authority.

Smoking Cessation Counseling

- Every provider should advocate for smoking cessation and consider prescribing Nicotine Replacement Therapy (both long acting patches and short acting gum or lozenges) to patients for 8-12 weeks
- Free smoking cessation resources include:
  - MetroPlusHealth Customer Service line:

    800-303-9626 | Mon-Sat from 8am to 8pm
  - New York State Toll-free Smokers' Quit line:

    866-697-8487 | Mon-Thurs from 9am to 9pm

    Fri-Sun from 9am to 5pm

Compliance Policy

Providers should be compliant with all MetroPlusHealth approved clinical treatment and preventive health guidelines and Public Health Guidelines.

MetroPlusHealth will periodically collect data regarding incident reporting and performance standards to monitor contractual compliance.

Our Clinical Policies and Benefit Grid can provide further information.

Our Fraud & Abuse Prevention Program

- MetroPlusHealth is committed to preventing fraud, waste and abuse by members, providers and employees
  - Examples include: member overutilization of ER services, oversupply of controlled substances, doctor shopping, pharmacy shopping, inappropriate medication combinations, prescription forgeries and member card loaning or sharing

  Information related to how MetroPlusHealth's works to prevent fraud, waste, and abuse can be found here: https://metroplus.org/about-us/fraud-abuse/

- **Providers are encouraged to report suspected fraud, abuse, questionable and illegal activities to MetroPlusHealth:**
  - **MetroPlusHealth Compliance Hotline:**
    - Call **888-245-7247**; you can give your name or report anonymously
    - Submit an anonymous report here: https://www.mycompliancereport.com/report?cid=MPH
  - **Corporate Compliance Officer:** Contact Raven Solon, MetroPlus Corporate
    - Compliance Officer, at **212-908-5205** or **complianceofficer@metroplus.org**
  - **Provider Services:** Contact your MetroPlus Provider Service Representative

Our Fraud & Abuse Prevention Program, cont'd

MetroPlusHealth Special Investigations Unit (SIU)

- MetroPlusHealth has a dedicated SIU responsible for performing provider-based fraud, waste and abuse audits and investigations.
- The SIU accepts tips, referrals and allegations of fraud or abuse from a variety of internal and external sources
- Some examples of the fraudulent and abusive activities that the SIU audits and investigates for include double billing, upcoding, overutilization, unbundling, billing for services not rendered, billing for services without a license, etc.

Our Privacy Program

- MetroPlusHealth places a high priority on the privacy of its members information and confirming to the requirements of all related laws and regulations. As a MetroPlusHealth provider, you must also protect the privacy of your patient's information. You are required to:
  - Have an established system of maintaining member records in a confidential manner
  - Develop policies and procedures to assure confidentiality of HIV-related, behavioral heath, and substance abuse information.
- MetroPlusHealth provides information on how member information may be used and disclosed and how members can get access to their information in our Notice of Privacy Practices found here: https://metroplus.org/about-us/privacy-policies/

- **Providers are encouraged to report suspected privacy violations to MetroPlusHealth:**
  - **MetroPlusHealth Compliance Hotline:**
    - Call **888-245-7247**; you can give your name or report anonymously
    - Submit an anonymous report here: https://www.mycompliancereport.com/report?cid=MPH
  - **MetroPlusHealth Privacy Officer:** Contact Raven Ryan Solon at 212-908-5205 or PrivacyOfficer@metroplus.org

Quality Management

- **MetroPlusHealth is committed to providing comprehensive, patient-centered, quality health care**
  - MetroPlusHealth strives to establish a coordinated, cost-effective medical delivery system which is timely and appropriate for member needs.

- **MetroPlusHealth works on various quality improvement activities (QIAs) and targeted, focused studies throughout the year to improve the care and service members receive**
  - Quality improvement projects focus on improving various aspects of behavioral health, preventive health, chronic care and member experience.
  - QIAs are conducted for all QARR/HEDIS measures and product lines and follow a PDSA process.

- **MetroPlusHealth collects and analyzes data for HEDIS and QARR annually**
  - Quality Assurance Reporting Requirements (QARR) for CHPlus, Medicaid, HIV SNP, HARP and Essential Plan products.
  - Healthcare Effectiveness Data and Information Set (HEDIS) for Medicare, UltraCare, QHP products.
  - Providers are required to assist with collecting HEDIS and QARR data as needed. ***This includes ensuring access to member medical records for quality review.***

Quality Management, cont'd

- **Quality Reporting**
  - MetroPlusHealth publishes monthly Provider performance profiles based on administrative (claim) and supplemental data. PCPs are compared statistically on a range of indicators including but not limited to the MetroPlusHealth Pay-for-Performance Program and the HEDIS/QARR Reportable dataset.

- **Quality of Care**
  - MetroPlusHealth uses QARR and HEDIS results to identify accomplishments and areas for improvement
  - If there is an area for improvement, MetroPlus collaborates with providers to develop and implement quality improvement projects

MetroPlusHealth Care Management

Case managers coordinate services to meet the medical, behavioral, psychosocial and functional goals of members helping them attain wellness and autonomy through advocacy, assessment, planning, communication, and education.

Case Managers collaborate with providers, health homes and other case managers around inpatient admissions, discharge planning and gaps of care. Case Managers coordinate the services of physical, substance use disorder and mental health providers to help members attain optimal health outcomes.

Our Case Managers are Social Workers, LMHCs, Nurses (RNs) and CASACs working with members' assigned Health Home and/or Care Management Agency workers, medical professionals, service providers and other community resources.

