

NEW YORK STATE HEALTH AND RECOVERY PLAN MEMBER HANDBOOK

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This handbook will tell you how to use your MetroPlus Enhanced plan.

Please put this handbook where you can find it when you need it.

WELCOME

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Health and Recovery Plan Member Handbook

WELCOME to MetroPlus Enhanced Health and Recovery Plan

We are glad that you enrolled in MetroPlus Enhanced. MetroPlus Enhanced is a Health and Recovery Plan, or HARP, approved by New York State. HARPs are a new kind of plan that provide Medicaid members with their health care, plus care for behavioral health. In this handbook, behavioral health means mental health, substance use disorder and rehabilitation. We are a special health care plan with providers who have a lot of experience treating persons who may need mental health and/or substance use care to stay healthy. We also provide care management services to help you and your health care team to work together to keep you as healthy as possible.

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 of MetroPlus Enhanced. In order to get to know you better, we will get in touch with you in the next two weeks. You can ask us any questions you have, or get help making appointments. If you want to speak with us sooner, just call us at 1-800-303-9626. You can also visit our website at www.metroplus.org/enhanced to get more information about MetroPlus Enhanced.

HOW HEALTH AND RECOVERY PLANS WORK

The Plan, Our Providers, and You

You may have seen or heard about the changes in health care. Many consumers get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, now those services may be available through MetroPlus Enhanced.

As a member of MetroPlus Enhanced, you will have all the benefits available in regular Medicaid, plus you can also get specialty services to help you reach your health goals. We offer extended services to help you get and stay healthy, and help with your recovery.

MetroPlus Enhanced offers new services, called Behavioral Health Home and Community Based Services (BHHCBS), to members who qualify.

BHHCBS may help you:

- Find housing.
- Live independently.
- Return to school.
- Find a job.
- Get help from people who have been there.
- Manage stress.
- Prevent crises.

As a member of MetroPlus Enhanced, you will also have a Health Home Care Manager who will work with all your physical and behavioral health providers to pay special attention to your whole health care needs. The Health Home Care Manager will help make sure you get the medical, behavioral health and social services you may need, such as help to get housing and food assistance.

You may be using your Medicaid card to get a service that is now available through MetroPlus Enhanced. To find out if a service you already get is now provided by MetroPlus Enhanced, contact Member Services at 1-800-303-9626.

- You and your health care team will work together to make sure you enjoy the best physical and emotional health possible. You can get special services for healthy living, such as nutrition classes and help to stop smoking.
- MetroPlus Enhanced has a contract with the New York State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care, mental health and substance use providers to help us meet your needs. These doctors and specialists, hospitals, clinics, labs, case managers, and other health care facilities make up our **provider network**. You will find a list in our provider directory. If you do not have a provider directory, call Member Services at 1-800-303-9626 to get a copy or visit our website at www.metroplus.org/enhanced.
- When you join MetroPlus Enhanced, one of our providers will take care of you. Most of the time that person will be your **Primary Care Provider (PCP)**. You may want to choose a PCP from your mental health or substance use clinic. If you need to have a test, see another specialist, or go into the hospital, your Primary Care Provider will arrange it.
- Your Primary Care Provider is available to you every day, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your Primary Care Provider will get back to you as soon as possible. Even though your Primary Care Provider is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page 13 for details.
- You may be restricted to certain plan providers if you are:
 - 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. MetroPlus Enhanced recognizes the trust needed between you, your family, your doctors and other care providers. MetroPlus Enhanced 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 MetroPlus Enhanced, your Primary Care Provider, your

Health Home Care Manager and other providers who give you care and your authorized representative. Referrals to such providers will always be discussed with you in advance by your Primary Care Provider and/or Health Home Care Manager. MetroPlus Enhanced staff have been trained in keeping strict member confidentiality.

HOW TO USE THIS HANDBOOK

- This handbook will tell you how your new health care plan will work and how you can get the most from MetroPlus Enhanced. 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. The rest of the handbook can wait until you need it. Use it 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 1-800-303-9626. You can also call the New York Medicaid Choice Helpline at 1- 800-505-5678.

HELP FROM MEMBER SERVICES

There is someone to help you at Member Services:
Monday through Saturday 8AM - 8PM
call us toll free: 1-800-303-9626

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.

For Behavioral Health Crisis call our Hotline toll-free at 1-866-728-1885

- You can call Member Services to get help **any time 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 report that you are pregnant, the birth of a new baby or ask about any change that might affect your benefits.
- 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 speak to 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/~~TDD~~ 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 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 MetroPlus 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 MetroPlus ID card, call us right away. Your ID card does not show that you have Medicaid or that MetroPlus Enhanced 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 MetroPlus Enhanced member. You should also keep your Medicaid benefit card. You will need your Medicaid card to get services that MetroPlus Enhanced does not cover.

PART I --- First Things You Should Know

HOW TO CHOOSE YOUR PRIMARY CARE PROVIDER (PCP)

- You may have already picked your PCP (Primary Care Provider). **If you have not chosen a PCP, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you. Member Services (1-800-303-9626) can check to see if you already have a PCP or help you choose a PCP. **You may also be able to choose a PCP at your behavioral health clinic.**

You can access your Provider Directory online at www.metroplus.org/enhanced. The Provider Directory lists all of the doctors, clinics, hospitals, labs, and others who work with MetroPlus. It lists the address, phone, 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 MetroPlus web site: www.metroplus.org/enhanced or by calling Member Services at 1-800-303-9626.

