PROVIDER MANUAL

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MetroPlusHealth

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TABLE OF CONTENTS

METROPLUS PHONE NUMBERS

Department	Telephone	Fax
Member Services	800.303.9626 212.908.3780 (TTY: 711)	212.908.8701
After Hours Service *(for calls after regular business hours)*	800.442.2560	
Member Services for Medicare Members	866.986.0356 (TTY: 711)	
Claims	800.303.9626 212.908.3780	212.908.8789
Compliance Department	212.908.5100	212.908.8620
Eligibility Verification	800.303.9626	800.303.8626
Care Management Action Line for Asthma, Diabetes, MetroMom, SSI, Medicare	800.303.9626 212.908.3780	212.908.8521
Behavioral Health Case Management	1.855.371.9228	
Partnership in Care/HIV Services	800.303.9626 212.908.8877	CONFIDENTIAL 212.908.8897 212.908.8525
Provider Services	800.303.9626 212.908.3780	212.908.8885
MetroPlus Main Number	212.908.8600	
Utilization Management	800.303.9629 212.908.3782	212.908.8521 212.908.8522
Utilization Review Appeals Coordinator	212.908.8816	212.908.8525

1. INTRODUCTION

1.1. WELCOME

MetroPlus Health Plan, Inc. (MetroPlusHealth) is pleased to welcome you as a Participating Provider. MetroPlusHealth is a Prepaid Health Services Plan (PHSP) and has been certified under Article 44 of the New York State Public Health Law since 1985 to operate in the New York City boroughs of Manhattan, Queens, Brooklyn and the Bronx. In January 2017, MetroPlus Health Plan was approved to operate in Staten Island for the following products: Medicaid, CHP, HARP, Essential Plan and QHP.

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

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

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

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

1.2. MISSION

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

1.3. GOVERNANCE

MetroPlusHealth is a wholly owned subsidiary corporation of NYC Health + Hospitals. The MetroPlusHealth Board of Directors serves as the governing authority for MetroPlusHealth. MetroPlusHealth is regulated by New York City, New York State and Federal agencies and is accountable to those agencies with respect to quality assurance and financial viability. Provider Agreements are subject to approval by the New York State Department of Health (NYSDOH), the New York City Department of Health and Mental Hygiene (NYCDOHMH), and the Centers for Medicare and Medicaid Services (CMS).

1.4. PRODUCT OVERVIEW

MetroPlusHealth offers the following managed care products:

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

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

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

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

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

MetroPlusHealth Medicare Advantage Plans offer all the benefits of Medicare as well as additional benefits not covered by Original Medicare. All MetroPlusHealth Medicare plans have the same basic requirements – members must have Medicare Parts A and B; reside in Brooklyn, the Bronx, Manhattan, Queens or Staten Island; and not have end stage renal disease (ESRD). In addition,

MetroPlusHealth Advantage Plan (HMO SNP) requires members to have Medicaid (full or partial). MetroPlusHealth Platinum Plan (HMO) is a plan for anyone eligible for Medicare Parts A and B.

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

MetroPlusHealth MarketPlus Plans are offered on the NY State of Health (https://nystateofhealth.ny.gov) marketplace and are available for purchase in the Individual or the SHOP (Small Business Health Options Program) markets. These comprehensive health plans cover the Essential Health Benefits which include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, preventative and wellness services and chronic disease management, laboratory services, pediatric services including oral and vision care. There are also plans that include adult vision and adult dental benefits. Plans are listed under MetroPlusHealth with BronzePlus, GoldPlus, SilverPlus, PlatinumPlus or MedPlus product names. For more information regarding covered benefits, please see *Appendix XG: Qualified Health Plan Benefit Summary.*

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

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

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

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

1.5. PROVIDER SERVICES AND THE *PROVIDER MANUAL*

MetroPlusHealth considers Participating Providers as partners and is committed to developing productive relationships to ensure that members receive the highest quality of care. MetroPlusHealth Provider Contracting and Network Relations Departments serve as the link between Participating Providers and MetroPlusHealth.

Provider Contracting works with Participating Providers to ensure they are informed of the responsibilities and standards to which they are held. Provider education and training is available

for new and established Participating Providers to assist in the development and refinement of their managed care knowledge and to acquaint them with MetroPlusHealth policies and procedures. Provider Contracting Representatives conduct initial orientation sessions for new Participating Providers and their staff and hold additional trainings as needed. Provider Contracting Representatives also make regular office visits to Participating Providers.

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

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

1.6. RESOURCES FOR PROVIDERS ON THE METROPLUSHEALTH WEB SITE

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

- Provider search and provider directories
- The *Provider Manual*
- Provider orientation
- Provider and member newsletters
- Provider bulletins
- Formularies
- Quick reference guide
- MetroPlusHealth plan descriptions, qualification tools, member handbooks, Evidence of Coverage, Summary of Benefits

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

1.7. DEFINITIONS

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

DOHMH shall mean the New York City Department of Health and Mental Hygiene.

CMS shall mean the Centers for Medicare and Medicaid Services which is the Federal agency that administers the Medicare program and oversees Medicare Advantage plans.

NYSDFS shall mean the New York State Department of Financial Services.

Participating Provider shall mean a Provider who:

(a) is either (i) directly under contract with MetroPlusHealth to provide Covered Services to members or (ii) indirectly under contract with MetroPlusHealth to provide Covered Services to members through its affiliation with a Provider that is directly under contract with MetroPlusHealth, and

(b) has been credentialed by MetroPlusHealth.

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

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

NYSDOH shall mean the New York State Department of Health.

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

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

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

(a) placing the health of the person afflicted with such condition in serious jeopardy, or in the care of a behavioral condition, placing the health of such person or others in serious jeopardy;

(b) serious impairment to such person's bodily functions;

(c) serious dysfunction of any bodily organ or part of such person; or

(d) serious disfigurement of such person.

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

2. PROVIDER RESPONSIBILITIES

2.1. KEY RESPONSIBILITIES

All Participating Providers contractually assume responsibility for the care of members and agree to adhere to administrative procedures, reporting requirements, medical records maintenance, quality assurance and utilization review policies, and regulatory standards. Participating Providers are also responsible for adhering to the provisions of the agreements between MetroPlusHealth and the NYSDOH, MetroPlusHealth and DOHMH, MetroPlusHealth and CMS, and any other agreement under which MetroPlusHealth administers health benefits.

Participating Providers' key responsibilities include, but are not limited to, the following:

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

2.1.1 Primary Care Provider Responsibilities

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

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

- Conducting baseline and periodic health examinations.
- Delivering medically necessary primary care services, in accordance with Preventive Health Guidelines (see Section 10).
- Diagnosing and treating conditions not requiring the services of a specialist.

- Arranging for inpatient care, specialist consultations, and laboratory and radiological services when necessary and coordinating follow-up care.
- Consulting with the admitting Physician and Participating in inpatient discharge planning and follow-up care when members are hospitalized.
- Reaching out to members who have not had an annual primary care appointment.
- Referring members for at least one dental visit a year and encouraging dental appointment attendance.
- Complying with standards for 24-hour coverage.
- Ensuring coverage by a Participating Provider for short and long-term leaves of absence.
- Counseling adult members regarding advance directives.

2.1.2 Specialty Care Provider (SCP) Responsibilities

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

- Ensuring continuity of care by communicating all testing and treatment to the member's PCP.
- Arranging for laboratory and radiological services when necessary and coordinating follow-up care.
- Participating in inpatient treatment, discharge planning, and follow-up care, as appropriate.

Medicaid/Members may self-refer for the following services:

- Mental health or substance abuse services with a Participating Provider.
- Vision services with a Participating Provider.
- Diagnosis and treatment of TB by public health agency facilities.
- Family planning and reproductive health from a Participating Provider or Medicaid Provider.
- Dental services with a Participating Dentist.

2.2. SPECIALTY CARE PROVIDERS AS PRIMARY CARE PROVIDERS (PCP)

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

2.3. OB/GYN PROVIDERS

A Participating OB/GYN Provider may be an obstetrician and/or gynecologist, Nurse Midwife or Nurse Practitioner (Nurses must be Board Certified to provide care to Medicare Advantage programs patients). OB/GYN Providers are SCPs who may also provide primary care services. Participating OB/GYN providers must comply with the presumptive eligibility standards for providing prenatal care services pending a full Medicaid eligibility determination on a potential enrollee.

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

- Routine gynecological services (up to two visits annually).
- Prenatal and all obstetrical care.
- Primary and preventive obstetrical and gynecological services required as a result of annual examinations or as a result of an acute gynecological condition.

Participating OB/GYNs are also required to comply with the informed consent procedures for hysterectomy and sterilization as specified in regulation and the DOHMH Public Health Guidelines (see Section 10).

2.4. CONTINUITY AND COORDINATION OF CARE

2.4.1 PCPs and SCPs

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

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

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

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

- Assessment of the effectiveness of discharge planning.

2.4.2 PCPs and Outpatient Behavioral Health Providers

2.4.2.1 Screening and Assessment

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

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

2.4.2.2 Consent and Communication

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

2.4.3 Continued Access to Terminated and Non-Participating Providers

MetroPlusHealth has established the following standards to ensure continuity of care for certain members whose Participating Provider's agreement is terminated or whose Provider does not participate with MetroPlusHealth:

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

- If a new enrollee has an established ongoing course of treatment with an out of network provider at the time of enrollment and is in the second trimester of her pregnancy, an authorization for out of network service will be given. This authorization will include the delivery and continue for a period to include provision of postpartum care directly related to the delivery.

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

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

2.5. ACCESSIBILITY OF SERVICE STANDARDS

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

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

2.5.2 Appointment Access and Availability Standards

2.5.2.1 Primary Care Provider Standards

- Emergency care must be provided immediately for a member with a medical emergency presenting at a PCP service delivery site.
- Urgent medical care must be provided within 24 hours of request.
- Non-urgent "sick" visits must be provided within 48 to 72 hours of request, as clinically indicated.
- Routine, non-urgent, preventive health visits must be provided within four weeks (28 calendar days) of request.
- Adult baseline and routine physicals must be provided within 12 weeks (84 calendar days) of the date of enrollment.
- Initial PCP visits for newborns must be provided within two weeks (14 calendar days) of hospital discharge.
- Well child visits must be provided within four weeks (28 calendar days) of request.
- Initial family planning visits must be provided within two weeks (14 calendar days) of request.
- Health assessments of a member's ability to work must be provided within 10 calendar days of request.

2.5.2.2 HIV Specialist PCP Standards for HIV Special Needs Plan Members

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

2.5.2.3 Specialty Care Provider Standards

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

2.5.2.4 OB/GYN Provider Standards

- Initial family planning appointments must be scheduled within two weeks (14 calendar days) of the request.
- First trimester initial prenatal care appointments must be scheduled within three weeks (21 calendar days) of the request. This appointment must be with the designated Participating OB/GYN Provider who will perform the ongoing coordination of care for the remainder of the pregnancy.
- Second trimester prenatal care appointments must be scheduled within two weeks (14 calendar days) of the request.
- Third trimester prenatal care appointments must be scheduled within one week (7 calendar days) of the request.

2.5.2.5 Behavioral Health Provider Standards

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

2.5.3 Office Waiting Time Standards

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

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

2.5.4 Facility Access Requirements

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

2.6. ADVANCE DIRECTIVES

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

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

2.7. CONFIDENTIALITY REQUIREMENTS

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

- All MetroPlusHealth staff receive privacy training upon employment and must sign a confidentiality agreement. Employees are subject to discipline, up to and including termination, for violation of policies and procedures for protecting member confidentiality.
- As part of the medical record review process, MetroPlusHealth verifies that Participating Provider's offices have established systems of maintaining member records in a confidential manner.

In addition, Participating Providers must develop policies and procedures to assure confidentiality of HIV-related information. The policies and procedures must include:

- An initial and annual in-service education of staff and contractors.
- Identification of staff allowed access to information and the limits of access.
- Procedures to limit access to trained staff and contractors.
- Protocols for secure storage including electronic storage.
- Procedures for handling requests for HIV-related information.
- Protocols to protect members with, or suspected of having, HIV from discrimination.

Providers may not discriminate against members in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

2.8. PROVIDER COMPLAINT PROCESS

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

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

2.9. DISCIPLINARY ACTION

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

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

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

2.9.1 Provider Sanction Levels

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

- Policies and procedures or guidelines related to medical record audits.
- Protocols for referring to non-Participating Providers.
- Obtaining required pre-authorization of services.
- Coding of claims.
- Access and Availability standards, including after-hours and 24-hour access.
- Minor quality issues not having an adverse effect on the member.

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

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

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

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

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

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

MetroPlusHealth will initiate a Level III sanction when the plan of correction requested in Level II is unacceptable or the Participating Provider remains non-compliant with the request. The Medical Director, on behalf of the Credentialing Committee, may recommend actions ranging from the initiation of practice limitations (i.e. restriction of certain procedures) to termination of the Participating Provider. In situations where severe quality issues may threaten member safety, the Credentialing

Committee may elect to recommend that the Participating Provider's participation be terminated. In such cases, sanction Level I and II would be bypassed and MetroPlusHealth would automatically initiate disciplinary actions as specified under Level III.