Care managers:

- **Link members to providers and resources**
- **Identify and reduce the impact of clinical and social determinants of health issues**
- **Ensure members receive medical, behavioral, and social services** consistent with their plan of care

Care Management Programs

- AsthmaPlus
- Behavioral Health
- Complex Case Management/Healthy Heart/Disabilities
- DiabetesCare
- MetroPlus Medicare
- Partnership in Care, for people living with HIV/AIDS
- Smoking Cessation
- Domestic Violence

Providers may refer any member by calling Care Management at **800-579- 9798.**

MetroPlusHealth Provider Services is responsible for ensuring that participating providers are aware of community resources for suspected victims of Domestic Violence. Providers are encouraged to participate in and take advantage of the family violence training made available by the Plan.

MetroPlusHealth Partnership In Care (PIC) Special Needs Plan (SNP)

MetroPlusHealth Special Needs Plan (SNP)

- Also known as Partnership In Care
- Available for Medicaid-eligible members who are living with HIV, transgender, or homeless
- Assesses members' needs and develops an individualized plan for care

- Benefits for Providers:
  - MetroPlusHealth's Partnership in Care provides a team approach to caring for people living with HIV.
  - Our Case Managers help make appointments with an HIV Specialist and help clients fill and adhere to their medications.
  - Educational sessions for providing access to the MetroPlusHealth resources (MetroPlusHealth report delivery system, etc.).
  - Enhance revenue by billing preventive medicine, individual counseling and case management activities.
  - Notify the provider of members admitted in hospitals or with high ER utilization.

Free 24/7 Virtual Visits

- Virtual Visits are a plan benefit through **NYC Health + Hospitals / ExpressCare** for medical and initial online behavioral health visits
- Members use online technology to connect to board certified medical providers by using a smart phone, tablet or computer
- Doctors are available 24/7 for the treatment of non-emergencies. BH Televisits must be scheduled.
  - Urgent Care: migraines, sinus infections, bronchial problems, cold, flu, sore throat, strep throat, pink eye, diarrhea, urinary infections
  - Mental Health Therapy: depression, anxiety, bereavement, trauma, couples therapy, stress
  - Psychiatry: insomnia, mild substance abuse, panic attacks, PTSD, OCD
- MetroPlusHealth members can access virtual visits at:

  https://metroplus.expresscare.video/landing
- Or you can call us 24/7 at 1-855-287-3508 to access Virtual Visit.

✓MetroPlusHealth

Vaccine for Children Program

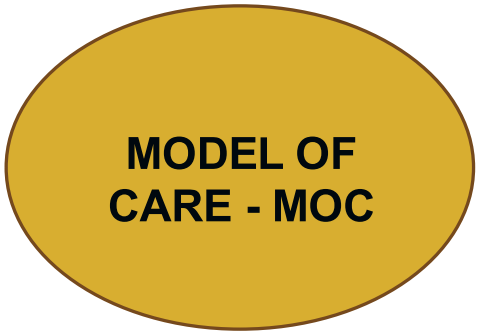
- The New York State Vaccines for Children Program (VFC) supplies selected vaccinations to providers caring for MetroPlus Medicaid and CHP members at no cost through the VFC program.
- Eligible members must be 19 years of age or younger and be enrolled in Medicaid and CHP LOB with the plans.
- Providers may order vaccines for Medicaid and CHP members at no cost through the VFC program.
  - For additional information on the VFC immunization Program or to order vaccines for MetroPlus Medicaid CHP members, call:
    - New York State Department of Health Bureau of Immunization **518-473-4437**
    - New York City Department of Health and Mental Hygiene Immunization Hotline **347-396-2400**
    - New York State Vaccines for Children Program **800- KIDSHOT (800-543-7468)**
    - Or review our **Quick Reference Guide** on our website

PROVIDER TRAININGS

Mandated Annual Provider Trainings

Cultural Competency is the ability to work effectively with your patients, regardless of their culture, religion, ethnicity, or socio-economic status. Gaining Cultural Competency skills will benefit your patients and your practice.

Please complete the mandated training at:
metroplus.org/provider/tools/Annual-Cultural-Competency-Training



MOC Provider Training & Communication

- Initial Orientation (MOC) on portal: Please complete the mandated training here.
- Notifications: posted in newsletter, email flyer to Providers, and quarterly calendar
- Updates: MOC via website, newsletters, emails, regular mail
- Face-to-face training sessions: MOC provided
- Coordination of webinar if MOC hasn't been completed

Claims Submission

Claims must be submitted detailing services rendered for every encounter within timelines defined in provider contract. This applies regardless of whether the provider is paid on a capitated or fee-for-service methodology.

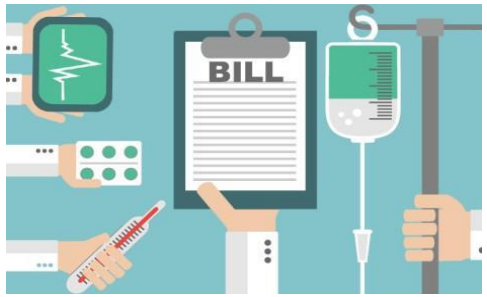
Please allow 30 days for electronic and 45 days for paper claim submission date to receive payment. Claims for all members can be submitted electronically using MetroPlus Emdeon Payer ID# 13265. Paper claims must be submitted on CMS 1500 or UB-04 forms.