You may want to find a doctor that:

- you have seen before,
 - understands your health problems,
 - is taking new patients,
 - can speak to you in your language,
 - is easy to get to,
 - is at a clinic you go to.
- Women can also choose one of our OB/GYN doctors for with women’s health care.
 - We also contract with several FQHCs (Federally Qualified Health Centers). 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 one of our providers. Or you can sign up with a PCP in one of the FQHCs that we work with, listed below. Just call Member Services (1-800-303-9626) for help.

A listing of available FQHC’s can be found in your Provider Directory.

- In almost all cases, your doctors will be MetroPlus Enhanced providers. There are four instances when you can still **see another provider that you had before you joined MetroPlus Enhanced**. In these cases, your provider must agree to work with MetroPlus Enhanced. You can continue to see your provider if:
 - You are more than 3 months pregnant when you join MetroPlus Enhanced and you are getting prenatal care. In that case, you can keep your doctor until after your delivery through post-partum care.
 - At the time you join MetroPlus Enhanced, 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 MetroPlus Enhanced, you are being treated for a Behavioral Health condition. In most cases, you can still go 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. MetroPlus Enhanced will work with you and your provider to make sure you keep getting the care you need.

At the time you join MetroPlus Enhanced, 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. MetroPlus Enhanced must tell you about any changes to your home care before the changes take effect.

- 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 which your PCP has referred you.

- If your **provider leaves** MetroPlus Enhanced, we will tell you within 5 days from when we know about this. If you wish, you may be able to see that provider *if* you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor through post-partum care. If you are seeing a doctor regularly for a special medical problem, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with MetroPlus Enhanced during this time. If any of these conditions apply to you, check with your PCP or call Member Services at 1-800-303-9626.

HEALTH HOME CARE MANAGEMENT

MetroPlus Enhanced is responsible for providing and coordinating your physical health care and your behavioral health services. We use Health Homes to coordinate services for our members. It is your choice if you want to join a Health Home, and we encourage you to join a Health Home for your Care Management.

MetroPlus Enhanced can help you enroll with a Health Home that will assign your personal Health Home Care Manager. Your Health Home Care Manager can help you make appointments, help you get social services, and keep track of your progress.

Your Health Home is responsible for giving you an assessment to see what Behavioral Health Home and Community Based Services you may need. Using the assessment, you and your Health Home Care Manager will work together to make a Plan of Care that is designed especially for you.

Your Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your physical and behavioral health care;
- Work with the people you trust, like family members or friends, to help you plan and get your care;
- Support you getting social services, like SNAP (food stamps) and other social service benefits;
- Develop a plan of care with you to help identify your needs and goals;
- Perform an assessment to determine your social service needs;
- Help with appointments with your PCP and other providers;
- Help managing ongoing medical issues like diabetes, asthma, and high blood pressure;
- Help you find services to help with weight loss, healthy eating, exercise and to stop smoking;
- Support you during treatment;
- Identify resources you need that are located in your community;
- Help you with finding or applying for stable housing;
- Help you safely return home after a hospital stay; and
- Make sure you get follow up care, medications and other needed services.

Your Health Home Care Manager will be in touch with you right away to find out what care you need and to help you with appointments. Your Health Home Care Manager or someone from your Health Home provider is available to you 24 hours a day, 7 days a week. You can contact Member Services at 1-800-303-9626 Monday through Saturday 8am – 8pm or if you need to talk to someone after hours, Sundays, during holidays or if you are in crisis, call 1-855-371-9228.

REGULAR HEALTH CARE

- Your health care will include regular check-ups for all your health care needs. We provide referrals to hospitals or specialists. We want new members to see his or her Primary Care Provider for a first medical visit soon after enrolling in MetroPlus Enhanced. This will give you a chance to talk with your Primary Care Provider about your past health issues, the medicines you take, and any questions that you have.
- 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.
- You can call MetroPlus Enhanced twenty-four (24) hours a day, seven (7) days a week at 1-800-303-9626, if you have questions about getting services or if for some reason you cannot reach your Primary Care Provider.
- Your care must be **medically necessary** -- the services you get must be needed:
 - to prevent, or diagnose and correct what could cause more suffering, or
 - to deal with a danger to your life, or
 - to deal with a problem that could cause illness, or
 - to deal with something that could limit your normal activities.
- Your PCP will take care of most of your health care needs. You should 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 him or her. 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 four weeks of your joining the plan. If you have the need for treatment over the coming weeks, make your first appointment in the first week of joining MetroPlus Enhanced. Your Health Home Care Manager can help you make and get ready for your first appointment.
- **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 for this concern. (You should still keep your first appointment to discuss your medical history and ask questions.)

- Use the following list as a guide for the longest time you may have to wait after you ask for an appointment. Your Care Manager can also help you make or get appointments.
 - urgent care: within 24 hours
 - non-urgent sick visits: within 3 days
 - routine, preventive care: within 4 weeks
 - first pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
 - first family planning visit: within 2 weeks
 - follow-up visit after mental health/substance use ER or inpatient visit: 5 days
 - non-urgent mental health or substance use specialist visit: within 2 weeks.
 - adult baseline and routine physicals: within 4 weeks

BEHAVIORAL HEALTH CARE AND HOME AND COMMUNITY BASED SERVICES (BHHCBS)

Behavioral health care includes mental health and substance use treatment services. You have access to services that can help you with emotional health. You can also get help with alcohol or other substance use issues.