Depending on the nature of the situation, two possible events may occur:

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

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

2.9.2 Suspension

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

2.9.3 Right of Appeal

Participating Providers have the right to appeal any disciplinary action except termination as a result of imminent harm to patient care, determination of fraud, suspension or a final disciplinary action by a governmental agency or licensing board that impairs the Participating Provider's ability to practice. The hearing must be requested in writing within 30 calendar days of receipt of the notification. The plan must include in the termination notice the reasons for the proposed action and notice that the provider has the right to request a hearing or review, at the providers discretion, before a panel appointed by the MCO; and a time limit for a hearing date which must be held within thirty days after the date of receipt of a request for a hearing.

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

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

2.10. GOVERNMENT PROGRAM STANDING

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

Compliance with 42 CFR 455.105 and 42 CFR 455.106

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

2.11. PUBLIC TRANSIT COVERAGE AND REIMBURSEMENT

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

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

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

Medicaid-enrolled facilities and practitioners may voluntarily participate in a web-based application established by the Department of Health called Public Transportation Automated Reimbursement

System (PTAR). Facilities and practitioners participating in PTAR purchase MetroCards directly from the MTA and when a patient enrolled in Medicaid uses public transportation to travel to a medical appointment covered by Medicaid, the participating facility or practitioner will distribute a pre-paid MetroCard to the enrollee. The facility or practitioner is then reimbursed by the State. Public transportation is only reimbursed through the PTAR system.

To learn more about Medicare transportation benefits please review the Summary of Benefits or call Member Services.

2.12. APPROVED IN-OFFICE LAB TESTS

MetroPlusHealth has contracts in place with several reference laboratories to ensure that our members receive the highest quality diagnostic testing available. MetroPlusHealth also understands that there are certain times when it is clinically appropriate and more efficient to administer tests while the member is in the provider's office. Please reference *Appendix XVII* to clarify which lab tests can be performed in your office for our members.

2.13. MARKETING ACTIVITIES

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

If you have members in your pactice who are interested in or eligible for a MetroPlusHealth program, you may refer them to MetroPlusHealth Member Services.

For providers interested in on-site marketing, MetroPlusHealth will schedule time for a representative to be available at your office or facility for the convenience of your members. Please call **212.908.3636** for more information.

2.14. HOMELESS MEMBERS

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

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

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

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

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

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

2.15 RESTRICTED RECIPIENT MEMBERS

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

2.16 CULTURAL COMPETENCE

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

2.17 VACCINES FOR CHILDREN (VFC) PROGRAM UPDATE: FEE SCHEDULE CODE REVISIONS

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

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

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

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

CPT Code	Description
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use

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

CPT Code	Description
90633	Hepatitis A vaccine, pediatric/adolescent dosage, 2-dose schedule, for intramuscular use
90644	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months, for intramuscular use
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3-dose schedule), for intramuscular use
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use
90651	Human Papillomavirus vaccine types 6,11,16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), female/male ages 9-26 yrs.
90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
90680	Rotavirus vaccine, pentavalent, 3-dose schedule, live, for oral use
90681	Rotavirus vaccine, human, attenuated, 2-dose schedule, live, for oral use
90685	Influenza, inactivated virus vaccine, seasonal, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90686	Influenza, inactivated virus vaccine, seasonal, quadrivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90687	Influenza virus vaccine, quadrivalent, split virus, 0.25 ml dosage when administered to children 6-35 months of age, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, 0.5 ml dosage when administered to individuals for intramuscular use. Age varies by product.
90696	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90710	Measles, mumps, rubella and varicella vaccine (MMRV), live, for subcutaneous use

CPT Code	Description
90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use
90714	Decavac, tetanus and diphtheria toxiods absorbed for adult use
90715	Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
90716	Varicella virus vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids (Td) adsorbed for use in individuals 7 years or older, for intramuscular use
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B and poliovirus vaccine, inactivated (DTaP-HepB-IPV), for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3-dose schedule), for intramuscular use

2.18 QUALIFIED MEDICARE BENEFICIARY PROGRAM (QMB)

- Federal law bars Medicare providers and suppliers, including pharmacies, from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. (Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.).
- The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost sharing, including deductibles, coinsurance, and copays.
- Providers and suppliers, including pharmacies, may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States may limit Medicare cost sharing payments, under certain circumstances.
- Persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost sharing.

3. MEMBER SERVICES

3.1. MEMBER SERVICES FUNCTIONS

The Member Services Department functions as a centralized resource for members and providers. Member Service Representatives help to facilitate member access to appropriate medical and preventive health services and help providers with claim status, member eligibility, prior authorizations, updating provider contact information and plan benefits. The Member Services Call Center is available 24 hours per day, 7 days per week at **1.800.303.9626** for Medicaid/CHPlus/Medicaid HIV SNP, **1.866.986.0356** for MetroPlusHealth Medicare, **1.877.475.3795** for MetroPlusHealth Gold and **711** for TDD/TTY. MetroPlusHealth provides support and assistance to members with disabilities or special language needs. Bilingual staff and language line services are available to assist our non-English-speaking members. A complete listing of MetroPlusHealth phone numbers can be found on page 6.

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

The Welcome packets for Child Health Plus, MetroPlusHealth Gold and GoldCare includes the *Member Handbook* and other materials. For all other lines of business the Welcome Packet consists of the ID card and Welcome Letter with information on how to access the *Member Handbook* and *Provider Directory* online or request a printed copy to be mailed.

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

MetroPlusHealth has partnered with Cyracom International, Inc., a language interpreting company. Cyracom International, Inc. offers a variety of services that will help with any of your language needs, including qualified interpreters. More information can be found at their official website, www.interpret.cyracom.com.

3.2. CHOOSING AND CHANGING A PRIMARY CARE PROVIDER

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

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

Members (except Medicare) have the freedom to change their PCP for any reason twice in a twelve-month period. After the second time in a twelve-month period they must show good cause. A new PCP confirmation letter and member ID card is sent to members who change their PCP. Medicare beneficiaries have the freedom to change their PCP as many times as they wish in a twelve-month period.

3.3. MEMBER HEALTH ASSESSMENTS

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

3.4. MEMBER COMPLAINT PROCESS

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

For Medicaid and CHPlus, MetroPlusHealth utilizes complaints as an important source of information for continuous quality improvement. Members have the right to file a complaint, without the risk of retaliation, about any matter associated with MetroPlusHealth services or its Participating Providers. Member Services Department staff may take complaints in writing or by telephone by calling **800.303.9626** or TTY **711**. All complaints are forwarded upon receipt to the Complaint Manager for resolution. If a complaint cannot be resolved within 24 hours, the Complaint Manager mails an acknowledgment letter to the member within 15 calendar days of receipt of the complaint.

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

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

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

For Medicare: For services that are covered by both Medicaid and Medicare the member has the option of having their grievance resolved through the Medicare Grievance Process below or the Medicaid Grievance Process as stated above.

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

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

Members may contact Livanta at:

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

3.5. MEMBER RIGHTS AND RESPONSIBILITIES

Members have the **right** to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get services from MetroPlusHealth.
- Be informed of their diagnosis, appropriate or medically necessary treatment options for their condition(s) and their prognosis by their PCP in language they understand.
- Receive a second opinion about their care.
- Give consent for any treatment or care plan after the plan has been fully explained.
- Refuse care and be advised of the potential risks of doing so.
- Obtain a copy of their medical record and discuss it with their PCP.
- Know that their medical record information is private and is not shared with anyone except as required by law, contract or with their consent.
- Utilize the member complaint process to settle any complaints or notify the NYSDOH or New York Medicaid CHOICE about dissatisfaction with the plan (Medicaid, CHPlus members).
- Appoint a relative, friend or another person they trust, as a representative if a member is unable to make decisions regarding their own care and treatment.

Members have the **responsibility** to:

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

4. ELIGIBILITY

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

Step 1. At the time of each service, the member should present a MetroPlusHealth ID card.

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

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

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

4.1. ELIGIBILITY VERIFICATION METHODS

Information obtained from any of the following sources is valid on the date of request only.

4.1.1 Online Verification

Eligibility can also be verified by logging on to the MetroPlusHealth portal at www.metroplus.org, selecting the "Search Page" and then "Member Eligibility." Up to ten members may be verified at one time.

4.1.2 Electronic Medicaid Eligibility Verification System

For Medicaid Managed Care and HIV SNP members, the Medicaid CIN may be used to check eligibility through the Electronic Medicaid Eligibility Verification System (EMEVS) web site. EMEVS provides real-time information about the member's eligibility status. EMEVS is available from 9 A.M. to 7 P.M. daily. EMEVS does not identify a member's PCP.

Eligibility information may also be obtained by calling the automated EMEVS telephone verification line at **1.800.997.1111** and entering the MetroPlusHealth Provider Number 01529762 and the Plan Code 092. For questions regarding EMEVS, call **1.800.343.9000**.

Providers who see dual members with Medicare and Medicaid must verify Medicare and Medicaid eligibility. Providers may bill Medicare cost-sharing not covered by Medicare to NY Medicaid.

4.1.3 Member Roster

PCPs may refer to the most recent member roster to verify eligibility. PCPs can view and print rosters by logging on to the portal at www.metroplus.org, selecting the "Reporting Tools" tab on the left and then select "Rosters in Excel." The member roster, updated online monthly, contains key information about eligible members as well as members whose participation has been terminated. The date and reason for termination are also included on the member roster.

Due to frequently changing member status, information on the roster is not guaranteed to be accurate after the date of printing. Some members may not appear on the roster. PCPs must verify eligibility by using the other methods mentioned above. The Provider Services Department can be contacted for a detailed explanation of the roster data elements.

4.1.4 Member Services Department

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

4.2. DISENROLLMENT

4.2.1 Voluntary Disenrollment

MetroPlusHealth is committed to the provision of quality services and the retention of members. To support MetroPlusHealth in this effort, Participating Providers must ensure members have appropriate access to care. If clinical or administrative problems cannot be resolved at the care site, the member may contact the Member Services Department for assistance. If the problem persists and the member remains dissatisfied with MetroPlusHealth, the member has the right to disenroll.

- Medicaid Managed Care, HARP and HIV SNP members who enrolled prior to January 1, 2014 and want to disenroll are required to call MAXIMUS. All others must contact the New York State of Health (NYSOH) to disenroll.
- CHPlus members may discontinue membership at any time and must contact the New York State of Health (NYSOH) to disenroll. If the enrollee requests disenrollment by no later than the 20th day of the month, the child will be disenrolled by the last day of that month. If the request is received after the 20th of the month, the child will be disenrolled effective the last day of the following month.
- MetroPlusHealth Gold, GoldCare I and GoldCare II members may change coverage only during the annual open enrollment period.
- Medicare Advantage Plan members may have limits to when they can switch or disenroll from their plan. Members may change plans during the Annual Election Period (AEP) from October 15 through December 7. Enrollment elections made during the AEP will take effect on January 1 (some exceptions apply; for more information contact MetroPlusHealth Member Services or visit www.metroplus.org). Medicare Advantage members may make a one-time switch from one Medicare Advantage plan to a different one or may return to original Medicare during the Medicare Advantage Open Enrollment Period (MA-OEP) from January 1 through March 31. Members may also change their plan election if they have a Special Election Period (SEP). For

example, anyone with Medicaid or who receives Low Income Subsidy (LIS) can make changes once per quarter during the first nine months of the year.

4.2.2 Involuntary Disenrollment

4.2.2.1 MetroPlusHealth Initiated Disenrollment

MetroPlusHealth may disenroll a member under the following circumstances:

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

4.2.2.2 Involuntary Disenrollment from Medicaid Programs

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

- Medicare/Medicaid dually eligible (member may be eligible for and apply to MetroPlusHealth Medicare Advantage plans).
- Individuals with a County of Fiscal Responsibility Code 98 in MMIS until further directions from the State.
- Individuals receiving family planning services who are not otherwise eligible for medical assistance and whose net available income is <200% FPL.
- Individuals who are eligible for Medical Assistance pursuant to the Medicaid buy-in for the working disabled and who are required to pay a premium.
- Individuals who are eligible for Medical Assistance, under 65 years of age, have been screened for breast and/or cervical cancer under CDC Breast and Cervical Cancer Early Detection Program and need treatment, and are not otherwise covered under creditable coverage.
- Individuals who become eligible for Medicaid only after spending down a portion of their income.
- Residents of State operated psychiatric facilities or residents of State certified or voluntary treatment facilities for children and youth.
- Patients of Residential Health Care Facilities (RHCF) at the time of enrollment, and members whose stay in a RHCF is classified as permanent upon entry into the RHCF or is classified as permanent at a time subsequent to entry except for short-term rehabilitative stays anticipated to be less than 30 days.
- Medicaid-eligible infants living with incarcerated mothers.
- Individuals with access to comprehensive private health care coverage. Such coverage must be determined to be cost effective by the local social services district.
- Foster children in the placement of a voluntary agency.
- Certified blind or disabled children living or expected to live separate and apart from their parents for 30 or more days.

- Individuals expected to be Medicaid eligible for less than six months i.e., seasonal agricultural workers, except for pregnant women.
- Foster children in direct care.
- Youths in the care and custody of the Commissioner of the New York State Office of Children and Family Services.
- Individuals in receipt of long-term care services through Long Term Home Health Care programs, or Child Care Facilities except Intermediate Care Facilities services for the Developmentally Disabled.
- Individuals eligible for medical assistance benefits only with respect to tuberculosis-related services.
- Individuals temporarily residing out of district, i.e., college students, will be exempt until the last day of the month in which the purpose of the absence is accomplished.
- Individuals placed in New York State Office of Mental Health licensed family care homes pursuant to New York State Mental Hygiene Law.
- Individuals who are eligible for Medical Assistance pursuant to the Medicaid buy-in for the working disabled and who are not required to pay a premium.
- Individuals admitted to a Hospice program at the time of enrollment.
- Individuals with a County of Fiscal Responsibility Code 97 in MMIS.