Send paper claims for Medicaid, CHP, EP, SNP, MetroPlus Gold, Managed Long-Term Care (MLTC), MetroPlus Enhanced (HARP) and QHP (Exchange) to:

MetroPlus Health Plan
P.O. Box 219080
Kansas City, MO 64121- 9080

Send paper claims for MetroPlus Medicare to:

MetroPlus Health Plan
P.O. Box 219080
Kansas City, MO 64121-9080



Claims Submission and Status

- Providers may not balance bill member above allowed co-pays, deductibles, or co-insurance for any covered services. Balance billing is prohibited.
  - If provider seeks payment from a member for any covered service, contractor may be subject to termination as a participating provider.
  - Provider is required to educate their staff and affiliated providers concerning this requirement.

Check Claim Status

- MetroPlusHealth Provider Portal: http://providers.metroplus.org
- MetroPlusHealth Customer Services: **800-303-9626**

Portal & Clearinghouse Claims Submission

- MetroPlusHealth is able to accept claims through its connection with Availity. For those Providers who are submitting claims through any clearinghouse excluding Change Healthcare, claims will start to flow through our system.

  Update-to-the-MetroPlusHealth-connection-with-Availity-.pdf

- Claims can be submitted through the MetroPlus Health provider portal at http://providers.metroplus.org
- Providers can register for access to the provider portal at: www.metroplus.org
- The Change HealthCare or Relay clearinghouse claims status can be checked at http://providers.metroplus.org or by calling MetroPlusHealth Customer Services at 800-300-9626.

Claim Reconsideration / Appeals

- Providers have appeal rights based solely on the denial reason. All pertinent information to support reasons for the appeal and requisite documents must be submitted in writing within 45 to 90 calendar days of the original denial notification. Please note, anything not covered under the benefit plan are not subject to appeal nor are accorded appeal rights.

- **Claims Reconsideration**

  Regular Mail

  MetroPlus Health Plan
  P.O. Box 219080
  Kansas City, MO 64121-9080

- **Utilization Management & Appeals:**

  Regular & Certified Mail

  50 Water Street, 7th Floor
  New York, NY 10004
  By phone: 800-303-9626

Balance Billing & Claim Status

- Balance billing is prohibited. Providers may not balance bill members above allowed co-pays, deductibles, or co-insurance for any covered services.
  - Providers who seek payment from a member for any covered service may be subject to termination as a participating provider.
  - Providers are required to educate staff and affiliated providers concerning this requirement.

Check Claim Status

- MetroPlus Health Provider Portal: http://providers.metroplus.org
- MetroPlus Health Customer Services: 800-303-9626

Specialty Referrals

- MetroPlusHealth does not require the submission of referral forms.
- PCPs should devise their own written correspondence method for conveying indications for referral and relevant medical history or test results to Specialists.
- Specialists are expected to provide PCPs with consultation reports.
- All claims should include the referring providers information.

Required Authorizations

- You must call MetroPlusHealth Customer Services at **800-303-9626** to obtain prior authorization and/or verification of benefits for the following services:

- Services provided by a Non-Participating Provider
- Behavioral Health and Substance Abuse Services
- Authorization required for inpatient services
  - Authorization for outpatient
  - Inpatient Admissions, Home Health Care, Skilled Nursing Facility Care, Durable Medical Equipment, Personal Care, Erectile Dysfunction Treatments, Potentially Cosmetic Procedures

For further authorization coverage please visit Provider Authorization

Required Authorizations, cont'd

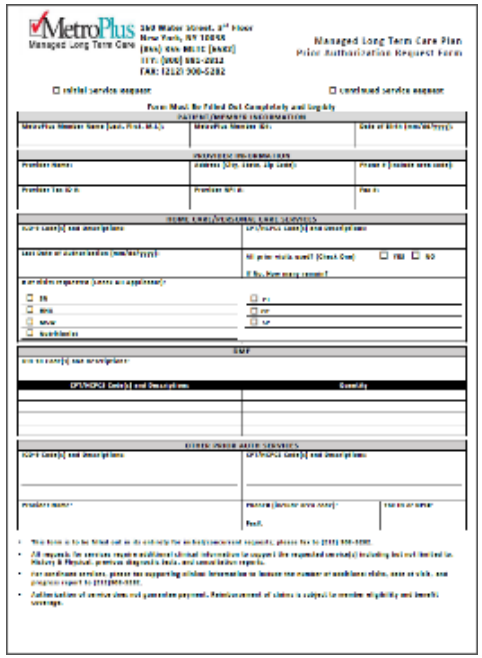
Outpatient Therapy & Chiropractic visits.

- MetroPlus Health members are entitled to all 3 disciplines of outpatient therapy and chiropractic services, benefits are configured based on the member's LOB. *See below*.
  - **Physical, Occupational, Speech Therapy**
    - Medicaid, HARP, HIV SNP, MAP (UltraCare), Essential Plan 3-4 and Medicare- Authorization is not required for the first 10 visits.
    - Essential Plan 1-2. All 3 disciplines combined- Authorization is not required for the first 10 visits.
    - GoldCare- All 3 disciplines combined. Authorization required for all visits. 90 visits combined per plan year.
    - MetroPlus Gold- All 3 disciplines combined. Authorization required for all visits. 60 visits combined per plan year.
    - QHP- All 3 disciplines combined. Authorization is not required for the first 10 visits. 60 visits combined per condition.
    - CHP- PT and OT are combined- Authorization is not required for the first 10 visits.
  - **Speech Therapy**- Medicaid, Medicare, HARP, Essential Plan 3-4, MAP (UltraCare) and CHP auth required for all visits
  - **Chiropractic Services**
    - Medicaid, HARP, HIV SNP, - Only covered through age 21. Authorization required for all visits for members under age 21.
    - Medicare, Essential 1-2, Essential Plan 3-4,GoldCare, MetroPlus Gold, QHP - Authorization is required for all visits
    - CHP- not a covered benefit