If you need help to support your living in the community, MetroPlus Enhanced provides additional services, called Behavioral Health Home and Community Based Services (BHHCBS). These services can help you stay out of the hospital and live in the community. Some services can help you reach life goals for employment, school, or for other areas of your life you may like to work on.

To be eligible for these services, you will need to get an assessment. To find out more, call us at 1-800-303-9626 or ask your Care Manager about these services.

See page 27 of this Handbook for more information about these services and how to get them.

HOW TO GET SPECIALTY CARE AND REFERRALS

- If you need care that your PCP cannot give, he or she 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 MetroPlus Enhanced 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 MetroPlus Enhanced 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 1-800-303-9626.
- **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 MetroPlus Enhanced for approval *before* you can get an out-of-network referral. If you or 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 co-payments 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 work 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 work days. For information on the status of your request, please call Member Services at 1-800-303-9626.**
 - Sometimes we may not approve an out-of-network referral because we have a provider in MetroPlus Enhanced 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 40 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 MetroPlus Enhanced'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 44 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 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, or
- you need OB/GYN services, or
- you need family planning services, or
- you want to see a mid-wife, or
- 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, or 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 MetroPlus 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 Member Services 1-800-303-9626 for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

HIV and STI screening

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.
- Or, if you'd rather not see one of our MetroPlus Enhanced providers, you can use your Medicaid card to see a family planning provider outside MetroPlus Enhanced. For help in finding either a Plan provider or a Medicaid provider for family planning services call Member Services at 1-800-303-9626.

- 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 1-800-541-AIDS (English) or 1-800-233-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.

HIV Prevention Services

Many HIV prevention services are available to you. We will talk with you about any activities that might put you or others at risk of transmitting HIV or getting sexually transmitted diseases. We can help you learn how to protect yourself. We can also help you get free male and female condoms and clean syringes.

If you are HIV positive, we can help you talk to your partners. We can help you talk to your family and friends and help them understand HIV and AIDS and how to get treatment. If you need help talking about your HIV status with future partners MetroPlus Enhanced staff will assist you. We can even help you talk to your children about HIV.

Eye Care

The covered service includes the needed services of an ophthalmologist, optometrist, and an ophthalmic dispenser and includes 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 just 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 provider that accepts Medicaid 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 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 during pregnancy and for up to a year after your delivery.

Harm Reduction Services

If you are in need of help related to substance use disorder, Harm Reduction Services can offer a complete patient-oriented approach to your health and well-being. MetroPlus Enhanced 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 1-800-303-9626 (TTY: 711).

Emergencies

You are always covered for emergencies. In New York State, 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 a person with an average knowledge of health be afraid that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.

Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop or a bad burn
- broken bones
- trouble breathing / convulsions / 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, or 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 MetroPlus Enhanced 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 MetroPlus Enhanced.***

Tell the person you speak with what is happening. Your PCP or MetroPlus Enhanced representative will:

- tell you what to do at home, or
 - tell you to come to the PCP's office,
 - tell you about community services you can get, like 12 step meetings or a shelter, or
 - tell you to go to the nearest emergency room.
- **You can also contact MetroPlus Enhanced Member Services at 1-800-303-9626, 24 hours a day, 7 days a week if you are in crisis or need help with a mental health or drug use situation.**
 - *If you are **out of the area*** when you have an emergency:
 - Go to the nearest emergency room or call 911.
 - Call MetroPlus Enhanced as soon as you can (within 48 hours if you can).

Remember

You do not need prior approval for emergency services.

Use the emergency room **only** if you have a **TRUE EMERGENCY**.

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

If you have questions, call your PCP or our plan at 1-800-303-9626.

BH Crisis Services Phone Number 1-855-371-9228

Member Services 1-800-303-9626

Behavioral Health Crisis 1-866-728-1885

TTY 711 15

Urgent Care

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

- 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. If you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-800-303-9626. 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 need, here are some other services we provide and ways to keep you in good health:

- Stop-smoking classes
- Pre-natal care and nutrition
- Grief / Loss support
- Breast 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

Call Member Services at 1-800-303-9626 or visit our website at www.metroplus.org/enhanced to find out more and get a list of upcoming classes.

Handbook -- Part 2

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.

BENEFITS

Health and Recovery Plans provide a number of services you get in addition to those you get with regular Medicaid. We will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning; HIV testing; mobile crisis services; and specific self-referral services, including those you can get from within MetroPlus Enhanced and some that you can choose to go to any Medicaid provider of the service.

SERVICES COVERED BY OUR PLAN

You must get these services from the providers who are in our plan. 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 1-800-303-9626 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
- help staying on schedule with medicines
- coordination of care and benefits

Preventive Care

- regular check-ups
- access to free needles and syringes
smoking cessation counseling
- HIV education and risk reduction
- referral to Community Based Organizations (CBOs) for supportive care
- smoking cessation care

Maternity Care

- pregnancy care
- doctors/mid-wife and hospital services

- screening for depression during pregnancy and up to a year after birth

Home Health Care

- Must be medically needed and arranged by MetroPlus Enhanced
- One medically necessary post-partum home health visit, additional visits as medically necessary for high-risk women
- 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 MetroPlus Enhanced
- Personal Care/Home Attendant - Help with bathing, dressing and feeding, and help preparing meals and housekeeping.
- CDPAS – Help with bathing, dressing and feeding, help preparing meals and housekeeping, plus home health aide and nursing. This is provided by an aide chosen and directed by you. If you want more information contact MetroPlus Enhanced at 1-800-303-9626

Personal Emergency Response System (PERS)

This is an item you wear in case you have an emergency and need help. To qualify and get this service, you must be receiving personal care/home attendant or CDPAS services. PERS will be arranged by MetroPlus Enhanced.