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

4.2.2.2.1 Disenrollment of Uninfected Children from HIV SNP

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

4.2.2.3 MetroPlusHealth Child Health Plus (CHPlus) Involuntary Disenrollment

MetroPlusHealth may disenroll a CHPlus member under the following circumstances on the last day of the month:

- of the grace period if the family fails to pay the required family premium contribution by the end of the grace period;
- in which they learn that the enrollee is enrolled in Medicaid;
- in which they learn that the enrollee has access to state health insurance benefits or becomes enrolled in other health insurance;
- of a 12-month enrollment period if the enrollee fails to re-certify his or her eligibility prior to that date;
- in which the enrollee reaches age 19;
- in which the health plan learned that an enrollee has moved outside the plan's service area;
- in which the health plan learned that an enrollee has become an inmate of a public institution as defined at §435.1009 of 42 CFR Chapter IV or a patient in an institution for mental diseases, as defined at §435.l009 of 42 CFR Chapter IV.

4.2.2.4 MetroPlusHealth Medicare Advantage Plans

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

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

5. CLAIMS SUBMISSION AND REIMBURSEMENT

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

For CHPlus, Medicaid, SNP, Essential Plan, MetroPlusHealth Gold, and Gold Care I and II Programs Submit claims electronically: **Emdeon Payer ID# 13265** Submit CMS 1500 or UB-04 Forms: **MetroPlus Health Plan, Inc.** **P.O. Box 1966** **New York, NY 10116-1966**
For Medicare Advantage Plans Submit claims electronically: **Emdeon Payer ID# 13265** Submit CMS 1500 or UB-04 Forms: **MetroPlus Health Plan, Inc.** **P.O. Box 381508** **Birmingham, AL 35238-1508**
For MarketPlus Plans Submit claims electronically: **Emdeon Payer ID# 13265** Submit CMS 1500 or UB-04 Forms: **MetroPlus Health Plan, Inc.** **P.O. Box 830480** **Birmingham, AL 35283-0480**

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

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

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

5.1. EXPLANATION OF PAYMENT

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

5.2. CLAIMS PAYMENT RECONSIDERATION OR APPEALS

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

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

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

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

For Medicaid, SNP, HARP, MLTC, CHPlus, Essential Plan, MetroPlus Gold, and Gold Care I and II Programs **MetroPlus Health Plan, Inc.** **P.O. Box 1966** **New York, NY 10116-1966**
For Medicare Advantage Plans **MetroPlus Health Plan, Inc.** **P.O. Box 381508** **Birmingham, AL 35238-1508**
For MarketPlus Plans **MetroPlus Health Plan, Inc.** **P.O. Box 830480** **Birmingham, AL 35283-0480**

All requests for payment reconsideration should include the following information:

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

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

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

Providers can view claims status on MetroPlusHealth's website at **www.metroplus.org** or providers may call **Provider Services** at **1.866.986.0356**, **Monday to Friday**, **9:00 A.M. – 5:00 P.M.**

REGARDING THE PRACTICE OF BALANCE BILLING BY PARTICIPATING PROVIDERS

Participating providers are prohibited from seeking payment from billing, or from accepting payment from any member, for fees that are the legal obligation of MetroPlusHealth.

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

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

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

OTHER IMPORTAINT INFORMATION

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

5.2.1 Medicaid, HIV SNP, HARP, MLTC, CHPlus, Essential, MarketPlus, Gold and GoldCare I&II Lines of Business:

Requests for reconsiderations (claim appeals of an initial determination) can be made via telephone, fax, or mail. Written appeals must explain the reason for the appeal and include all pertinent information as well as a copy of the original claim. All claim determination appeals must be received within 45

calendar days of the date of the initial check or denial notification. Payment adjustments may be made retrospectively by adding or subtracting the adjustment amount from subsequent payments. A revised EOP accompanied by a check, if applicable, will be sent indicating the adjustment reason. All requests for reconsideration will be handled within 60 calendar days of receipt. MetroPlus will allow providers to ask for reconsideration of rejected claims submitted after the deadline and are permitted to reduce payment up to 25%. MetroPlusHealth my pay the claim if the provider shows that the disagreement was due to an unusual action and the provider usually submits claims on time.

5.2.2 Medicare Lines of Business:

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

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

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

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

5.3. CLAIMS REVIEW SOFTWARE

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

5.4. ADVERSE REIMBURSEMENT CHANGES

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

5.5. OVERPAYMENTS AND RECOUPMENTS

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

This notice shall state the patient name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment. MetroPlusHealth shall provide a health care provider with the opportunity to challenge an overpayment recovery, and will upon request share of claims information, for the purposes of challenging an overpayment recovery. This policy establishes written procedures for health care providers to follow to challenge an overpayment recovery initiated by MetroPlusHealth. When challenging an overpayment, the provider must set forth the specific grounds on which the provider is challenging the overpayment recovery. MetroPlusHealth shall not initiate overpayment recovery efforts more than 24 months after the original payment was received by a health care provider, except in the case of the Medicaid Managed Care program, as the overpayment recovery period for such programs is six years from the date payment was received by the health care provider. However, no such time limit applies to overpayment recovery efforts which are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, (ii) required by, or initiated at the request of, a self-insured plan, or (iii) required or authorized by a state or federal program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees, or members. Notwithstanding the aforementioned time limitations, in the event that a health care professional asserts that a health plan has underpaid a claim or claims, MetroPlusHealth may defend or set off an assertion of underpayment based on overpayments going back in time as far as the claimed underpayment. For the purposes of this policy, "abusive billing" is defined as a billing practice which results in the submission of claims that are not consistent with sound fiscal, business, or medical practices and at such frequency and for such a period of time as to reflect a consistent course of conduct.

In addition to the above requirements set forth in the New York State Insurance Law, MetroPlusHealth has confirmed with the New York State Department of Health Division of Managed Care on January 12, 2010 that providers are not required to be notified prior to recovery efforts pursuant to retroactive changes to provider reimbursement, where such reimbursement is based on rates established by the New York State Medicaid program (e.g. retroactive DRG changes).

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

5.6. READMISSION REIMBURSEMENT POLICY

MetroPlusHealth will conduct hospital readmission review to determine if a readmission is considered clinically related to the previous admission. Readmissions determined to be related to the previous admission will not be separately reimbursed. This applies to facilities for readmissions that have occurred within thirty (30) calendar days of a previous discharge within the same hospital.

A clinical review,overseen by a Medical Director will determine if the readmission was clinically related to the previous admission based on clinical criteria. This medical record review is to determine if the admission is related and not an assessment of medical necessity or appropriateness of the setting.

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

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

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

6. CREDENTIALING

6.1. CREDENTIALING CRITERIA

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

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

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

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

Provider Data Validation During the Credentialing Process:

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

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

Compliance with 42 CFR 455.105 and 42 CFR 455.106

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

6.2. PRIMARY CARE PROVIDER (PCP) CREDENTIALING

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

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

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

6.2.1. HIV Specialist Primary Care Providers

HIV-experienced PCP providers in Family Practice, Pediatrics, Internal Medicine, Adolescent Medicine or Infectious Disease may be designated as HIV Specialist PCPs. For a full description of the credentialing criteria for HIV Specialist PCPs, please see *Section 9.1.*

6.3. COLLABORATIVE PRACTICE AGREEMENTS

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

6.4. OFFICE STANDARDS

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

6.5. CREDENTIALING FILES

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

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

6.6. RECREDENTIALING

Participating Providers are recredentialed at least once every three years. The recredentialing cycle begins with the date of the initial Credentialing Committee decision. The Credentialing Committee reviews all information contained in the Participating Provider's credentialing file in its recredentialing review process.

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

- New York State license registration renewal
- DEA registration renewal
- Malpractice coverage renewal
- Changes to a Participating Provider's name
- Medicaid and/or Medicare participation status
- License disciplinary status/sanction
- Changes in office hours
- Change to open/closed status
- Annual verification of HIV specific continuing medical education for those Participating Providers credentialed as HIV Specialists
- Medicaid and/or Medicare sanction/exclusion

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

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

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

6.7. DELEGATION OF CREDENTIALING AND RECREDENTIALING

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

7. UTILIZATION MANAGEMENT

7.1. UTILIZATION/CARE MANAGEMENT PROGRAM AND PLAN

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

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

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

7.2. UTILIZATION MANAGEMENT STAFF

The Utilization Management staff consists of qualified, licensed health professionals whose education, training and experience are commensurate with the type of utilization review they conduct. A licensed Physician makes medical necessity determinations for all authorization requests that have not met the clinical criteria (see *Section 7.11*). A psychiatrist reviews all authorization requests for behavioral healthcare that have not met the clinical criteria. MetroPlusHealth may also use board certified physician specialists for utilization review decisions.

Medically Necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap.

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

7.3. COVERED SERVICES AND BENEFIT PACKAGES

Each MetroPlusHealth product line has a separate benefit package that specifies the types of services covered or not covered by MetroPlusHealth. The benefit package also outlines any limitations on the number or frequency of services allowed. Members in Medicaid Managed Care, Medicaid HIV Special

Needs Plan (Partnership in Care), MetroPlusHealth Enhanced Plan (HARP), and MetroPlusHealth Advantage Plan (HMO SNP) retain eligibility for some additional services through Medicaid Fee-for-Service. These services must be billed directly to Medicaid. Summaries of the covered services and benefit packages for each of the product lines can be found in *Appendix X*. Providers may also call the Member Services Department with the member's identification number to obtain specific information about covered services and inquire about benefit limitations.

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

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

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

All women enrolled are presumed eligible for one medically necessary postpartum home health care visit which may include assessment of the health of the woman and newborn, postoperative care as appropriate, nutrition education including breastfeeding, family planning counseling to ensure optimal birth spacing, and parenting guidance. Referrals to the attending physician and/or health plan case manager of the pregnant woman or infant shall be made as needed. Other than the initial postpartum visit, additional home health visits must meet one of the four medical necessity criteria listed above.

7.4. BENEFIT MANAGEMENT SERVICES

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

7.4.1 Dental Services

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

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

7.4.2 Pharmacy Services

MetroPlusHealth provides Prescription Drug Coverage to its plan members as outlined in the benefit summaries found in *Appendix X*. This includes MetroPlusHealth Gold members who have enrolled in the MetroPlusHealth Gold Optional Prescription Drug Rider. The formularies can be accessed online at www.metroplusmedicare.org.

MetroPlusHealth provides Medicare Prescription Drug Coverage (Part D) to MetroPlusHealth Advantage Plan, and MetroPlusHealth Platinum Plan members. Providers may access the Medicare Formulary, changes to the Formulary and Part D related information online at www.metroplus.org/member-services/formularies.

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

7.4.3 Durable Medical Equipment (DMEs)

MetroPlusHealth provides Durable Medical Equipment services to its plan members, as outlined in the benefit summaries found in *Appendix X*. While all utilization management activities are delegated to our DME benefit manager, MetroPlusHealth retains ultimate responsibility for those activities. At least annually, the benefit manager's utilization management program descriptions and annual plans – including authorization, denial and appeal policies and procedures – are reviewed for approval.

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

7.4.4 Behavioral Health and Substance Abuse Services

MetroPlusHealth provides Behavioral Health and Substance Abuse Services to its plan members, as outlined in the benefit summaries found in *Appendix X*. While all utilization management activities are delegated to our behavioral health benefit manager, MetroPlusHealth retains ultimate responsibility for

those activities. At least annually, the benefit manager's utilization management program descriptions and annual plans – including authorization, denial and appeal policies and procedures – are reviewed for approval.

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

7.5. EVALUATION OF NEW MEDICAL TECHNOLOGY

MetroPlusHealth has a procedure for evaluating new technologies and the new application of existing technologies for possible inclusion within the benefits packages. Such medical technologies include medical procedures, behavioral interventions, pharmaceuticals and medical equipment.

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

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

MetroPlusHealth has established a Medical Policy Subcommittee to review new medical technology, as outlined in *Section 7.11: Clinical Criteria for Utilization Review Decisions.*

7.6. MEDICAL SPECIALTY OUTPATIENT REFERRALS TO PARTICIPATING PROVIDERS

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

7.7. OUTPATIENT PERINATAL CARE NOTIFICATION REQUIREMENTS

Outpatient perinatal care services provided by a Participating Provider do not require authorization. However, notification of a member's initiation into prenatal care is required. Participating Providers must submit a "Notification of Pregnancy Form" or the initial obstetrical risk assessment. This

notification ensures that the member is evaluated for enrollment into the high-risk obstetrics care management and education program. This notification also enables the facilitation of enrollment of eligible unborn children into the Medicaid program and helps to ensure prompt claims payment.

7.8. EMERGENCY ROOM VISITS

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

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

- Limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms; or
- Refuse to cover emergency room services based on the failure of the Provider or the member to give MetroPlusHealth notice of the emergency room visit; or
- Require members to obtain emergency services from Participating Providers.