Required Authorization Forms

MLTC Authorization Request Form

https://www.metroplus.org/provider/forms


MetroPlus
Managed Long Term Care

Managed Long Term Care Plan
Prior Authorization Request Form

☐ initial service request ☐ continued service request

Form Must Be Filled Out Completely and Legibly

PATIENT/BENEFITS INFORMATION

PROVIDER INFORMATION

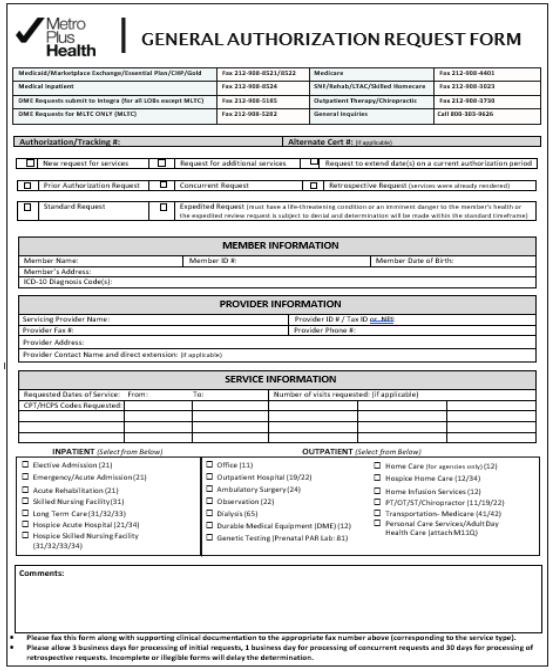
HOME CARE/PERSONAL CARE SERVICES

SNF

DME

Authorization Request Form

https://www.metroplus.org/provider/forms


Metro Plus Health

GENERAL AUTHORIZATION REQUEST FORM

Medicaid/Marketplace Exchange/Essential Plan/CHP/Gold	Fax 212-908-8521/8522	Medicare	Fax 212-908-4401
Medical Inpatient	Fax 212-908-8524	SNF/Rehab/LTAC/Skilled Homecare	Fax 212-908-3023
DME Requests submit to Integra (for all LOBs except MLTC)	Fax 212-908-5185	Outpatient Therapy/Chiropractic	Fax 212-908-3750
DME Requests for MLTC ONLY (MLTC)	Fax 212-908-5202	General Inquiries	Call 800-303-9626

Authorization/Tracking #: Alternate Cert #: (if applicable)

☐ New request for services ☐ Request for additional services ☐ Request to extend date(s) on a current authorization period

☐ Prior Authorization Request ☐ Concurrent Request ☐ Retrospective Request (services were already rendered)

☐ Standard Request ☐ Expedited Request (must have a life-threatening condition or an imminent danger to the member's health or the expedited review request is subject to denial and determination will be made within the standard timeframe)

MEMBER INFORMATION

Member Name: Member ID #: Member Date of Birth:
Member's Address:
ICD-10 Diagnosis Code(s):

PROVIDER INFORMATION

Servicing Provider Name: Provider ID # / Tax ID or NPI
Provider Fax #: Provider Phone #:
Provider Address:
Provider Contact Name and direct extension: (if applicable)

SERVICE INFORMATION

Requested Dates of Service: From: To: Number of visits requested: (if applicable)
CPT/HCPS Codes Requested:

INPATIENT (Select from Below)
☐ Elective Admission (21)
☐ Emergency/Acute Admission (21)
☐ Acute Rehabilitation (21)
☐ Skilled Nursing Facility (31)
☐ Long Term Care (31/32/33)
☐ Hospice Acute Hospital (21/34)
☐ Hospice Skilled Nursing Facility (31/32/33/34)

OUTPATIENT (Select from Below)
☐ Office (11)
☐ Outpatient Hospital (19/22)
☐ Ambulatory Surgery (24)
☐ Observation (22)
☐ Dialysis (65)
☐ Durable Medical Equipment (DME) (12)
☐ Genetic Testing (Prenatal PAR Lab: 81)
☐ Home Care (for agencies only) (12)
☐ Hospice Home Care (12/34)
☐ Home Infusion Services (12)
☐ PT/OT/ST/Chiropractor (11/19/22)
☐ Transportation- Medicare (41/42)
☐ Personal Care Services/Adult Day Health Care (attach M1 Q)

Comments:

- Please fax this form along with supporting clinical documentation to the appropriate fax number above (corresponding to the service type).
- Please allow 3 business days for processing of initial requests, 1 business day for processing of concurrent requests and 30 days for processing of retrospective requests. Incomplete or illegible forms will delay the determination.