Adult Day Health Care

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

Therapy for Tuberculosis

- This is help with 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 MetroPlus Enhanced
- 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.

If you have any questions about these services, you can call Member Services at 1-800-303-9626.

Dental Care

MetroPlus Enhanced believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with HealthPlex, an expert in providing high quality dental services. . Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. *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. MetroPlus uses HealthPlex to provide dental services. HealthPlex has participating dentists who specialize in general dentistry, pediatric dentistry, oral surgery and gum disease. Call HealthPlex at 1-888-468-2189 to choose a primary care dentist. You can obtain a listing of participating dentists online at www.metroplus.org or upon request by calling MetroPlus Member Services at 1-800-303-9626. 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 he/she participates with HealthPlex.

- If you need to find a dentist or change your dentist, please call HealthPlex at 1-888-468-2189 or please call MetroPlus Enhanced at 1-800-303-9626. 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. Call Member Services at 1-800-303-9626 if you need help in locating an academic dental center clinic.

Vision Care

- services of an ophthalmologist, ophthalmic dispenser and optometrist.
- 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, with 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

Pharmacy

- Prescription drugs
- Over-the-counter medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Emergency Contraception (6 per calendar year)
- Medical and surgical supplies

A pharmacy co-payment may be required for some people, for some medications and pharmacy items. There are no co-payments for the following members or services:

- Consumers who are pregnant: during pregnancy and for the two months after the month in which the pregnancy ends.
- Family Planning drugs and supplies like birth control pills, male or female condoms, syringes and needles.
- Consumers in a Comprehensive Medicaid Care Management (CMCM) or Service Coordination Program.
- Consumers in an OMH or OPWDD Behavioral Health Home and Community Based Services (BHHCBS) Waiver Program.
- Consumers in a DOH BHHCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Family Planning drugs and supplies like birth control pills and male or female condoms.
- Drugs to treat mental illness (psychotropic) and tuberculosis

Prescription Item	Co-payment Amount	Co-payment Details
Brand name prescription drugs	\$3.00/\$1.00	1 co-pay charge for each new prescription and each refill
Generic prescription drugs	\$1.00	
Over the counter drugs, such as for smoking cessation and diabetes	\$0.50	

- If you have a co-pay, there is a co-payment for each new prescription *and* each refill.
- If you have a co-pay, you are responsible for a maximum of \$50 per quarter year. The co-pay maximum resets each quarter, regardless of the amount you paid last quarter.
 - The quarters are: January 1 - March 31; April 1 - June 30; July 1 - September 30; and October 1 - December 31.
- If you are unable to pay the requested co-pay you should tell the provider. The provider cannot refuse to give you services or goods because you are unable to pay the co-pay. (Unpaid co-pays are a debt you owe the provider.)

- To learn more about these services, call Member Services at 1-800-303-9626 (TTY 711).
- If you transferred to a new plan during the calendar year, keep your receipts as proof of your co-payments or you may request proof of paid co-payments from your pharmacy. You will need to give a copy to your new plan.
- Certain drugs may require that your doctor get prior authorization before writing your prescription. Your doctor can work with MetroPlus Enhanced to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.
- You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates with our plan or you can fill your prescriptions by using a mail order pharmacy. For more information on your options, please contact Member Services at 1-800-303-9626.

Hospital Care

- inpatient care
- outpatient care
- lab, x-ray, other 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 your 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 page 15.

Specialty Care

Includes the services of other practitioners, including

- physical therapist
- occupational and speech therapists
- audiologist
- midwives
- cardiac rehabilitation
- other specialty such as:
Rheumatology, Gastroenterology, ENT, Hematology/Oncology, Pulmonology, Allergy/Immunology, Neurology

To learn more about these services, call Member Services at 1-800-303-9626 (TTY 711).

Residential Health Care Facility Care (Nursing Home)

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

Member Services 1-800-303-9626

Behavioral Health Crisis 1-866-728-1885

TTY 711 21

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

If you are in need of long term (permanent) placement in a nursing home, your local department of social services must determine if you meet certain Medicaid income requirements. MetroPlus Health Plan and the nursing home can help you apply. Long term (permanent) nursing home stays are not a covered benefit in MetroPlus Health Plan HARP product. If you qualify for permanent long term placement, you will need to disenroll from MetroPlus Health Plan HARP Plan. This benefit will be covered by Medicaid fee-for-service until you are enrolled in a Medicaid managed care plan.

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 services to help with emotional health, or to help with alcohol or other substance use issues. These services include:

Mental Health Care

- Intensive psychiatric rehab treatment (IPRT)
- Outpatient Services
- Inpatient mental health treatment
- Partial hospital care
- Continuing day treatment
- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment Services (ACT)
- Individual and group counseling
- Crisis intervention services

Substance Use Disorder Services

- Crisis Services
 - Medically Managed Withdrawal Management
 - Medically Supervised Withdrawal Management (Inpatient/Outpatient*)
- Inpatient addiction treatment services (hospital or community based)
- Residential addiction treatment services
 - Stabilization in Residential Setting
 - Rehabilitation in Residential Setting
- Outpatient addiction treatment services
 - Intensive Outpatient Treatment
 - Outpatient Rehabilitation Services

- *Outpatient Withdrawal Management
- Medication Assisted Treatment
- Opioid Treatment Programs (OTP)

Behavioral Health Home and Community Based Services (BHHCBS)

BHHCBS can help you with life goals such as employment, school, or other areas of your life you want to work on. To find out if you qualify, a Health Home Care Manager must complete a brief screening with you that will show if you can benefit from these services. If the screening shows you can benefit, the Care Manager will complete a full assessment with you to find out what your whole health needs are including physical, behavioral and rehabilitation services.