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

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

ER claims should not be submitted for:

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

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

7.9. SERVICES REQUIRING AUTHORIZATION

The following services require authorization for payment (see *Appendix X* for benefit information and authorization requirements):

- Services provided by a Non-Participating Provider (except in an emergency)
- Behavioral Health and Substance Abuse Services

- Inpatient Admissions (except maternity)
- Inpatient Private Duty Nursing
- Home Health Care
- Personal Care and Consumer Directed Personal Care Services
- Hospice Services
- Prenatal or Genetic Testing
- Transgender Services
- Surgical Services
- Organ Transplants
- Personal Emergency Response System (PERS)
- Skilled Nursing and Acute Rehab Facility Care
    - Under MetroPlusHealth's community-based Skilled Nursing Facility agreements, each facility is financially responsible for all medical services (with some limitations) provided to a resident. Therefore, Providers who administer services to MetroPlusHealth members in Skilled Nursing Facilities must seek reimbursement from the facility. If you have questions regarding this policy, please contact your Provider Relations Representative. Before seeking payment from MetroPlusHealth, an authorization would be required.
- Durable Medical Equipment, including Orthotics and Prosthetics, and Enteral Formula and Supplies
- Erectile Dysfunction Treatments
- Potentially Cosmetic Procedures (see *Section 7.20*)
- Experimental/Investigational or Rare Disease Treatment
- Physical Therapy, Occupational Therapy and Speech Therapy
    - For Medicaid members, Physical Therapy, Occupational Therapy and Speech Therapy visits in excess of 20 visits in a calendar year for "exempt members." This includes members who are children 0-20 years of age and/or members with developmental disabilities (R/E code 95), or a member in a Home and Community Based Services (HCBS) Waiver Program for Traumatic Brain Injury (TBI) (R/E code 81). All other non-exempt Medicaid members are subject to a limit of 20 visits per calendar year per specialty type.
- Drugs requiring prior authorization and specialty drugs contact the pharmacy benefit manager at the number listed on metroplus.org and the Provider Quick Reference guide. Restricted members who are restricted to a particular Provider cannot be seen by another Provider (of the same specialty) without a prior authorization.
- Habilitative Services
- Chiropractic Services
- House Calls (Home Provider Visits)

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

7.9.1 Services Requiring Authorization per MetroPlusHealth Medical Policies

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

The following require prior approval as per our Medical Policies for all members (or applicable Health Plan), unless noted otherwise:

- Abdominoplasty Panniculectomy
- Automatic External Defibrillators
- Bariatric Surgery
- Blepharoplasty
- BRCA 12 Genetic Testing
- Capsule endoscopy camera pill
- Gender Reassignment Surgery
- Varicose Vein Treatment
- Video Electroencephalographic (EEG) Monitoring
- Exondys 51
- Urine Drug Testing
- Kymriah
- Long-acting Opioids
- Continuous Glucose Monitoring
- Topical Oxygen Therapy
- Exchange Transfusion for Sickle Cell Disease
- Readmission
- Cardiac Rehab
- MRgFUS
- Pasteurized Human Donor Milk
- Yescarta
- Allergy Testing
- Insulin Pump
- Spinraza
- Perinatal Care
- OnabotulinumtoxinA
- Nerve Conduction Study
- Penile Prosthesis Implantation
- Sleep Studies
- Treatment for HIV Associated Facial Lipoatrophy
- Remicade Biosimiliar Step Therapy
- High Tech Radiologic Studies
- Medicare Supervised Exercise Therapy (SET) for PAD
- EM Reimbursement Policy
- CardioMEMS
- Whole Genome Sequencing
- Gene Expression Profile Testing for Multiple Myeloma
- Chemical Peels and Dermabrasion
- Cardiac PET
- Infertility Services – Commercial LOBs

7.9.2 Fertility Benefits

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

Medicaid Fertility Coverage: Effective 10/1/2019:

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

For details about infertility and the state's demonstration project, see the infertility information on the DOH website and the New York State Medicaid Update – June 2019 Volume 35 – Number 7.

Commercial Plan Fertility Coverage: Effective 1/1/2020:

New York State (NYS) recently passed legislation that requires insurers like MetroPlusHealth to update the infertility services coverage they provide to members as policies issue, renew or are amended on and after January 1, 2020. MetroPlusHealth will comply with NYS mandate for IUI/IVF and fertility preservation by creating new Medical Policy for Commercial Plans for IVF and adding pre-authorization requirements to specific CPT codes; please refer to our website for the latest Medical Policy and list of codes within that will require prior authorization. The IVF law requires large group medical plans to cover three cycles of IVF used in the treatment of infertility. The fertility preservation law requires individual, small, and large group insurance policies or contracts to provide coverage of fertility preservation services for iatrogenic infertility.

7.9.3 Services Requiring Authorization for Special Populations

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

MetroPlusHealth Children Services HCBS offers personal, flexible support services for children, youth, and families at home and in the community. A MetroPlusHealth care manager will help members get the services that are right for them.

Effective July 2019 – Children and Family Treatment and Support Services (CFTSS):

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

Community Psychiatric Support & Treatment – Services to help members learn about their behavioral health needs and receive supportive therapy.

Psychosocial Rehabilitation – Behavioral health services designed to support a child's/youth's ability to reach appropriate developmental functioning.

Other Licensed Practitioner – Non-physician licensed behavioral health therapist who provides clinical services to help members with their behavioral health needs.

Family Peer Support Services – Activities and supports for families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use, and/or behavioral health issues in the home, school or in the community.

Crisis Intervention (Available January 1, 2020) – Behavioral Health treatment provided to children and youth experiencing serious psychological/ emotional issues that require urgent attention.

Youth Peer Support and Training (Available January 1, 2020) – Services for youth experiencing social, medical, emotional, substance use, and/or behavioral challenges in their home, school or the community.

Effective October 2019 – Children's Home & Community Based Services (HCBS)

These new services give children and their families the ability to improve their care and their quality of life by identifying needs early, and providing support in the home or community. To find out more, contact your healthcare provider, Health Home care manager, or care coordinator.

Respite (planned & crisis) – Short term assistance and/ or relief for children with disabilities. Direct care services required to support children/youth improve their functioning. Skilled nursing services must be ordered by a physician.

Prevocational Services – Designed to prepare youth to obtain paid work, volunteer work or learn about various careers.

Supported Employment – Services designed to support children/youth to be able to continue work.

Caregiver/Family Supports and Services – Improve the child/ youth's ability to remain with their family and improve the caregiver's ability to care for them in the home/ community.

Community Self-Advocacy Training & Support – Assists child and family/caregiver in understanding and addressing the child's needs related to their disability in order to assist the child's ability to participate with peers in age-appropriate activities.

Habilitation (including Day and Community Habilitation) – Assistance with obtaining, retaining or improving member's ability to help themselves, develop social skills and perform daily living skills to take care of themselves.

Adaptive and Assistive Equipment – Technological aids and devices that enable a child to obtain daily living skills that are necessary to support their health, safety and well-being.

Environmental Modifications – Providesinternal and external physical changes to the home or other residence to support the health, safety, independent functioning and well-being of the child.

Vehicle Modifications – Provides physical changes to the primary vehicle of the child which are necessary to support the health, safety, or greater independent functioning of the child.

Palliative Care (Pain & Symptom Management, Bereavement Service, Massage Therapy, Expressive Therapy) – Specialized medical care focused on providing relief for the symptoms and stress of chronic or life-threatening illness.

Non-medical transportation – Non-medical transportation will be paid by Medicaid for eligible children/youth, whether the child/youth is enrolled in Medicaid Managed Care or not.

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

Medicaid Managed Care Model Contract

OHIP Principles for Medically Fragile Children

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

7.10. CLINICAL CRITERIA FOR UTILIZATION REVIEW DECISIONS

The Utilization/Care Management clinical staff uses InterQual® criteria for making inpatient utilization review decisions about medical necessity and appropriate level of care. The member's individual circumstances and the local health care delivery system are also considered. InterQual® criteria are based on scientific evidence and the consensus of national experts. When criteria, as applied by the Utilization/Care Management clinical staff, are not met, a Physician Advisor or a medical specialist will review the clinical information and render a determination.

MetroPlusHealth has established Medical Policy Subcommittee (MPS). The MPS institutes clinical policy to support enterprise-wide coverage determinations for the health of the plan's membership. Specific MPC activities include:

- Assesses bioethical, clinical and legal implications of medical technologies (defined as biologics, devices, diagnostics, drugs, procedures, systems or techniques) and the appropriate utilization.
- Evaluate new medical technologies/new application of existing technologies.
- Develop and publish evidence-based intervention-specific clinical criteria in a guideline format. Review evidence-based Utilization Management (UM) and Quality Management (QM) clinical decision-making criteria for approval and adoption.
- Review both licensed and national standard UM decision making clinical criteria, the procedures for applying them and communicate update expectations, as appropriate.
- Evaluate clinical appropriateness of scope of service/privileging requests when consulted, as appropriate.
- Evaluate clinical appropriateness of in-house/delegate coding-edit proposals, or outlier coding issues with clinical ambiguity, when consulted as appropriate.
- Lend expertise for special project guidance when consulted as appropriate.

A copy of the criteria used for making utilization review decisions is available to providers upon request. To ensure consistent application of the criteria, the Utilization/Care Management clinical staff, including Physician Advisors, are evaluated at least annually on their application of the criteria used in decision-making.

Please refer to the Provider Section of our website under Tools for the most current list of Medical Policies and services requiring Prior authorization at: https://www.metroplus.org/provider/tools.

7.11. REQUIREMENTS FOR UTILIZATION REVIEW DECISIONS

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

Providers must phone or fax all the required information requests to the Utilization/Care Management Department. Providers may use their own forms to submit this information if all necessary member and medical information is captured, or they may contact the Utilization/Care Management Department for a copy of form templates.

Medically necessary emergency services and medical care for stabilizing or evaluating an emergency condition are not subject to prior authorization. If a member believes that a medical emergency exists, they should be directed to go the nearest emergency room or call 911 for assistance.

7.11.1 Services Provided by a Non-Participating Provider

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

- Member's name, date of birth, and identification number.
- Referring Participating Provider name and phone number.
- Type of care being requested.
- Non-Participating Provider's name and phone number.
- Rationale for proposing the use of a Non-Participating Provider.
- Diagnosis and ICD-10 code(s), including co-morbidities.
- Proposed tests, treatment and care to be rendered by the Non-Participating Provider.
- Member's medical and treatment history.
- Current medications.
- Diagnostic test and lab results to date.
- Number of visits requested and frequency of visits.

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

- Member's name, date of birth, and identification number.
- Non-Participating Provider's name and phone number.
- Tests, treatment and care rendered to date.
- Outcome of treatment to date.

- Current signs and symptoms.
- Proposed future tests, treatment and care to be rendered.
- Diagnostic test and lab results to date.
- Number of visits requested and frequency of visits.

7.11.2 Behavioral Health and Substance Abuse Services

Members may self refer to a Participating Provider for an initial behavioral health or substance abuse visit. Please see *Appendix XE* for benefit information and authorization requirements.

7.11.3 Inpatient Admissions (except maternity)

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

- Member name, date of birth, and identification number.
- Referring Participating Provider name and phone number.
- Admitting Physician's name and phone number.
- Admitting facility name.
- Utilization review contact name, phone and fax numbers.
- Admission date.
- Diagnosis and ICD-10 code(s), including co-morbidities.
- Level of care (medical, surgical, rehabilitation, mental health, and chemical dependency services).
- Signs and symptoms necessitating admission (severity of illness).
- Estimated length of stay.
- Proposed procedure(s) and treatment(s).
- Member's medical and treatment history (including failed attempts at conservative outpatient medical treatment, if applicable).
- Diagnostic test and lab results to date.
- Co-morbidities.
- Current medications including proposed or actual medication changes during the admission.
- Proposed discharge plan.

Concurrent reviews will be conducted approximately every three to seven days following the initial review, or as deemed necessary by the Utilization/Care Management clinical staff. The following information is required for concurrent review:

- Member name, date of birth, and identification number.
- Member medical record number.
- Diagnosis and ICD-10 code(s), including co-morbidities.
- Signs and symptoms necessitating continued stay (severity of illness).
- Current condition/medical status.
- Treatment Plan (intensity of services needed).
- Procedures, treatments and consults completed and scheduled.
- Diagnostic test and lab results to date.

- Medication changes since the last review.
- Estimated discharge date.
- Proposed discharge plan.
- Utilization review contact name and phone number.

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

If the newborn is admitted to the Neonatal Intensive Care Unit, the Utilization/Care Management Department must be notified. Concurrent review for the newborn will be conducted as outlined above (not applicable to Medicare members).

7.11.4 Home Health Care

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

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

The following information is required for authorization:

- Member name, date of birth, and identification number.
- Diagnosis and ICD-10 code(s), including co-morbidities.
- Referring Participating Provider name and phone number.
- Participating Home Health Care Provider's name and phone number.
- Proposed date of initiation of services.
- Type of service(s) to be rendered.
- Member's medical and treatment history.
- Treatment plan, including short and long-term goals, number, type and frequency of visits requested.
- Signs and symptoms.
- Current medications.
- Diagnostic test and lab results to date.
- Discharge plan.

If an extension of the authorization is needed, the Participating Home Health Care Provider must submit a clinical justification for the continuation of treatment. The following information is required:

- Member name, date of birth, and identification number.
- Diagnosis and ICD-10 code(s), including co-morbidities.