PHARMACY BENEFITS

- **Managed by NYRx**
- Medicaid Managed Care (MMC)
- Partnership in Care (SNP)
- MetroPlus Enhanced (HARP)

- Phone: 518-486-3209

- **Managed by CVS Caremark**
- Medicare Advantage Plan (HMO SNP)
- Medicare Platinum Plan (HMO)
- UltraCare (HMO SNP)

- Phone: 855-344-0930
- Fax: 855-633-7673

- **Managed by CVS Caremark**
- Child Health Plus (CHP)
- Phone: 877-433-7643
- Fax: 866-255-7569

- Essential Plans
- Marketplace Plans
- MetroPlusHealth Gold
- GoldCare Plan
- Phone: 855-582-2022
- Fax: 855-245-8333

For Child Health Plus, Essential, Marketplace, MetroPlusHealth Gold and GoldCare Plan members who require specialty drugs, call MetroPlus Health Pharmacy department at:

Phone: 800-303-9626
Fax: 844-807-8455

- **Formularies available at www.metroplus.org/member/pharmacy**
- **Some drugs may have additional requirements or limits on coverage, including prior authorization, quantity limits and step therapy. Please see above for contact info to initiate a request.**

Pharmacy Benefits, cont'd

- Effective April 1, 2023, Medicaid members enrolled in mainstream Managed Care (MC) plans, Health and Recovery Plans (HARPs), and HIV-Special Needs Plans (SNPs) receive their pharmacy benefits from NYRx, the Medicaid Pharmacy program.
- For more information regarding the pharmacy benefit transition, click here.

- All other Plan members receive pharmacy benefits through our pharmacy benefit manager, CVS Caremark.
  - Members can receive a 90-day supply for maintenance medications.

Restricted Recipients Program

- Medicaid consumers in the Restricted Recipients Program are required to enroll in a Medicaid Managed Care Plan.
- Restricted Recipients are individuals with a pattern of misusing or abusing benefit package services and are restricted to one or more providers to receive their services.
  - Restrictions include PCPs, specialists, dentists, podiatrists, hospitals, pharmacies, and durable medical equipment (DME) vendors.
- Plans are responsible for enforcing the restrictions and assessing the members to determine if the restrictions should remain in place.

Restricted Recipients Program, cont'd

- Rosters contain a two-digit code field to identify restricted members and it will include their specific restrictions.
- MetroPlusHealth Restricted Recipients have an "R" on their ID card.
- Providers must verify member eligibility before every encounter and identify any restrictions:
  - If a member is restricted to a particular doctor, the member cannot be seen by another doctor without a prior authorization; claims without an authorization will be denied.
  - If a member is restricted to a NYC Health + Hospitals facility, a prior authorization is required for visits to another NYC Health + Hospitals facility.

Access to Care Standards | Appointment Availability

Did you know that Health Plans frequently call to check that your office is complying with appointment availability agreements? **As a reminder, as a contracted provider, you have agreed to maintain the following availability standards:**

- Providers are required to schedule appointments in accordance with the appointment and availability standards.
- Providers ***must not*** require a new patient to provide prerequisites to schedule an appointment, such as a copy of their medical record, a health screening questionnaire, and/or an immunization record.
- The provider may request additional information from a new member, if the appointment is scheduled at the time of the telephonic request.
- To access the *full* **Medical Access and Availability Standards**, please click here.

Emergency Care

Requires immediate face-to-face medical attention. Call 911 or go to the nearest ER.

Urgent Care

Requires timely face-to-face medical attention. Call 911 or go to the nearest ER.

Non-Urgent Care

Requires face-to-face medical attention within 48 to 72 hours.

Primary Care

Requires a face-to-face visit within 4 weeks.

✓MetroPlusHealth

Access to Care Standards | After-Hours Appointment Availability

Correct emergency instructions provided to the caller.	Instructions must state: • "If this is a life-threatening emergency, please hang up and dial 911 or go to your nearest emergency room." • Must be stated within the first 30 seconds of answering call or the recorded message.
Process to reach physician *Physician/on-call physician or medical professional is available during business hours & after hours.*	Appropriate actions: • **Directly connects** the caller to a medical professional (physician/on-call physician, or medical professional). • **Page** the medical professional and inform the caller that the physician/on-call physician or medical professional will call him/her back **within 30 minutes**. • The caller can **select an option** on their telephone and **be directly connected** to a physician/on-call physician or medical professional. • Answering machines must have the capability to **leave a message** and inform the caller that he/she will receive a **call back** from a physician/on-call physician or medical professional **within 30 minutes**. • **Call forwarding** - call is automatically forwarded to the physician/on-call physician or medical professional.
Timeframe for response *Caller is informed that he/she will get a call back within 30 minutes.*	Requirement for response: • **Immediate:** Direct connect or transfer of call to physician/on-call physician or medical professional. • Call back from physician/on-call physician or medical professional within 30 minutes or less. **Caller must be informed he/she will receive a call back within 30 minutes.**

Access & Availability / After-Hours Audit

MetroPlusHealth's Vendor (Press Ganey) conducts a survey to Participating Providers through telephonic monitoring. A score of 80% at any one of the categories is considered passing.

Upon receipt of the vendor's ***quarterly report***, providers found to be **non-compliant** will be issued a notification (non-Compliant email) indicating the area(s) of non-compliance.

- Providers delegated or participating via a group of facility will be reported to the entity responsible for their agreement and the entity will ensure that such providers are educated and become compliant with access and availability requirements.
- Independent providers will be sent a notification which will include actions to be taken by the provider to ensure they are compliant.
- The Non-Compliant Education Attestation is completed by the individual providers or by the contracting entity on behalf of its providers with a Plan of Correction from the provider.
- MetroPlusHealth will conduct a **follow-up audit outreach** through the Vendor with the non-compliant providers **within 30 business days of completion of the education** to ensure compliance by the provider.