BHHCBS includes:

- Psychosocial Rehabilitation (PSR) – helps you improve your skills to reach your goals.
- Community Psychiatric Support and Treatment (CPST) - is a way to get treatment services you need for a short time at a location of your choosing, such as your own home. CPST helps connect you with a licensed treatment program.
- Habilitation Services - helps you learn new skills in order to live independently in the community.
- Family Support and Training - teaches skills to help the people in your life support you in your recovery.
- Short-term Respite - gives you a safe place to go when you need to leave a stressful situation.
- Intensive Respite - helps you stay out of the hospital when you are having a crisis by providing a safe place to stay that can offer you treatment.
- Education Support Services - helps you find ways to return to school to get education and training that will help you get a job.
- Pre-Vocational Services - helps you with skills needed to prepare for employment.
- Transitional Employment Services - gives you support for a short time while trying out different jobs. This includes on-the job training to strengthen work skills to help keep a job at or above minimum wage.
- Intensive Supported Employment Services- helps you find a job at or above minimum wage and keep it.
- Ongoing Supported Employment Services- helps you keep your job and be successful at it.

- Empowerment Services-Peer Supports - people who have been there help you reach your recovery goals.
- Non-Medical Transportation – transportation to non-medical activities related to a goal in your plan of care.

Adult Behavioral Health Home and Community Based Services (BH) – HARP Members HCBS

Behavioral Health Home and Community Based Services (BHHCBS) can help MetroPlusHealth HARP members achieve their life goals and be more involved in the community. These services can help with:

- Independence: Daily Living and Social Skills
- Education and Employment
- Peer and Family Supports
- Managing Crises - Crisis Respite Services help manage mental health and substance use crises in a safe environment.

BHHCBS Eligibility & Tiers

Health Home Care Managers (HHCMs) use the NYS Eligibility Assessment to determine if HARP eligible/HIV SNP enrollees are eligible for Adult BHHCBS and, if so, which tier of service they qualify for.

- Prior to the assessment, the HHCM must verify current HARP or HIV SNP enrollment. ~~through EPACES/EMEDNY.~~
- Tier 1 Services Offers the following services:
 - Education
 - Employment
 - Peer Support
- Tier 2 Services includes all items from Tier 1, plus
 - Habilitation/Residential Supports
 - Psychosocial Rehabilitation
 - Community Psychiatric Support and Treatment
 - Family Support and Training
- Note: NYS is in the process of changing the BHHCBS assessment process and are rebranding BHHCBS services as CORE (Community Oriented Recovery & Empowerment) services. The goal is to eliminate the barriers to access and broaden the referral network to promote increased use of the services.
- HARP eligibility is based on certain factors, such as past use of behavioral health services in Medicaid.
- Individuals can ask their treating providers to look up their eligibility status or they can call New York Medicaid Choice at 1-855-789-4277; TTY users: 1-888-329-1541.

Enrolling HARP Eligible Members into a HARP

- NYS determines who is eligible for HARP and generates an updated list of potential enrollees every other month.
 - By calling NY Medicaid Choice @ 1-855-789-4277 (TTY users: 1-888-329-1541), you can find out if you are eligible.
- As HARP enrollment is voluntary, eligible members can choose to enroll in a HARP at any time. All you will need to do is call NY Medicaid Choice
 - Remember to have your Medicaid CIN or SSN, full name, DOB, home address & phone number
- Eligible members must be 21 or older and be insured by Medicaid only
- Insurance companies, including MetroPlusHealth, are not allowed to directly enroll patient into HARP plans. The process must be initiated by you either alone or with your provider.

DESCRIPTION OF ADULT BHHCBS

There are a variety of health and human services that can be provided by Behavioral Health Home and Community Based services that are available that can help you achieve your life goals and more active in your community. If you are eligible, you can receive the following services:

Peer Support Services:

- Members with a preference for persons with similar experiences of the member, such as history of behavioral health and/or substance abuse, hospitalization, and incarceration
- Services may include:
 - Advocacy, such as helping the member navigate the public benefits system to get food stamps;
 - Education on self-help tools;
 - Assistance when transitioning from a hospital or incarceration;
 - Support during a crisis or pre-crisis situation

Education Support Services:

- Members who want to obtain formal education to become competitively employed. (Competitive employment refers to jobs that any person in the general community can apply for and pays at least minimum wage.)
- Services include:
 - Assistance applying for financial aid and schools;
 - School registration;
 - Navigating the school system;
 - Negotiating reasonable accommodations;
 - Identifying tutoring resources.

Employment Services:

Pre-Vocational Services

- Preparing members for competitive employment, who have little to no work experience or haven't worked in a long time.

- Opportunities must be in an integrated workplace setting where people in the general community are employed.

Transitional Employment:

- Preparing members for competitive employment in the general community who have little to no work experience or haven't worked in a long time.
- Transitional employment slots are arranged by the BHHCBS provider in a formal agreement with businesses who hire people in the general community.