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

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

- Member name, date of birth, and identification number.
- Diagnosis and ICD-10 code(s), including co-morbidities.
- Outcome of treatment.
- Member's progress towards meeting goals.
- Proposed discharge date.
- Plan for follow up with the PCP.

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

7.11.5 Personal Care and Consumer Directed Personal Care Services

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

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

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

7.11.6 Personal Emergency Response System (PERS)

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

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

7.11.7 Durable Medical Equipment (DME), Orthotics and Prosthetics and Enteral Formula/Supplies

The following information is required for authorization:

- Member name, date of birth, and identification number
- Member address and phone number
- Participating DME Provider's name and phone number
- Diagnosis and ICD-10 code(s), including co-morbidities
- Type and specifications of DME requested
- DME codes
- Medical need for the DME
- Purchase or rental (include projected duration of need for rentals)
- Number of units required

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

For some MetroPlusHealth plans, enteral formula must be obtained through CVS Caremark. See *Section 7.4.2: Pharmacy Services* and *Appendix X*.

7.11.8 Erectile Dysfunction Treatments

The following information is required for authorization:

- Member name, date of birth, and identification number
- Referring Participating Provider name and phone number
- Admitting facility name
- Proposed date of service
- Diagnosis including ICD-10 code(s), CPT code(s) and HCPCS code(s)
- Level of care (inpatient or outpatient)
- Estimated length of stay
- Utilization review contact name, phone and fax numbers

7.12. TYPES OF SERVICE AUTHORIZATION DETERMINATIONS AND TIMEFRAMES FOR REVIEW (SEE *SECTION 7.18* FOR MEDICARE)

When a service authorization is requested, the process to review the request depends on the clinical urgency of the member's situation, the level of care requested, and whether the request is for prior authorization, concurrent review, or retrospective review. When a determination is not made within the timeframes described below, it is considered an Adverse Determination or Action and a notice of denial is sent on the date the timeframe expired.

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

7.12.1 Prior Authorization Request

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

- ***Standard review –***
  Medicaid, HARP, CHP, Medicaid HIV/SNP,
  MetroPlusHealth Gold, MetroPlusHealth GoldCare, MLTC:
  a decision is made within three (3) business days of the receipt of all necessary information, but no later than fourteen (14) days after the request is received.
- ***Standard review –***
  Marketplace & Essential:
  a decision is made within three (3) business days of the receipt of all necessary information, but no later than forty-five (45) days from the date that the request is received.
- ***Fast track review –***
  Medicaid, HARP, CHP, Medicaid HIV/SNP,
  MetroPlusHealth Gold, MetroPlusHealth GoldCare, MLTC:
  a decision is made, and notification occurs within 72 hours from the date that the request is received.
- ***Fast track review –***
  Marketplace & Essential:
  a decision is made, and notification occurs within 72 hours from the date and time that the request is received

7.12.2 Concurrent Review Request

A concurrent review request is a request for continuation or addition of a service that was previously authorized or a request for authorization of payment for services that the member is currently receiving. Upon receipt of the request, the Utilization/Care Management Department staff will review the authorization request under either a standard or fast track process. The fast track process is used if it is requested by the Provider or if it is believed that a delay in the review of the request will cause serious harm to the member's health. In either case, the Utilization/Care Management staff will review the request and notify the Provider and the member by phone and in writing as fast as the member's medical condition requires but no later than the timeframes outlined below. MetroPlusHealth delegates member phone notification to the Provider, when the authorization is requested by the Provider.

- ***Standard review –***
  Medicaid, HARP, CHP, Medicaid HIV/SNP, MetroPlusHealth Gold, MetroPlusHealth GoldCare, MLTC:
  a decision is made within one (1) business day of the receipt of all necessary information, but no later than fourteen (14) days from the date that the request is received.
- ***Standard review –***
  Marketplace & Essential:
  a decision is made within one (1) business day of the receipt of all necessary information, but no later than forty-five (45) days from the date that the request is received.
- ***Fast track review –***
  Medicaid, HARP, CHP, Medicaid HIV/SNP, MetroPlusHealth Gold, MetroPlusHealth GoldCare, MLTC:
  a decision will be made within one (1) business day of the receipt of all necessary info, but no later than 72 hours from the date that the request is received.
- ***Fast track review –***
  Exchange & Essential:
  If the request is received at least 24 hours prior to the expiration of the previously approved service, a determination made within 24 hours of receipt of the request. If request is not received at least 24 hours prior to the expiration of a previously approved service, determination made within the earlier of 72 hours or 1 business day of receipt of the request.

7.12.3 Service Authorization Determination Extensions

Timeframes for the service authorization determinations noted above may be extended if:

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

Extension Timeframe –
Medicaid, HARP, CHP, Medicaid HIV/SNP, MetroPlusHealth Gold, MetroPlusHealth GoldCare, MLTC:
Timeframes for the service authorization determinations may be extended fourteen (14) calendar days.

7.12.4 Retrospective Review Request

A retrospective review request is an initial review of a service for which the request for authorization for payment is received after the service or treatment has been provided to the member. If payment for a service is denied, a notice is sent to the Provider and member on the date that the payment is denied. MetroPlusHealth reserves the right to deny a request for retrospective review when the service has been deemed non-urgent and authorization requirements are not met.

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

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

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

7.12.5 Timeframes for Notices of Other Actions

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

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

7.13. SERVICE AUTHORIZATION REQUEST DENIALS

Any decision to deny a service authorization request or to approve for an amount that is less than requested is called an action or initial adverse determination. An action or initial adverse determination on a service authorization request is an activity that results in:

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

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

- The member is ineligible on the date of service.
- Authorization procedures were not followed including failure to request authorization within the required timelines and failure to obtain prior approval for services which are retrospectively deemed to have been non-emergent.
- The service is not a covered service under the benefit plan.
- The benefit limit for the requested service has been met.
- The treatment being requested is a result of a motor vehicle accident and the primary insurer is no fault coverage.
- The treatment being requested is a result of a work-related injury and the primary insurer is workers' compensation.
- The proposed Provider does not participate with MetroPlusHealth and the service(s) could be performed by a Participating Provider. If the following information is provided upon appeal, the appeal will not be considered administrative:

Out-of-Network Service:

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

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

Out-of-Network Referral:

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

(a) the in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee for the health service; and

(b) recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the enrollee, and who is able to provide the requested health service.

7.13.1 Notice of Denial of Request for Authorization

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

At a minimum the notice of utilization review (UR) clinical denials include:

- The reasons for the determination including the clinical rationale, if any. Clinical rationale will identify:
  - The nature of the member's medical condition
  - The medical service, treatment or procedure in question, and
  - The basis for determining that the service, treatment or procedure is or was not medically necessary or experimental/investigational, which demonstrates that the member-specific information was considered when making the determination.
- Instructions on how to initiate internal standard and expedited appeals
- Description of any additional information required to render a decision on the Appeal
- Clinical review criteria are available for review, when applicable.
- Eligibility for an external appeal

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

- A description of action to be taken
- A statement that the Plan will not retaliate or take discriminatory action if appeal is filed
- The process and timeframe for filing/reviewing appeals, including enrollee right to request expedited review.
- The member's right to contact DOH, with 1-800 number, regarding their complaint.
- The Fair Hearing notice including aid to continue rights
- A statement that the notice is available in other languages and formats for special needs and how to access these formats.

Definition of an External Appeal

Members may file a Standard or Expedited Appeal

- If a denial upheld on expedited internal appeal, a member may choose to file an internal standard appeal or apply for an external appeal.
- The member must file for an external appeal with four (4) months of receiving the final adverse determination or agreement to waive the internal appeal process. A Provider who is filing an external appeal on his/her own behalf will have 60 days from the date of the final adverse determination to file an external appeal.

7.13.2 Reconsideration of Clinical Denials

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

7.14. NON-COVERED BENEFITS

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

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

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

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

- Poly-L-lactic acid injection (Sculptra) or calcium hydroxylapatite injection (Radiesse) for HIV lipoatrophy
- Chin implant (genioplasty, mentoplasty)
- Cheek implant (malar implants)

7.15. AUTHORIZATION DENIAL APPEALS (SEE *SECTION 7.18* FOR MEDICARE PLANS)

7.15.1 Internal Appeals

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

- MetroPlusHealth will assist members with completion of forms and procedural steps for filing an action appeal.
- The member may designate a representative to file on their behalf.
  - Providers cannot request aid to continue on behalf of the member without the written consent from the member.
- An enrollee has the right to Aid Continuing in the following circumstances:
  - The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or
  - For an enrollee in receipt of long-term services and support or nursing home services (short- or long-term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long-term services and support or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.
- An enrollee does not generally have a right to Aid Continuing for concurrent review determinations for extended services beyond the original authorization period unless the above circumstances exist. The plan must still provide Aid Continuing if so directed by the Office of Administrative Hearings.
- Member will automatically be provided with aid continuing without interruption if they submit an appeal within 10 days of when the Plan sends the Initial Adverse Determination, or prior to the effective date of the determination, whichever is later.
- The member may file an action appeal orally or in writing.
- The member may present the action appeal in person and may access the case file and any medical records related to the action appeal.
- An action appeal resulting from a concurrent review determination will be handled as an expedited appeal.
- The member may request an expedited appeal and if the request is denied the member will be notified orally and in writing within two days of the denial.
- Action appeal notices are available in several languages and for members who are visually impaired. Oral interpretation and alternate formats can be requested through the Member Services Department.

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

of the agreement to waive the internal appeal process. MetroPlusHealth does not require the member to exhaust the second level of internal appeal to be eligible for an external appeal.

Appeals should be sent to:

Metro Plus Health Plan
Appeals Coordinator
160 Water St, 3rd Floor, 33ML
New York, NY 10038
Tel: 212.908.8532

7.15.2 Administrative Appeals

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

- The Provider submits the appeal which must be received within 60 calendar days of the date on the denial notice.
- An acknowledgment of receipt notice is sent to the Provider within 15 calendar days of the receipt of the appeal.
- A decision is made within 30 calendar days of the receipt of all information needed to make a determination.
- A notice of appeal decision is mailed to the Provider within two business days.
- If the denial decision is upheld, the notification will include the rationale for the decision and instructions for filing a Fair Hearing request.

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

7.15.3 Clinical Appeals

A member, their designee or a Provider may appeal clinical authorization denials, also known as adverse determinations. A provider may file a utilization review appeal for a retrospective denial. Adverse determinations are made by a clinical peer reviewer at MetroPlusHealth. There are two types of clinical appeals, standard and expedited. There are two appeal levels, first and second, of standard and expedited appeals. The following plans are not eligible for an internal second level appeal with MetroPlusHealth: Managed Medicaid, HIV SNP, HARP, Marketplace, Essential, Medicare, and MLTC.

7.15.3.1 First Level Standard Appeals

The following steps and timeliness will be followed:

- The member, the member's designee or the Provider submits the appeal to the Utilization Review Appeals Coordinator by phone, fax or mail. Medicaid members who submit an oral appeal must follow up with a signed, written appeal. The appeal must be received within
  - 60 calendar days of the date on the denial notice for Medicaid, HARP & HIV SNP Plans;
  - 180 days for Marketplace and Essential Plans;
  - 60 business days for the MLTC Plan.
- An acknowledgment notice will be mailed to the appealing party within 15 calendar days of receipt of the appeal.
- If additional information is required to make a determination, the request for information will be in writing within 15 business days of receipt of the appeal.
- If only a portion of the additional information requested is received, the request for the missing information will be in writing within five business days of receipt of the partial information.
- A Physician Advisor other than the Physician Advisor who issued the initial denial will review all of the necessary medical information according to MetroPlusHealth' clinical criteria.
- A decision will be made within the following timeframes:
  - Medicaid/HARP/HIV SNP/MLTC/Marketplace/Essential: 30 calendar days of the date that the appeal was received. This time may be extended for up to 14 days if requested by the member or provider, or if MetroPlusHealth demonstrates more information is needed and delay is in best interest of member. If the timeframe is extended, a notice will be sent to the member and provider.
  - CHP/MetroPlusHealth Gold/MetroPlusHealth GoldCare: 60 calendar days of the date that the appeal was received.
- If a decision is not made within this timeframe, the clinical denial is reversed and the service is authorized.
- For Medicaid, HARP, HIV SNP, and MLTC a decision will be made as fast as the member's condition requires, and no later than 30 days from receipt of the appeal. This time may be extended for up to 14 days upon member or Provider request; or if MetroPlusHealth demonstrates more information is needed and delay is in the best interest of the member and MetroPlusHealth makes the member aware of this delay.
- A written notice is mailed within two business days of the decision.
- If the initial clinical denial decision is upheld, the appeal determination notice, called a Final Adverse Determination, will include the rationale for upholding the original determination and instructions for requesting a second level standard appeal (where applicable) and/or an External Appeal. Medicaid Managed Care, HIV SNP members also received a notice of the right to a Fair Hearing and an application and filing instructions with the final adverse determination (Action) notice. The Final Adverse Determination will also include the member's coverage type, a description of the denied service and contact information for MetroPlusHealth and the Utilization Review department.
- The member or designee may see their case file at any time before or during the appeal review and may present evidence to support their appeal in person or in writing.
- A member or designee may also ask for an External Appeal within four (4) months. Providers filing an External Appeal on their own behalf must submit an external appeal within 60 days of

the final adverse determination. Providers should also enclose a fifty-dollar ($50.00) check or money order made out to MetroPlusHealth with the External Appeal application. Members have 4 months to request an external appeal from the date of the Final Adverse Determination and are not required to submit a check or money order.