Appointment Availability/ After-Hours Plan of Corrections (POC)

Plan of Correction (POC)

- Staff will be trained regarding MetroPlusHealth access & availability standards through education and training materials provided by MetroPlusHealth.
- Self-audits will be conducted to ensure adherence with the standards.
- Request additional MetroPlusHealth orientation (approx. 30 minutes)

After-Hours Access POC

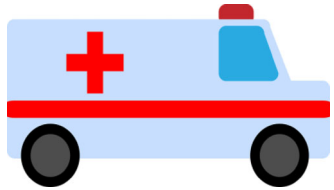
- Answering service will be used.
- Answering machine will be purchased/fixed.
- Emergency number/in-network covering provider wil be added to the answering machine.
- Call will be returned within 30 minutes.

Emergency Care POC

- Emergency appointment will be offered immediately upon request.
- Patient will be referred to MetroPlusHealth to find emergency care.

Transportation and Language Interpreter Services

Transportation Services



- Providers are responsible to pre-purchase MetroCards from the MTA and distribute to members of the following plans for public transportation:
  - Medicaid Managed Care
  - Medicaid HIV Special Needs Plan
- Providers must register to participate for reimbursement in the Public Transportation Automated System (PTAR) available on: http://www.nyc.gov/html/hra/html/services/ptar_system.shtml

Language Interpreter Services

For language interpreter services, contact Provider Services at 1-800-303-9626.

Lab Services & Approved In-Office Lab Tests

- Participating labs can be found on www.metroplus.org
- To perform in-office lab testing, a location must have a CLIA (Clinical Laboratory Improvement Act) certificate.
- **Providers may bill one draw fee per patient (CPT Code 36415 or 36416) per day and should not split the bills into 2 claims submission on the same day.**
- Providers paid under a capitated arrangement will be reimbursed for in-office lab services in their monthly capitation payment.
- All other lab tests must be referred to a MetroPlusHealth participating reference laboratory.
- Any lab test not available at an in-network laboratory, call **Utilization Management at 800-303-9626** to obtain an out-of-network prior authorization.
- Any claims from a provider for tests other than the list of approved tests will be denied; please remember that MetroPlusHealth members cannot be billed for these services.

OUR WEBSITE AND PROVIDER PORTAL

Visit metroplus.org to access information 24/7

Provider Manuals, Newsletters, Formularies, Benefits Provider Search, Provider Directory (PDF).

For Language Interpreter Services, please contact

Provider Services at **1-800-303-9626.**

Once you register, you can access the Provider Portal to:

- Check member eligibility & authorization status
- Check the status of submitted claims
- Access Provider orientation, benefit changes and clinical guidelines
- PCPs can access membership rosters, updated rosters are posted weekly
- Obtain MetroPlusHealth reports:
  - Membership reports
  - Utilization reports
  - Provider Performance Profiles
  - Diagnosis Code lists
- For Provider Portal Self-Paced Learning, please click here.

To register, go to metroplus.org

Click **here** to link to additional details regarding **Provider Portal Navigation Training.**

METROPLUSHEALTH BEHAVIORAL HEALTH PROGRAM & POPULATIONS

Behavioral Health Related Functions:

- Provider Network Development and Contracting
- Care Management and Coordination
- Utilization Management
- Claims Processing and Payment
- Quality Management
- Behavioral Health Peer Services
- Member Services and Grievance Management

Behavioral Health Populations:

- Adults with behavioral health needs and/or substance use disorders.
- Children, and transition age youth with behavioral health needs and/or substance use disorders, and coordination with Voluntary Foster Care Agencies.
- Children or adults who experience First Episode Psychosis (**FEP**).
- High risk groups such as individuals with co-occurring disorders, co-morbid medical needs or those involved in multiple services systems (education, justice, medical, welfare, and child welfare).
- Individuals with Intellectual/Developmental Disorders with behavioral health needs and/or Applied Behavioral Analysis (**ABA**).

METROPLUSHEALTH ENHANCED (HARP) & ELIGIBILITY

This plan offers the following benefits:

- It is a comprehensive and integrated Physical Health, BH and Substance Use Disorder Plan with added Social Services and Supports.
- Additionally, the plan manages physical health, MH, and substance use services in an integrated way for adults with BH needs.
- HARP is qualified by New York State and has specialized expertise, tools and protocols that are not part of most medical plans.

To be eligible for MetroPlusHealth Enhanced:

- Must be 21 or older, be insured only by Medicaid, and eligible for Medicaid Managed Care.
- Members are deemed eligible for HARP by meeting the criteria established by the New York State Department of Health (DOH), the Office of Mental Health (OMH), and the Office of Addiction and Substance Abuse Services (OASAS).
- Eligibility criteria include a diagnosis of a serious mental illness and/or substance use disorder, among other factors.
- HARP eligibility status may be found in ***MAPP***, ***PSYCKES, and EMEDNY***, and in ***e-PACES*** it appears on an individual's file in the restriction/exception code part of the report.
- A **H9 code** indicates that the member is HARP eligible, but not yet enrolled in a HARP plan.

This plan does not require you to change your current health care providers.