Habilitation (Residential Supports):

- Members in need of basic living, functional, and social skills building.
- Help member attain skills including effective communication and relationship building in the community, as well as the use of community resources.
- Habilitation may be helpful after long-term homelessness, hospitalization, or incarceration.

Psychosocial Rehabilitation (PSR):

- Members who need to regain functional and social skills they once had.

Services may include:

- Rehabilitation counseling;
- Relapse prevention;
- Stress management;
- Anger management;
- Identifying and pursuing personal interests;
- Medication management;
- Scheduling appointments;
- Healthy living choices

Community Psychiatric Support & Treatment (CPST):

- Members who are disengaged from site-based services due to behavioral or physical setbacks
- Clinical treatment including prescribing medication and psychotherapy as well as psychosocial rehabilitation / habilitation-type services.
- CPST is not meant to be ongoing or long-term, but until such time as a person can go to a service provider in the community.

Family Support & Training:

- Members who want to engage their family and significant others in education, treatment planning, and ongoing services.
- This is NOT family therapy. The member must consent and be in agreement with this service, but need not be present.

Services include training and counseling

- Mental health and substance abuse disorders;

- Treatment delivery;
- Medication management;
- Behavioral intervention strategies;
- Recovery support options;
- Recovery concepts.
- Family Support & Training may also provide training on community integration, housing options, advocacy, as well as benefits and entitlements.

Short Term Crisis Respite:

* Available for all HARP enrollees, BHHCBS eligibility assessment is not required. Need not be health home enrolled.

- Members who are experiencing challenges in daily life and are at risk for an escalation of symptoms
- Members feel that they cannot manage at home or in a community environment.

Services may include:

- Peer support;
- Coordination with other providers;
- Health and wellness coaching;
- Crisis prevention planning;
- Education on self-help tools;
- Conflict resolution;
- Engagement of family and other natural supports;
- Referrals or linkages to community providers

Intensive Crisis Respite:

* Available for all HARP enrollees, BHHCBS eligibility assessment is not required.

- Members who are experiencing an acute escalation of mental health symptoms and need supports to stabilize the behavioral health crisis.
- Designed for members who may prefer to be in a home-like setting with peer supports.
- Intensive crisis respites are locked facilities.

Services may include:

- Psychiatric evaluation;
- Comprehensive assessment including screening for physical health conditions;
- Risk assessment;
- Medication management;
- Individual and group counseling;
- Family support;
- Peer support;
- Referrals or linkages to community providers

Crisis Residence Services for Adults

MetroPlusHealth will pay for Crisis Residence services. These are overnight services. These services treat adults who are having an emotional crisis. These services include:

Residential Crisis Support

This is a program for people who are age 21 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 21 or older who are having severe emotional distress.

To learn more about these services, call Member Services at 1-800-303-9626 (TTY: 711).

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 also cover services related to prescribing and monitoring the use of such drugs. 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 1-800-303-9626 (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 covers diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit covers 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 21 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 1-800-303-9626 (TTY: 711).

Other Covered Services

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics / Orthotics
- Court Ordered Services
- Case Management
- Help getting social support services
- FQHC
- Family Planning
- Services of a Podiatrist.

Benefits You Can Get From Our Plan *OR* With Your Medicaid Card

For some services, you can choose where to get your care. You can get these services by using your MetroPlus Enhanced 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 Member Services if you have questions at 1-800-303-9626.

Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. Or you can visit one of our family planning providers. 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.

HIV and STI Screening

You can get this service any time from your PCP or MetroPlus Enhanced doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit.

Everyone should talk to their doctor about having an HIV test. To access free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

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 MetroPlus Enhanced does not provide. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit card.

Transportation

Emergency and non-emergency transportation are covered by regular Medicaid.

To get non-emergency transportation, you or your provider must contact Medical Answering Services (MAS) at 1-844-666-6270. 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. For more information about how to access your transportation services, call 1-844-666-6270 or visit their website at www.medanswering.com

Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

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

Developmental Disabilities

- Long-term therapies
- Day treatment

- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Behavioral Health Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

Services NOT Covered

*These services are **not available** from MetroPlus Enhanced 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 MetroPlus Enhanced, unless it is a provider you are allowed to see as described elsewhere in this handbook, or MetroPlus Enhanced or your PCP sends you to that provider.

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

This includes:

- non-covered services (listed above),
- unauthorized services,
- services provided by providers not part of MetroPlus Enhanced

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 MetroPlus Enhanced at 1-800-303-9626 right away. MetroPlus Enhanced can help you understand why you may have gotten a bill. If you are not responsible for payment, MetroPlus Enhanced will contact the provider and help fix the problem for you.

You have the right to ask for fair hearing if you think you are being asked to pay for something Medicaid or MetroPlus Enhanced should cover. See the Fair Hearing section later in this handbook.

If you have any questions, call Member Services at 1-800-303-9626.

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 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 MetroPlus if you:

- Are referred to a provider who is not in the MetroPlus 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 your pharmacy benefits manager)
- Receive more than 40 visits of physical therapy, or 20 visits of occupational or speech therapy, AND are in one of the categories listed below:
 - Children through 20 years old

- Anyone with a developmental disability
- Anyone with a traumatic brain injury

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 1-800-303-9626 or you can 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 MetroPlus Health Plan. Doctors and nurses make the decisions. They do this by checking your treatment plan against medically acceptable standards. Our UR staff is available 8:30 a.m. to 5:00 p.m. Monday through Friday. We have a 24-Hour Health Care Hotline number 1-800-442-2560 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:

MetroPlus Health Plan
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:

The health plan has a review team to be sure you get the services we promise. 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.