7.15.3.2 Second Level Standard Appeals

The following plans are eligible for an internal second level appeal with MetroPlusHealth: CHP/ MetroPlusHealth Gold/MetroPlusHealth GoldCare I & II.

The following steps and timeliness will be followed:

- A second level appeal must be requested within 30 calendar days of receipt of the Final Adverse Determination notice. Requests for a second level administrative appeal must be requested within 90 calendar days of receipt of the Final Adverse Determination notice.
- A Physician Advisor other than the Physician Advisor involved in the original clinical denial or in the first level appeal decision will perform the second level appeal.
- The appeal determination will be rendered within 60 calendar days of the receipt of the second level appeal request.
- Written notification of the second level appeal decision will be mailed within two business days of the decision.

Please note that by filing a second level appeal, members and Providers may lose their opportunity to file an External Appeal which must be filed within 60 calendar days of the Final Adverse Determination if you are a Provider appealing on your own behalf. Providers appealing on their own behalf must also enclose a fifty-dollar ($50.00) check or money order made out to MetroPlusHealth with the External Appeal application. Members have 4 months to request an external appeal from the date of the Final Adverse Determination and are not required to submit a check money order.

7.15.3.3 Expedited Appeals

Expedited appeals can be requested by a member, their designee or Providers when there is reason to believe that a delay in the provision of services may result in an increased risk to the member's health. The following steps and timeliness will be followed:

- Expedited appeal requests must be phoned or faxed to the Utilization Review Appeals Coordinator.
- If additional information is required to make a determination, the member and the Provider will be notified immediately by phone or fax followed by a written notice of request for additional information by mail.
- A Physician Advisor other than the one who issued the initial denial will review all necessary medical information according to MetroPlusHealth's clinical criteria. The Physician Advisor will be available to talk to the treating Provider within one business day of receipt of the expedited appeal.
- A decision regarding the appeal will be made and notification will be provided within the following timeframes:

- *Medicaid, HARP, HIV SNP, CHP MetroPlusHealth Gold, MetroPlusHealth GoldCare, MLTC:* as fast as the member's condition requires and within 2 business days of receipt of all necessary information, but no more than 72 hours from the date that the request was received. This time may be extended for up to 14 days if requested by the member or provider, or if MetroPlusHealth demonstrates more information is needed and delay is in best interest of member. If the timeframe is extended, a notice will be sent to the member and provider.
- *Marketplace and Essential Plans:* as fast as the member's condition requires and within 72 hours of receipt of the Appeal or 2 business days of receipt of the information necessary to conduct the Appeal, whichever is sooner.

If the decision is not made within these timeframes, the clinical denial is deemed to be reversed and the service requested is authorized.

- Immediately upon making a decision, MetroPlusHealth will attempt to notify the member and the Provider of the decision by phone or fax. A written notice of the decision will be sent within 24 hours of rendering the determination.
- Expedited appeals not resolved to the satisfaction of the appealing party may be appealed again through the standard appeal process or through the external appeal process. For CHP/MetroPlusHealth Gold/MetroPlusHealth GoldCare I & II, a second level appeal of an expedited internal appeal may be requested following the standard second level appeal process in *Section 7.15.3.2*.

7.15.4 Final Adverse Determination Notice

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

- The basis and clinical rationale for the determination;
- The words "final adverse determination";
- MetroPlusHealth contact person and phone number;
- The member's coverage type;
- The name and address of Plan, contact person and phone number;
- A description of the health service that was denied, including facility/provider and developer/manufacturer of the service, as available;
- Statement that member may be eligible for an external appeal and timeframes for appeal;
- For CHP/MetroPlusHealth Gold/MetroPlusHealth GoldCare, which offer a second level appeal, a statement that the Plan cannot require the member to exhaust both levels. The letter includes a clear statement in bold that the member has 4 months from the final adverse determination to request an external appeal and choosing a second level of internal appeal may cause the time to file external appeal to expire;
- A standard description of external appeals process and application are attached.

For Medicaid, HARP, HIV SNP & MLTC the notice will also include:

- A summary of the appeal and date filed;
- The date that the appeal process was completed;
- A description of member's fair hearing rights;

- The right of the member to complain to the Department of Health at any time including the toll-free number: **1.800.206.8125**, or for MLTC: **1.866.712.7197**;
- A statement that the notice available in other languages and formats for special needs and how to access these formats.

7.15.5 External Appeals

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

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

An external appeal may also be filed:

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

  A physician certification under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation,
- **and** the specific health service or procedure recommended by the attending would otherwise be covered under the policy except for the plan's determination that the health service or procedure is experimental or investigational.
- **Please note:** The Plan does not require the member to exhaust the second level of internal appeal to be eligible for an external appeal.

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

The notice of Final Adverse Determination will contain the following information:

- The member may be eligible for external appeal and timeframes for appeal;
- If MetroPlusHealth offers two levels of appeal, the Plan cannot require the member to exhaust both levels.
- The member has 4 months from the final adverse determination to request an external appeal and choosing second level internal appeal may cause the time to file an external appeal to expire. Providers appealing their your own behalf have 60 days. Providers appealing on their own behalf must also enclose a fifty-dollar ($50.00) check or money order made out to MetroPlusHealth with the External Appeal application.
- For Medicaid/HARP/HIV SNP & MLTC, the notice will also include:
  - Summary of appeal and date filed;
  - Date appeal process was completed;
  - Description of member's fair hearing rights;
  - Member's right to complain to the Department of Health at any time by calling DOH;
  - Statement that the notice is available in other language and formats for special needs and how to access these formats.

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

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

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

MetroPlusHealth will waive application fees for all Medicaid, HARP, HIV SNP, MLTC and CHP members. Other members must pay the fee or prove financial hardship in order to receive a fee waiver. A waiver form is included with the application materials. Providers are responsible for the full cost of an appeal for a concurrent adverse determination upheld in the favor of MetroPlusHealth. MetroPlusHealth is responsible for the full cost of an appeal that is overturned. The Provider and MetroPlusHealth must evenly divide the cost of a concurrent adverse determination that is partially

overturned. The fee requirements do not apply to Providers who are acting as the member's designee, in which case the cost of the external appeal is the responsibility of MetroPlusHealth.

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

7.15.6 Standard External Appeals

For standard External Appeals, MetroPlusHealth will provide the EAA with any requested clinical information within three business days of receipt of the request. The EAA must make a decision within 30 calendar days of the receipt of the completed application. If additional information is requested, the EAA has five additional business days from receipt of the information to make a decision. Once the determination has been made, the EAA must notify the member, Provider and MetroPlusHealth within two business days. If MetroPlusHealth receives no communication from the Provider, member or EAA within 55 days of the date on the Final Adverse Determination notice, the Final Adverse Determination will be deemed upheld.

7.15.7 Expedited External Appeals

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

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

7.15.8 Fair Hearing

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

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

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

For denials involving the reduction, suspension or termination of payment for treatments or benefits, a determination letter will be sent at least ten days prior to the effective date. If the member would like to keep their services the same after an initial adverse determination (aid continuing), they must ask the plan for a Plan Appeal with in 10 calendar days of the initial adverse determination or by the date the decision takes effect, whichever is later. The member's services will stay the same until the plan makes a final adverse determination.

If the member would like to keep their services the same after a final adverse determination, they must ask for a Fair Hearing request within 10 days of the Final Adverse Determination.

Aid continuing applies in such cases and services must continue during the Fair Hearing process until a decision is issued or the period of care initially ordered by the Provider ends, whichever occurs first.

A member may apply for an External Appeal simultaneously with a Fair Hearing. However, once a Fair Hearing decision is issued, the External Appeal process is suspended. If an External Appeal is decided first, the member may still continue with the Fair Hearing. The determination made at the Fair Hearing supersedes all other determinations.

7.16. DISCHARGE PLANNING

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

7.17. MEMBER TRANSITION TO OTHER CARE

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

7.18. TIMEFRAMES AND NOTICE REQUIREMENTS FOR METROPLUSHEALTH MEDICARE PLANS

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

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

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

If MetroPlusHealth does not provide the member with timely notice of an organization determination, this constitutes an adverse organization determination and may be appealed.

MetroPlusHealth is required to provide a timely notice to members whose services in a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) are ending.

7.18.1 Standard Timeframes and Notice Requirements for MetroPlusHealth Medicare Plans

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

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

Effective January 1, 2020 for Medicare Part B Drugs Only

When a request for a Part B Drug is received, MetroPlusHealth provides notification of the determination as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request.

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

Written Notice for MetroPlusHealth Denials:

If a decision is made to deny service or payment, in whole or in part, or if the member disagrees with the decision to discontinue or reduce the level of care for an ongoing course of treatment, a written notice of the determination is provided.

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

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

7.18.2. Timeframes and Notice Requirements for Expedited Organization Determinations for MetroPlusHealth Medicare Plans

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

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

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

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

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

Effective January 1, 2020 for Medicare Part B Drugs Only

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

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

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

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

Notification of the determination occurs as expeditiously as the member's health condition requires, but no later than upon expiration of the extension.

7.18.3 Adverse Organization Determinations for MetroPlusHealth Medicare Plans

If the determination is not completely favorable, MetroPlusHealth provides a written notice that:

- Uses approved notice language in a readable and understandable form.
- States the specific reasons for the denial.
- Informs the member of his or her right to a reconsideration.
- Describes both the standard and expedited reconsideration processes, including the member's right to request, and conditions for obtaining, an expedited reconsideration, and the rest of the appeal process.
- Explains the right to submit additional evidence in writing or in person.
- Complies with any other requirements specified by CMS.

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

7.18.4 Timeframes and Notice Requirements for Termination of Coverage in a SNF, HHA, or CORF for MetroPlusHealth Medicare Plans

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

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

7.18.4.1 Quality Improvement Organization (QIO) review of ending services at SNF, HHA or CORF

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

SNFs, HHAs, and CORFs (or their agent) are responsible for delivering the NOMNC and DENC to members and assuring a valid delivery. Valid delivery means that the member signed the NOMNC to acknowledge that they received and understood the notice. If the member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the member's legal authorized representative. If no authorized representative has been appointed, then the Provider should seek the requested signature from the caregiver on record (i.e. the family member involved in the plan of treatment). Although the caregiver is not a legal authorized representative, he/she has assumed responsibility for the member's medical treatment. If the member has no legal authorized representative or caregiver on record, then the facility should annotate the notice and sign on behalf of the member.

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

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

With every Medicare inpatient stay, hospitals are required to issue a revised version of the Important Message from Medicare (IM), CMS-R-193 to all Medicare beneficiaries, including MetroPlusHealth members. This notice explains the discharge appeal rights. Hospitals must issue the IM within 2 calendar

days of the day of admission and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each MetroPlusHealth member within 2 calendar days of the day of discharge. Thus, in cases where the delivery of the initial IM occurs more than 2 days before discharge, hospitals will deliver a follow up copy of the signed notice to the beneficiary as soon as possible prior to discharge, but no more than 2 days before. Only one notice is required for inpatient stays that are 5 days or less in length. Hospitals must retain a copy of the signed IM and may do so wherever it makes sense given their record retention system. Scanning and electronic storage of notices is acceptable. Hospitals also must be able to demonstrate compliance with the requirement for delivery of the follow-up copy of the notice. However, as noted above, hospitals have some flexibility in terms of methods for documenting delivery of the follow-up copy, such as obtaining the beneficiary's initials on an "Additional Information" area of the notice.

The template notice can be located online at:
www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

QIO Review of Inpatient Hospital Care

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

7.19. LIABILITY FOR HOSPITAL COSTS FOR METROPLUSHEALTH MEDICARE PLANS

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

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

7.20. RECONSIDERATIONS FOR MEDICARE MEMBERS – MEDICAL BENEFITS

When MetroPlusHealth receives a request for payment or to provide services to a member, it must make an organization determination to decide whether or not coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member has the right to request a reconsideration or appeal. A member that disagrees with a Provider's decision about a request for a service or a course of treatment has a right to request an organization determination

from MetroPlusHealth. This member should be told to consult their Evidence of Coverage (EOC) or contact MetroPlusHealth Member Services for additional information.

MetroPlusHealth is required to make re-considerations as expeditiously as the member's health status requires but no later than as follows:

- **Standard (Pre-Service Related):** Not to exceed 30 calendar days. (The 30-day deadline may be extended by an additional 14 calendar days if the member requires the extension or MetroPlusHealth justifies the need for additional information which will benefit the member.)
- **Expedited (Pre-Service Related):** Not to exceed 72 hours. (The 72-hour deadline may be extended by an additional 14 calendar days if the member requires the extension or MetroPlusHealth justifies the need for additional information which will benefit the member.)
- **Standard Only (Payment/Claims Related):** Not to exceed 60 calendar days.

Effective January 1, 2020 for Medicare Part B Drugs Only

MetroPlusHealth is required to make re-considerations as expeditiously as the member's health status requires but no later than as follows:

- **Standard (Pre-Service Related):** Not to exceed seven (7) calendar days.
- **Expedited (Pre-Service Related):** Not to exceed 72 hours.
- **Standard Only (Post-Service/Retrospective Related):** Not to exceed fourteen (14) calendar days.