HARP TEAM: COORDINATING CARE OF MH & PH SERVICES

Mental Health Benefits

- Home and Community Based Services (HCBS) that can be delivered in members' home or social setting
- Inpatient and outpatient psychiatric care
- Partial Hospitalization Program (PHP)
- Substance Use Disorder Inpatient Detoxification
- Substance Use Disorder Inpatient Rehabilitation
- Crisis Residence and/or Crisis Respite
- Assertive Community Treatment (ACT)
- Personalized Recovery Oriented Services (PROS)

Physical Health Benefits

- Making PCP (Personal Care Physician) appointments
- Looking up Providers
- DME (Durable Medical Equipment)
- PCS (Personal Care Services)
- Transportation to appointments
- Dental Care
- Vision
- Hospital stays
- Promote Medication Adherence
- Collaborate with providers/vendors
- Assisting with integrated care

Children's Special Services Program (CSS)

- Our CSS team serves medically fragile children and children with complex behavioral and/or developmental issues under 21 years old by:
  - Coordinating care-oversight of utilization and case management to support the complex physical, behavioral, and developmental health needs of members
  - Referring to community-based organizations for ongoing support
  - Monitoring plans of care for children eligible for Home and Community Based Services to anticipate complex needs by collaborating with Health Homes and assessing if services in place are meeting member needs

CHILDREN'S SPECIAL SERVICES PROGRAM (CSS)

Our CSS team serves children under 21 years old who have complex medical (medically fragile), developmentally delayed, and behavioral health needs by:

- Monitoring plans of care for children eligible for Home and Community Based Services (HCBS) to anticipate complex needs by collaborating with Health Homes and assessing if services in place are meeting member needs.
- Following up on issues raised by members/families, Care Management Agencies (CMA), Voluntary Foster Care Agencies (VFCAs), PCPs, specialty providers, homecare agencies, DME providers, pharmacy, and any other collateral contacts to support the complex member's needs.
- The CSS team takes a multi-generational approach to care management that supports the needs of the caregiver to help ensure that the child/youth will continue to receive support to remain in the community and engage in their care. Many of the new services in this program are designed to support the whole family unit to promote better outcomes for the member.
- Guidance for the HCBS program can found here: https://omh.ny.gov/omhweb/guidance/hcbs/
- Guidance for Health Home and HCBS Eligibility can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/eligibility.htm

IMPROVING CARE FOR CHILDREN

The CSS team supports New York State's focus on improving health outcomes, managing costs, and providing care management services for Medicaid children and youth under 21 years with complex medical, behavioral, and/or developmental issues and helps to coordinate these services available to MetroPlusHealth members:

Child and Family Treatment Supports and Services (CFTSS)

- Medicaid, Child Health Plus, and SNP members 0-21 have access to 6 CFTSS behavioral health services that members can receive in clinics, home, or in the community.
- Prior authorization is not required for contracted providers designated to provide these services.

Home and Community Based Services (HCBS)

- For Medicaid enrolled children with complex medical, behavioral, and/or developmental health issues who are at risk for institutional placement and have been determined eligible for these waiver services.
- Prior authorization is required for these services.
- The medical necessity criteria to evaluate authorization requests is defined by Children's Health and Behavioral Health Medicaid System Transformation: Children's Home and Community Based Services Manual March 2023: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/hcbs_manual.pdf
- The link to the HCBS authorization request form: https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/childrens_hcbs_authorization_cm_notification_form_fillable.pdf
- MetroPlusHealth CSS HCBS Training is available for more details.

Crisis Residence (CR) Services for Children and Families (ny.gov)

- The major goal of the program is to stabilize the situation and return the child to the home, rather than to provide long-term care.
- CRs serve children and adolescents exhibiting acute distress who may need stabilization in an alternate setting.

Support for Children placed in the care of Voluntary Foster Care Agencies

Linkage to Health Home Care Management for children

Children's Special Services Program (CSS), cont'd

- Following up on issues raised by members/families, Care Management Agencies (CMA), Voluntary Foster Care Agencies (VFCAs), PCPs, specialty providers, homecare agencies, DME providers, pharmacy, and any other collateral contacts to support the complex member's needs

- The CSS team takes a multi-generational approach to care management. Supporting the caregivers' needs helps to ensure that the child/youth will continue to receive support to remain in the community and engage in their care. Many of the new services in this program are designed to support the member and family to promote better outcomes.

CSS Department can be reached by calling MetroPlus Health at 1-800-303- 9626

Improving Care for Children

- NYS focus on improving health outcomes, managing costs, and providing care management services for Medicaid children and youth under 21 years with complex medical, behavioral, and/or developmental issues makes these services available to MetroPlus Health members:
  - **Child and Family Treatment Supports and Services (CFTSS)**
    - Medicaid or SNP members 0-21 have access to 6 CFTSS behavioral health services that members can receive in clinics, home, or in the community
  - **Home and Community Based Services (HCBS)**
    - For children with complex medical, behavioral, and/or developmental health issues who are at risk for institutional placement and have been determined eligible for waiver services

Improving Care for Children, cont'd

- **Crisis Residence**
- **Referrals to Health Home (HH) care management for children with Medicaid 0-21 years**
  - Members with two or more chronic conditions **or**
  - A single qualifying condition (HIV/AIDS, Sickle Cell Disease, Serious Emotional Disturbance (SED), or Complex Trauma)
- **Support for Children placed in the care of Voluntary Foster Care Agencies (VFCAs)**
  - Members will have access to new benefits and care

Additional Initiatives

Psychotropic Pharmacy Initiative

- Medicaid children on multiple psychotropic medications receive telephonic MetroPlusHealth CSS team support to assess needs, review gaps in care, and assist with community linkages including treatment, housing, food insecurity, health coverage for caregivers, and technology/educational issues.

Children/youth on Blood Clotting Factor Medications

- CSS provides care management for members on blood clotting factor.

Children/Youth with Sickle-Cell Anemia

- CSS provides care management for these members.