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 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 work 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 work 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 work 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 work 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 you are asking for an outpatient prescription drug we will make a decision within 24 hours of your request.
- A step therapy protocol means we require you to try another drug first, before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision with 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days 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 the plan to help decide your case. This can be done by calling 1-800-303-9626 or writing to:

MetroPlus Health Plan
50 Water Street
New York, NY 10004
Attention: Prior Authorization

You or your representative can file a complaint with the plan 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 1-800-206-8125.

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 other decisions about your care:

- 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 the plan or by Medicaid even if we later deny payment to the provider.**

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service:** 711)

Web: www.icannys.org | **Email:** ican@cssny.org

How Our Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services (1-800-303-9626) if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a **salary**. The number of patients they see does not affect this.
- 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 whether the patient needs one visit or many -- or even none at all. This is called **capitation**.
- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an **incentive** fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by the Plan.

- Providers may also be paid by **fee-for-service**. This means they get a Plan-agreed-upon fee for each service they provide.

You Can Help With Plan Policies

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at 1-800-303-9626 to find out how you can help.

Information from Member Services

Here is information you can get by calling Member Services at 1-800-303-9626 or by visiting our website at www.metroplus.org.

- A list of names, addresses, and titles of MetroPlus Enhanced'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 MetroPlus Enhanced.
- How we keep your medical records and member information private.
- In writing, we will tell you how our plan checks on the quality of care to our members
- We will tell you which hospitals our health providers work with.
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by MetroPlus Enhanced.
- If you ask us in writing, we will tell you the qualifications needed and how health care providers can apply to be part of our MetroPlus Enhanced.
- If you ask, we will tell you 1) if our contracts or subcontracts include physician incentive arrangements that affect the use of referral services; and, if so, 2) the types of arrangements we use; and 3) if stop loss protection is provided for physicians and physician groups.
- Information about how our company is organized and how it works.

Keep Us Informed

Call Member Services at 1-800-303-9626 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
- When you enroll in a new case management program or receive case management services in another community based organization

If you no longer get Medicaid, check with the New York State of Health. You *may* be able to enroll in another program.

DISENROLLMENT AND TRANSFERS

1. If YOU Want to Leave the Plan

You can try us out for 90 days. You may leave MetroPlus Enhanced 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 MetroPlus Enhanced for nine more months, *unless* you have a good reason (good cause).

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, the plan, and your local department of social services all agree that disenrollment is best for you.
- You are or become exempt or excluded from managed care.
- We do not offer a Medicaid managed care service that you can get from another health plan in your area.
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk.
- We have not been able to provide services to you as we are required to under our contract with the State.

To change plans:

- Call the Managed Care staff at your local department of social services.
- If you live in Bronx, Kings, New York, Richmond or Queens counties, call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans.

You may be able to disenroll or 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. MetroPlus Enhanced 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. Just call your local department of social services or New York Medicaid Choice.

2. You Could Become Ineligible for Medicaid Managed Care and Health and Recovery Plans

- You may have to leave MetroPlus Enhanced if you:
 - move out of the County or service area,
 - change to another managed care plan,
 - join an HMO or other insurance plan through work,
 - go to prison, or
 - otherwise lose eligibility.
- **If you have to leave MetroPlus Enhanced 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 1-800-505-5678 right away if this happens.

3. We Can Ask You to Leave MetroPlus Enhanced

You can also lose your MetroPlus Enhanced membership, if you often:

- Refuse to work with your PCP in regard to your care,
- Don't keep appointments,
- Go to the emergency room for non-emergency care,
- Don't follow MetroPlus Enhanced's rules,
- Do not fill out forms honestly or do not give true information (commit fraud),
- 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

You can also lose your MetroPlus Enhanced membership, if you cause abuse or harm to plan members, providers or staff.

4. If you lose Medicaid Coverage: The HIV Uninsured Care Programs may be able to help you.

If you are HIV positive and lose Medicaid coverage, you may be eligible for the New York State Department of Health, HIV Uninsured Care Programs (aka ADAP). The programs provide limited coverage for the care and treatment of HIV. If you have private health insurance, you also may be able to get help paying for your insurance premiums. Call 1-800-542-AIDS (2437) for more information.

5. No matter what reason you disenroll, we will prepare a discharge plan for you to help you get services you need.

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 the plan's 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 1-800-303-9626 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 ten 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 is 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 1-800-303-9626.

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

Phone..... 1-800-303-9626
Fax..... 1-212-908-8824
Mail..... Appeals Coordinator
50 Water Street
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 are asking for 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 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) that recommends 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 MetroPlus Enhanced at 1-800-303-9626 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 an **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 1-800-206-8125.

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 in 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:

- 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**
- If 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**
- If your request was denied when you asked for home health care after you were in the hospital; **or**
- 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.

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;
- 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 the plan to help decide your case. This can be done by calling 1-800-303-9626 or writing.

You or your representative can file a complaint with the plan 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 1-800-206-8125.

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.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:
1) not medically necessary; 2) experimental or investigational; 3) not different from care you can get in the plan's network; or 4) available from a participating provider who has correct training and experience to meet your needs, the original denial will be reversed. This means your service authorization request will be approved.