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

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

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

All appeal requests must be made within 60 calendar days from the date of the notice of organization determination. MetroPlusHealth may extend the period for filing a request for reconsideration for good cause. A member or a member's representative or a Provider must request a standard reconsideration request of an adverse organization determination in writing. A member can name a relative, friend, advocate, attorney, doctor, or someone else to act on his/her behalf or others authorized under State law.

Participating Providers acting on behalf of a member must complete an Appointment of Representative Statement – but not if the participating provider is acting on its own behalf. Non-participating providers acting on their own behalf must complete and send to MetroPlusHealth the Waiver of Liability Form before the Plan can act on an appeal. If further information about the member's appeal is required to render a reconsideration decision, providers must submit the additional information in a timely manner.

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

A member or a member's representative can request an expedited determination or expedited reconsideration (appeal) regarding a service or a referral under the following circumstances:

- The request is for continued or extended healthcare services or additional services for a member undergoing a continued course of treatment.
- The standard appeal process would lead to a delay which would pose a serious or imminent threat to the health of the member.
- The provider believes an immediate appeal is warranted. Providers requesting expedited reconsiderations must do so on behalf of the member as an authorized representative.

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

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

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

If CMS's contractor upholds the MetroPlusHealth adverse organization determination, the contractor will notify the member in writing and explain further appeal options that may be available to the member.

If MetroPlusHealth does not complete an expedited appeal process within 72 hours or a standard appeals process within 30 days, the case will be automatically referred to CMS's contractor for an independent review.

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

7.21. COVERAGE DETERMINATIONS AND APPEALS (RECONSIDERATIONS) MEDICARE – PRESCRIPTION DRUG BENEFITS

When MetroPlusHealth receives a request to pay for or provide a Part D drug it must make a coverage determination. Coverage determinations include exception requests. An exception is a request to cover a drug that is not on our formulary, requires utilization management or to reduce cost-sharing for that drug. To request a coverage determination or exception, members or providers should visit www.metroplus.org to submit an electronic request or call our pharmacy vendor CVS Caremark at **1.866.693.4165** (TTY: 1.800.881.2812) or fax the request to **1.855.633.7673**.

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

Members who disagree with a coverage determination and want MetroPlusHealth to reconsider and change its decision about a Part D prescription drug benefits, may file a redetermination (appeal). MetroPlusHealth will decide an appeal as expeditiously as the member's health status requires. MetroPlusHealth will decide on an expedited appeal no later than 72 hours after receiving the request for expedited cases, or no later than seven (7) calendar days after receiving the request for standard cases. For payment reconsiderations, the plan must make the determination no later than 14 days from receipt of the request.

If MetroPlusHealth fails to meet the appeal timeframes, it must automatically forward member's request to the Independent Review Entity (IRE) contracted by CMS. If the IRE upholds the adverse coverage determination, the IRE will notify the member in writing and explain further appeal options that may be available to the member.

8. CARE MANAGEMENT SERVICES

8.1. DISEASE/CARE MANAGEMENT PROGRAMS

8.1.1 MetroPlusHealth Integrated Care Management Program

MetroPlusHealth Integrated Care Management (ICM) program is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the services and options available to meet the health and human service needs of members with complex care needs and are at risk for increased hospital admissions and emergency room visits.

The ICM program provides face-to-face interaction (when needed) to foster member engagement, member centered care planning and goal attainment.

ICM has two components:

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

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

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

The goal of the ICM program is to:

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

Behavioral/Medical Integrated Care Management:

Members with Behavioral Health needs are referred to MetroPlusHealth's Behavioral Health vendor for care coordination.

Members with both medical *and* behavioral health needs are co-managed by the ICM care manager and a Behavioral Health care manager.

Integrated care management rounds are conducted regularly to ensure members receive comprehensive integrated services.

High Risk OB Program:

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

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

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

The goal is a healthy delivery for mother and newborn> 39 weeks gestation, decrease NICU and low birth weight deliveries, increase postpartum examinations compliance prior to 56 days post-delivery, and complete newborn Pediatric follow-up within 1 week of birth.

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

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

Children with Special Care Needs:

Our stratification algorithm is applied to all members, this facilitates the identification of children with special health care needs (chronic debilitating conditions; disabilities; behavioral, developmental or emotional conditions) that may require health and related services to maintain or improve their health status and to prevent deterioration of their health.

In addition to providing the care coordination activities outlined in this document, care managers where applicable interact with school districts, pre-school services, early intervention officials, behavioral health and developmental disabilities service organizations to coordinate and assure appropriate delivery of needed services.

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

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

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

Health Risk Assessment (HRA):

The Member Services department conducts Health Risk Assessment (HRA) for all new members. This information is populated into MetroPlusHealth's care management system, Disease Case Management System (DCMS). The care management staff has access to all completed HRAs and reviews this information as part of care plan development. The Member Services department notifies the Case Management Department of any urgent issues identified when conducting HRA. Additionally for dual eligible members in the Medicare Advantage Program, existing members receive an annual HRA which is reviewed by the interdisciplinary care team.

8.1.2 Behavioral Health Care Management and Outreach Program

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

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

Members with a serious behavioral health disorder as well as a complex or chronic co-morbid medical condition are also eligible to receive care management services. Care management services are particularly encouraged for members with a history of treatment and/or medication non-compliance as well as members who are dually diagnosed with a serious mental illness and substance use disorder.

Members in the Behavioral Health Care Management and Outreach Program receive regularly scheduled outreach calls and/or visits to support a greater level of treatment compliance. The care manager also maintains contact with both participating medical and behavioral care providers to ensure proper treatment.

8.2. HEALTH EDUCATION CLASSES

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

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

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

9. MEDICAID HIV SPECIAL NEEDS PLAN, PARTNERSHIP IN CARE

9.1. HIV SPECIALIST PRIMARY CARE PROVIDERS

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

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

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

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

(a) a designated practitioner is named for backup; (b) patients are cared for by a well-defined care team;

(c) There are systems in place to guarantee continuity of care and to meet all SNP access and availability standards; and

(d) members will be educated about how the primary care model operates in the facility and how their care will be coordinated, including the name of the primary care provider and the system for backup.

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

9.1.2. Credentialing and Recredentialing of HIV Specialist PCPs

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

9.1.2.1. HIV Medicine Association (HIVMA) designation as an HIV-experienced physician demonstrating continuous professional development.

The HIVMA designation is valid for 36 months from the date of application and renewal of this designation is subject to the same criteria. Providers must meet the following criteria:

- Attestation to having provided in the immediately preceding 36 months, provision of continuous and direct medical care, or direct supervision of medical care, to a minimum of 25 patients with HIV; ***and***

- Submission of evidence of completion, in the immediately preceding 36 months, a minimum of 40 hours of Category 1 continuing medical education (CME) addressing diagnosis of HIV infection, treatment for HIV disease and co-morbidities, and/or the epidemiology of HIV disease, and earning a minimum of 10 hours per year; ***and***
- Board certification or equivalent in one or more medical specialties or subspecialties recognized by the American Board of Medical Specialties or the American Osteopathic Association;

or

- In the immediately preceding 12 months, has completed recertification in the subspecialty of Infectious Diseases with self evaluation activities focused on HIV or initial board certification in Infectious Diseases. In the 36 months immediately following certification, newly certified Infectious Diseases fellows should be managing a minimum of 25 patients with HIV and earning a minimum of 10 hours of category 1 HIV-related CME per year.

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

American Academy of HIV Medicine (AAHIVM) certification as an HIV Specialist is available, through AAHIVM, to MD, DO, and NP practitioners with a current valid license, patient care experience and evidence of completion of HIV-related Category 1 CME/CEU/CE. Certification is valid for two calendar years and recertification is subject to the same criteria. Providers seeking AAHIVM certification or recertification may contact AAHIVM directly (https://aahivm.org) for further details.

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

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

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

9.1.3. HIV Continuing Medical Education

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

- Antiretroviral therapy in the ambulatory care setting.
- Latest information about HIV disease and treatments.
- State-of-the-art diagnostic techniques including resistance testing.
- Immune system monitoring.
- Strategies to promote treatment adherence.

- Management of opportunistic infections and diseases.
- Management of HIV infected patients with commonly associated co-morbid conditions.
- Access and referral to clinical trials.
- Pre-exposure prophylaxis for high-risk individuals.
- Post-exposure prophylaxis protocols and infection control issues.
- Care coordination with other Providers for specialty care.
- Patient education including risk reduction/harm reduction counseling.

9.1.3.1. Obstetric CME

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

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

9.1.3.2. Pediatric CME

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

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

9.2. CO-MANAGEMENT WITH HIV AND NON-HIV PCPS

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

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

9.3. HIV-NEGATIVE SPECIAL POPULATIONS

Members identified as HIV-negative homeless or transgender may enroll with the Partnership In Care program. HIV-negative homeless and transgender members must be reassured a new member outreach is conducted, and medical and psychosocial support needs are assessed, including potential barriers to access. A comprehensive plan of care is implemented to assure adherence to treatment and care is coordinated across the continuum of care. MetroPlusHealth assures that members identified as transgender have access to basic medical care, as well as care coordinated by a plan contracted PCP (if HIV negative), and coordination of specialty medical care with participating providers.

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

9.4. SNP ACCESS TO CARE GUIDELINES

9.4.1 24 Hour Access

All PCPs must provide access, either directly or through a covering Participating Provider, to medical services for members on a 24 hour a day, seven day a week basis. PCPs must also ensure that pregnant members have the same access to OB/GYN services.

9.4.2 Walk-ins

PCPs must have policies and procedures addressing members presenting for unscheduled, walk-in visits particularly for adolescents and substance abusers.

9.4.3 PCP Appointment Availability Standards

Adult baseline or routine physicals must be performed within four weeks of enrollment.

Initial appointments for PCP office visits for newborns must occur within 48 hours of hospital discharge. For non-urgent matters, the member must be scheduled for an appointment within 48 to 72 hours as clinically indicated. For urgent medical or behavioral problems, the member must be scheduled for an appointment within 24 hours of request.

9.4.4 Missed Appointments

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

- Canceled appointments must be rescheduled within one week.
- Members without telephones must be mailed a letter. If the letter is returned "addressee unknown," it must be documented in the chart. If the letter is not returned but the member makes no contact, a home visit by a community liaison and/or community health nurse must be arranged. This can be in conjunction with Partnership in Care.
- Members requiring "urgent" review should be contacted by telephone and, if unsuccessful, by telegram.
- All follow-up attempts must be documented in the member's chart.
- Members with four or more missed appointments should be referred to a care manager to ascertain any psychosocial problems that may be affecting adherence.
- Notify the member's designated care manager if a problem arises with the member's care so they can facilitate problem solving.
- Monitor any problems through chart review of quality assurance.

9.5. NEW MEMBER OUTREACH

MetroPlusHealth conducts new member outreach within 30 days of the effective date of enrollment. Contact attempts are made by phone and mail; when phone and mail attempts to reach the member are unsuccessful, one community outreach visit attempt to meet the member at a participating provider facility where Partnership in Care staff are stationed. Upon successful contact, a member is provided with:

- Plan policies with respect to obtaining Benefit Package services, including services for which the member may self-refer, procedures for obtaining standing referrals, the use of specialty care centers, the use of a specialist as primary care provider, and what to do in an emergency.
- A brief health screening to assess the Enrollee's need for any special health care (for example, prenatal or behavioral health services) or language/communication needs. When a special need is identified, the Plan assists the member in arranging an appointment with his/her PCP or other appropriate provider on a timely basis.

- Information regarding basic primary and preventive services specific to the care, treatment, and prevention of HIV infection, as well as the advantages of new treatment regimens and therapies and information on different primary care options, if available, such as those that provide co-located primary care and substance abuse services.
- Assistance in arranging an initial visit to the Enrollee's PCP for a baseline physical and other preventive services, including a comprehensive risk assessment.

9.6. VERIFICATION OF HIV SNP ENROLLMENT ELIGIBILITY

9.6.1 Verification for HIV-Positive Special Populations

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

(a) HIV antibody screen assay;

(b) Viral Identification Assay (e.g., p24 antigen assay, viral culture, nucleic acid [RNA or DNA] detection assay); or

(c) CD4 Level Measurement of less than 200. For patients currently under treatment without diagnosis-confirming laboratory results and with undetectable viral load, a physician's statement verifying HIV status will be accepted when other verifying tests are not available.

9.6.2 Verification for HIV-Negative Special Populations

Members identified on the Human Resources Administration (HRA) homeless roster likewise qualify for the Partnership In Care program and may remain enrolled in the Special Needs Plan for an indefinite period, and until such time that the member has achieved an extended period of housing stability. Homeless members enrolled in the SNP will be considered HIV-unverified until confirmation of HIV-positive status has been obtained by the Plan.

Enrollment of populations defined as "homeless" into the HIV SNP will not be limited to those connected to the DHS shelter system at time of SNP enrollment. For verification of homeless eligibility, plans are provided with a bi-weekly "H-file" from HRA/Maximus showing homeless members, including those accessing services in DHS shelters or street homeless accessing services at DHS drop-in centers. Such designation of "homeless" is not intended to reflect other definitions of homeless but will allow for monitoring by SDOH of enrollment and associated activities. If connection to DHS is not documented through H file, the Plan will provide an Attestation by certified organization (not the health plan) providing homeless services to the member deemed homeless. The Attestation can include written documentation by outreach or intake worker of member circumstances with qualifying dates of contact with member.