Additional Supports

- Children/youth in HCBS services are usually enrolled with **Children's Health Homes** to coordinate care and promote health outcomes
  - **Health Homes** provide ongoing care management to help members/families connect to the services that meet their needs
- Foster care children receive care coordination from MetroPlus Health, Voluntary Foster Care Agencies (VFCAs), and community providers
  - If eligible, children in foster care will also receive HCBS services and care coordination from Children's Health Homes
- The additional services that have been transitioned to managed care allow MetroPlus Health and providers to work together to support children's goals and development as they transition to adulthood
- To support pediatricians and promote access to mental health treatment, MetroPlus promotes collaboration with Project Teach
  - **Provider Tools/MetroPlus Health Plan**
  - **Project TEACH (projectteachny.org)**

Benefits for SNP Members

- HIV Specialist as their PCP
- Multiple appointments on the same day
- Designated Health and Wellness Advisor
- Flexibility with authorizations and referrals
- Rewards program

How Will MetroPlusHealth's Partnership In Care Help Members?

- Every SNP member has access to a Health and Wellness Advisor at MetroPlusHealth and a medical case manager at the facility.
- If a facility does not have a medical case manager, MetroPlusHealth and Wellness Advisory team will provide support, care coordination and complex case manager services to the member.
- The Case Managers at the facilities and the Health and Wellness Advisors at MetroPlusHealth will coordinate efforts to help members get the following services:
  - Housing Assistance
  - Meals/Nutritional Counseling
  - Education Programs
  - Legal Services
  - Day Care Services
  - Pregnancy Services
  - Parenting Education

Benefits for the Providers

- Member plan of care developed by the health and wellness advisor with the provider.
- Discharge planning in coordination with social worker and providers at the facility.
- Notification to provider of members admitted in hospital or with high ER utilization.
- Additional member support for health education, prevention risk reduction, HIV testing and treatment adherence as well as referrals to community organizations as needed.

Benefits For The Providers, cont'd

- Enhanced revenue by billing preventive medicine, individual counseling and case management activities.
- Educational sessions about getting access to the MetroPlus resources such as web page and provider portal.
- Flexibility with prior authorization for medications, special procedures and out of network referrals.
- Support with the credentialing process to become an HIV specialist.

Ways To Enroll In SNP Partnership In Care

To choose an HIV SNP program follow these steps:

- Contact a MetroPlusHealth Facilitated Enroller (FE) at 855-809-4073 and press Option #3.
- Call MetroPlusHealth Customer Services for assistance at 800-303-9626.
- For Medicaid members who received Medicaid through the New York State of Health (NYSOH) also known as Marketplace:
  - Members can choose a plan through the Marketplace. Sign in and go to the plan selection page. Members can select a SNP for enrollment themselves.
  - Members can contact NYSOH Customer Service at 855-355-5777. Tell the counselor they have questions about joining a Special Need Plan or SNP.

Ways To Enroll In SNP Partnership In Care, cont'd

If the applicant has Medicaid eligibility through HRA:

- They can call New York Medicaid Choice at 800-505-5678 for help selecting the right SNP plan.
- They can talk to a Helpline Counselor for support in selecting the right Medicaid plan, or they can call The New York Medicaid Choice office at 800-505-5678.

Can Members Transfer To Another Plan?

- Medicaid recipients living with HIV can be transferred to an HIV SNP at any time.
- Any questions about transferring to another plan, should be answered by:
  - NY Medicaid Choice at **800-505-5678**
  - New York State of Health at **855-355-5777**

Assistance with MetroPlusHealth MFE Marketplace

- The Medicaid Managed Care Special Needs Plans (SNPs) are displayed on the NY State of Health site as a plan selection option for all Medicaid eligible applicants who reside in the SNPs' service areas.
- SNPs are Medicaid health plan options for consumers who are:
  - Living with HIV
  - Transgender
  - Homeless (currently registered with the New York City shelter system)
- SNP program covers all services as other Medicaid health plans. It also provides additional specialty services important to people living with HIV.
- In addition, it offers easy access to expert HIV and specialty care through an enhanced network of providers and hospitals.

Assistance with MetroPlusHealth MFE Marketplace, cont'd

- There are no changes to the NY State of Health application and there are no additional eligibility questions or documentation requirements for people to enroll in SNP.
- If a member believes he/she is eligible, he/she can enroll, and the SNP will verify eligibility.
- Ways to connect with a MarketPlace Facilitated Enroller (FE):
  - Contact a Facilitated Enroller at 1-855-809-4073 and press option # 3 to enroll
  - Visit or website at www.metroplus.org and go to our "Virtual Office" to find a Facilitated Enroller near you and who speaks your language
  - Fill out the "Contact Us" form on our website at www.metroplus.org and a Facilitated Enroller will contact you ASAP

Key Points to Remember

- Check eligibility for each visit
- Always check Prior Authorization requirements
- Submit claims for all services rendered on every encounter
- Notify MetroPlusHealth immediately of any changes in your practice, including extended leave of absence
- The Provider Manual including medical coverage policies can be accessed from the MetroPlus website: https://www.metroplus.org/provider/tools
- Call MetroPlusHealth Provider Services at **800-303-9626** with any questions

Conclusion

Thank you for participating in the MetroPlusHealth Primary Care Provider Orientation.

You have successfully completed this training. This satisfies the requirement for onboarding as a new MetroPlusHealth Provider.

For any general queries or concerns please contact the Provider Call Center at

800-303-9626 or to

connect with a Provider Education Trainer.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metroplus.org