External Appeals

You have other appeal rights if we said 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; or
- 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 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 the state. These reviewers are qualified people approved by New York State. 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 the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have **4 months** after you receive the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's 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 1-800-303-9626 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, 1-800-400-8882
- Go to the Department of Financial Services' web site at www.dfs.ny.gov.
- Contact the health plan at 1-800-303-9626

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 the plan 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 the 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 or leaving MetroPlus Enhanced.

- 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 MetroPlus Enhanced. If MetroPlus Enhanced agrees 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 co-pay 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 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 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 1-800-342-3334

2. By fax – 518-473-6735
3. By internet – www.otda.state.ny.us/oah/forms.asp
4. By mail – NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

When you ask for a Fair Hearing about a decision MetroPlus Enhanced 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 1-800-303-9626 to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling 1-800-206-8125.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711)

Web: www.icannys.org | **Email:** ican@cssny.org

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 the plan. 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 described below.

You can call Member Services 1-800-303-9626 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 1-800-206-8125 or write to: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, New York 12237.

You can instead contact the New York State Office of Mental Health phone number for Complaints at 1-800-597-8481.

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 (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with Our Plan:

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 1-800-303-9626, Monday through Saturday 8am – 8pm. If you call us after hours, leave a message. We will call you 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:

MetroPlus Health Plan
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:

MetroPlus Health Plan
50 Water Street
New York, NY 10004
Attention: Complaints Manager

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 work 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 MetroPlus Enhanced at 1-800-303-9626 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 in 45 days of when we have all the information we need to answer your complaint, but 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 in 48 hours of when we have all the information we need to answer your complaint but 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.
- 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 the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work 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:

MetroPlus Health Plan
50 Water Street
New York, NY 10004
Attention: Complaints Manager

What happens after we get your complaint appeal:

After we get your complaint appeal we will send you a letter within 15 work 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 work days. If a delay would risk your health you will get our decision in 2 work days of 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 1-800-206-8125.

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (**TTY Relay Service:** 711)

Web: www.icannys.org | **Email:** ican@cssny.org

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of MetroPlus Enhanced, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from MetroPlus Enhanced.
- 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.
- Refuse enrollment into a Health Home and be told how to receive your physical and behavioral health care needs without having an assigned Health Home Care Manager.
- 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 MetroPlus Enhanced complaint system to settle any complaints, or you can complain to the New York State Department of Health or the New York State of Health any time you feel you were not fairly treated.
- Use the 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 MetroPlus Enhanced, you agree to:

- Work with your care team to protect 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 yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, 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 can't 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. Be sure to talk with your PCP, your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and change these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Health Care Proxy

With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

CPR and 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 (Do Not Resuscitate) 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.

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To allow space for local adaptations.)**

Important Phone Numbers

Your PCP.....	
MetroPlus Enhanced Member Services.....	1-800-303-9626
Other Units....(e.g., Nurse Hotline, Utilization Review, etc)	
Your nearest Emergency Room.....	
New York State Department of Health (Complaints).....	1-800-206-8125
OMH Complaints.....	1-800-597-8481
OASAS Complaints	1-800-553-5790
Ombudsman	1-888-614-5400
County Social Services.....	1-718-557-1399
Information on NYS Medicaid Managed Care	1-800-597-8481
New York State of Health	1-855-355-5777
New York Medicaid Choice	1-800-505-5678
NYS HIV/AIDS Hotline.....	1-800-541-AIDS (2437)
Spanish.....	1-800-233-SIDA (7432)
TDD.....	1-800-369-AIDS (2437)
NYCHIV/AIDS Hotline (English & Spanish).....	311 or 212-New York (639-9675)
HIV Uninsured Care Programs	1-800-542-AIDS (2437)
TDD.....	Relay, then 1-518-459-0121
Child Health Plus	1 800-541-2831
-Free or low-cost health insurance for children	
PartNer Assistance Program.....	1-800-541-AIDS (2437)
-In New York City (CNAP).....	1-212-693-1419
Social Security Administration.....	1-800-772-1213
NYS Domestic Violence Hotline.....	1-800-942-6906
Spanish.....	1-800-942-6906
	Press 2
Hearing Impaired.....	1-800-942-6906, 711
Americans with Disabilities Act (ADA) Information Line...	1-800-514-0301
TDD.....	1-800-514-0383
Local Pharmacy	
Other Health Providers:	

Important Web Sites

MetroPlus Enhanced

<https://www.metroplus.org/Plans/nyc-care-other/harp>

NYS Department of Health

www.health.ny.gov

NYS OMH

www.omh.ny.gov

NYS OASAS

www.oasas.ny.gov

NYS DOH HIV/AIDS Information

[AIDS Institute \(ny.gov\)](#)

NYS HIV Uninsured Care Programs

<http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm>

HIV Testing Resource Directory

www.health.ny.gov/diseases/aids/general/resources/

NYC DOHMH

<https://www1.nyc.gov/>

NYC DOHMH HIV/AIDS Information

www.nyhiv.com/office_of_aids_policy_dohmh_hiv_aids_bureau.html



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
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
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
ATENCION: 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، فان خدمات المساعدة اللغوية متوافر لك بالمجان. اتصل برقم هاتف الصم والبكم (TTY:711) 1-800-303-9626	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 פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (TTY: 711) 1-800-303-9626.	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
নকশ্য করুনঃ যদি আপদন বাাংলা, কথা বলতে, পাতনে, হেতল দনঃখচোয় ভাষা সহায়ণে পদতেশবা উপলব্ধ আতলে ফ্রান করুন ১-1-800-303-9626 (TTY: 711)	Bengali
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