Members identified as "transgender" may similarly enroll with the Partnership In Care program, if a physician, nurse practitioner or physician assistant who has treated, or reviewed and evaluated the gender-related medical history of the member submits a signed and dated statement which includes language stating that the member has undergone appropriate clinical treatment for a person diagnosed with gender dysphoria. The second option that may be submitted, in lieu of the provider statement, is a copy of a Certified Amended Birth Certificate; or a passport; or a New York State Driver's License; or a Non-Driver ID card; or a statement from the Social Security Administration reflecting the change in gender designation.

9.7. CARE MANAGEMENT SERVICES

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

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

9.7.1 Medical Case Management

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

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

- Screening for eligibility, assistance in completing applications for entitlements, referral to special benefit programs;
- Advocating and negotiating on behalf of a client/family;
- Documenting changes which may have impact on a client's functioning, and making appropriate referrals;
- Arranging for services which support a client's ability to remain at home;
- Maintaining a system for tracking clients to ensure that they are not lost to follow-up;
- Contacting clients to ensure that services are received;
- Case conferencing with service providers and other involved case managers;
- Crisis intervention, including assessment and intensive short-term treatment of acute medical, social, or emotional distress.

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

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

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

When indicated, a referral to a psychosocial support services provider or community-based organization is made to address the member's psychosocial support needs. Such referrals will be documented in the PCP medical record.

In certain circumstances where the PCP site does not provide on-site case management and prior arrangement has not been made by the PCP to refer the member to case management services, the Plan may offer medical case management services on an interim basis until such time that a referral is made. The Plan will notify the member and the provider regarding the availability of case management services at an alternate facility.

9.7.2 Psychosocial Support Services

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

- individual or group HIV prevention and risk reduction services, education, and counseling services;
- treatment education to support and promote adherence to treatment regimens;
- chemical dependence treatment readiness
- harm reduction and needle exchange
- counseling and assistance with partner/spousal notification;
- permanency planning and transitional service providers;
- community education;
- housing and supportive services for the homeless;
- shelters and other providers of services for victims of domestic violence;
- services to migrants;
- nutritional services;
- transportation services to supportive services;
- legal services

9.7.3 Health Home Case Management

Health Home case management is offered to those clients requiring intensive medical case management coordination and/or coordination of psychosocial support service needs. Participating Providers are expected to refer members who need intensive case management services to a certified Health Home program. The services may be provided at the Participating Provider site or at a designated community-based organization. The Health Home case manager is responsible for coordination of services between the different case managers providing services to the member.

9.7.4 Service Utilization Monitoring and Care Advocacy

The SNP Health and Wellness Advisement Team, with a personally designated Health and Wellness Advisor, reviews the New Member Orientation and Health Assessment, and other assessments, as necessary, including, but not limited to member telephonic assessments conducted by the Plan, and review of medical records provided to the Plan by the PCP, and ensures that the a comprehensive case management assessment and service plan has been completed for each member within sixty (60) days of the effective date of SNP enrollment. Care advocacy assessments focus on:

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

The SNP Health and Wellness Advisement Team, with appropriate consent of the member, communicates significant findings and coordinates information exchange between the Plan, the member, the member's PCP, and other Case Management and psychosocial support service providers, including, as necessary, multidisciplinary case conferencing.

The SNP Health and Wellness Advisement Team conducts subsequent reviews of the member's service utilization and care advocacy needs at regular intervals, approximately every 120 days, including hospitalizations and ER visits, provider referrals and care advocacy efforts provided on behalf of the member.

9.7.5 Linkage Agreements

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

9.7.6 Quality Monitoring

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

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

MetroPlusHealth monitors case management services provided to members through:

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

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

9.8. CLINICAL GUIDELINES FOR THE TREATMENT OF HIV

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

9.8.1 Adult Member Management Guidelines

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

As part of this a baseline (and subsequently annual) physical examination should include:

- A complete gender and age appropriate medical history (including substance use history, smoking/vaping and sexual history if appropriate) conducted in vocabulary or language that members can understand without regard to education level.
- A full physical examination.
- A pelvic examination consisting of cervical cancer screening and STD screening (including for Gonorrhea and Chlamydia).
- Screening for colorectal cancer (preferably by colonoscopy) as appropriate for both male and female members.
- A mental health screening that includes but is not limited to assessments of cognitive function, appetite, behavior, depression, sleep, anxiety as well as a screening for domestic violence.
- Immunizations when clinically indicated (see www.hivguidelines.org for more details).
- Appropriate laboratory tests (such as CD4 count and HIV-1 viral load tests), health maintenance screening tests (e.g. annual syphilis screening and tuberculin skin testing) and appropriate use of opportunistic infection prophylaxis, quantification of antiretroviral adherence, subspecialty referrals as needed (ex: Gynecologist, Ophthalmologist, Dentist, Endocrinologist, Psychiatrist, Smoking/Vaping Cessation services and Podiatrist).
- Access and referral to approved needle exchange programs.

Before initiating Highly Active Antiretroviral Therapy (HAART), HIV PCPs should consider the following:

- Assess a member's willingness, readiness to start and ability to adhere to treatment.

- Weigh start decisions against clinical factors such as CD4 count, viral load, and HIV related symptoms as well as social factors such as living environment, mental health, HIV disclosure to others, pregnancy, substance use and health beliefs.
- Ensure that the member is an active, engaged partner in the decision-making process and is educated about how ARVs work and their potential adverse effects of therapy as well as on the development of drug resistance with non-adherence to the medication regimen.
- Make an assessment of treatment adherence, proper dosing, side effects and toxicity of medications at each visit including quantification of ARV adherence over a specified period of time.
- Assess HIV positive members at least once every trimester with appropriate laboratory evaluations.
- Discuss on an ongoing basis issues regarding safer sex, birth control and partner notification in the context of prevention of HIV transmission and acquisition and transmission of other STDs.

Treatment Adherence / ARV Adherence Strategies:

- Develop open lines of communication with client to facilitate frank discussions regarding barriers to adherence.
- All medications, both prescribed and non-prescribed, should be evaluated at each visit in order to minimize the risk of drug interactions.
- Perform quantitative assessments of ARV adherence at each visit. The results of this discussion should be correlated to lab results to determine if member is appropriately virologically controlled, and if resistance testing is warranted. If deficiencies are noted, then an assessment of barriers to adherence is necessary and a plan should be formulated to address identified barriers.
- Provide medication counseling (including side effects, long-term and short-term toxicities) as well as consider offering adherence supports such as pre-packed pill boxes or blister packs to patient should they have medication storage issues, confidentiality issues or housing issues.
- Coordinate with pharmacists to determine patient refill habits as pertaining to prescribed medication.
- Consider provision of reminder tools as necessary to ensure adherence with ARV such as beepers, watches or a written daily schedule of medications.
- Instruct how to proceed if medication dosages are missed.
- Provide access to nutritional counseling to ensure that patient is evaluated for adequate nutritional intake and has access to food.
- Assess adherence with medical appointments/tests at every visit.
- Coordinate with social work or mental health workers or care managers as necessary to ensure patient compliance with an annual mental health and chemical dependency screening to rule out underlying psychiatric issues and to ensure that they have fully accessed social benefits and supports depending on their needs.
- Referral to psychiatrist for evaluation, should mental health issues play a part in member non-adherence with ARVs. Appropriate referrals for substance use/drug rehabilitation services.
- Provide access to transportation (such as MetroCards, as outlined in *Section 2.11*) and/or health-related incentives for members to reduce barriers to medical care.

- Provide referral to support groups as necessary.
- Provide HIV education counseling to patients so that they may become empowered to become advocates for their healthcare, as well as gain insight into their disease. This would also allow for safer sex discussions conducted in a non-judgmental manner as well as HIV transmission risk reduction counseling.
- Provide non-judgmental ongoing substance use assessments for those members that are actively using or have used substances. HIV PCPs should provide routine HIV risk-reduction counseling and behavioral health counseling for HIV-infected patients.
- Consider referral to alternative/adjunctive therapy such as massage, acupuncture, acupressure, aromatherapy, biofeedback as necessary.
- Provide referral to intensive care management services such as COBRA should patient need multi-disciplinary help beyond the scope of the care management at the HIV PCP's office.

9.9. HIV PREVENTION/RISK REDUCTION SERVICES

HIV PCPs must ensure that the following prevention/risk reduction services are available and provided, or accessed via referral, to members when appropriate:

- HIV risk screening.
- Information and health education on HIV risk.
- HIV testing.
- Partner notification services including risk screening for family violence.
- Information on harm reduction and needle exchange programs.
- Information on safer sex, sexually transmitted disease (STD) treatment and prevention and condom use.
- Information about Undetectable = Untransmittable as key HIV prevention strategy. People with HIV should be on ART as soon as possible after an individual's HIV positive status is known. ART treatment is lifelong.
- Education and counseling on the reduction of perinatal transmission.
- Baseline history and physical examination and laboratory evaluation.
- Social work evaluation to anticipate financial needs, eligibility for entitlements, need for counseling and long-range planning such as childcare, power of attorney, health care proxy, etc.
- Individualized care plan based on clinical presentation, laboratory data, psychosocial issues and stage of illness.
- Teaching of health promoting behaviors to enhance immunocompetence such as nutrition, exercise, stress management, etc.
- Arranging for medical follow up at scheduled intervals.
- Monitoring lab data to ensure that antiretroviral therapy and prophylaxis protocols are followed appropriately.
- Monitoring of clinical status at least quarterly.
- Evaluating adherence to therapy with emphasis on lifetime suppressive drug therapy.

- Identifying development of drug resistance to prescribed therapies.
- Teaching symptom management to members and care partners.
- Arranging for hospitalization on an as needed basis.
- Arranging and coordinating support services such as physical therapy, home care, hospice care, etc.
- Providing education and referrals to clinical trial and experimental treatments, as appropriate.

9.10. MATERNAL, PEDIATRIC AND ADOLESCENT HEALTH CARE

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

- Counsel all adolescents and women of childbearing age who present with risk factors.
- Identify pregnant members and members with infants to ensure early entry and access to care and to diagnose or rule out HIV infection.
- Assess risk issues at the annual physical evaluation, including sexual activity and substance use, as well as issues regarding home environment, history of violence, family history and school.
- Use sensitivity when asking questions about history of physical and sexual abuse, sexual assault, and suicidal ideation, gestures or attempts.
- Know that the right to consent to or refuse HIV testing in New York State is based on a person's capacity to understand, without regard to chronological age, what an HIV antibody test detects, the implications and consequences of being HIV infected, and why they are at risk for HIV.
- Test HIV exposed newborns/infants to establish HIV infection status and follow NYSDOH recommended diagnostic schedules for HIV DNA PCR testing, that is, within one week of birth and at two weeks, four to six weeks, six to twelve weeks and four to six months of age.

A baseline physical examination should include:

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

Before initiating HAART, HIV PCPs should:

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

- Ensure that the member is an active, engaged partner in the decision-making process and is educated about how the medications work.
- Make an assessment of treatment adherence, proper dosing and toxicity at each visit.
- Follow HIV positive members at least once every three months and conduct laboratory evaluations.
- Discuss, on an ongoing basis, issues regarding birth control, safe sex, and partner notification.

When making psychosocial intervention referrals, HIV Provider team members should identify drug treatment programs, community-based organizations and counseling and support programs that are focused to address and support members' presenting needs (see the MetroPlusHealth Community Based Organization Resource Directory). Adolescent focused services need to be age and developmentally appropriate and be familiar with New York State laws pertaining to adolescents' rights to consent to certain forms of health care.

The MetroPlusHealth Partnership in Care staff helps to facilitate access for adolescent members to HIV PCPs who are knowledgeable about adolescent development, HIV treatment, methods of reducing the risk of transmission and methods of effective communication with teens. HIV PCPs treating adolescents should be aware of the diverse populations of HIV infected youths that may include perinatally infected, gay, transgender, pregnant, substance using and homeless adolescents. Interventions and referrals should be individualized and address issues with sensitivity and skill and include, but not be limited to:

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

9.11. HIV HOMELESS MEMBERS

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

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

- Completing a comprehensive assessment at the member's first office visit, including inquiries about the member's housing status and documenting the housing status in the member's medical record; reassessment should occur at least annually.
- Notifying MetroPlusHealth HIV Services care management staff who will conduct targeted outreach efforts to members who do not present for an appointment with the Provider within three consecutive months of the effective date of enrollment.

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

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

9.12. MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE

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

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

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

9.13. CLINICAL TRIALS

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

- The member has a life threatening or disabling condition or disease.
- Standard health services or procedures have been ineffective or would be medically inappropriate.
- A more beneficial health service or procedure is not available in current practice.

- The clinical trial, as documented from available medical and/or scientific evidence, is believed to be more beneficial to the member than any standard health service or procedure.
- An appropriate Institutional Review Board (IRB) has given approval for the investigational/ experimental treatment.

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

9.14. DISENROLLMENT FROM THE PARTNERSHIP IN CARE HIV SPECIAL NEEDS PLAN

9.14.1. Voluntary Disenrollment from the Partnership In Care Special Needs Plan

When the member's county of residence requires enrollment in a Medicaid Managed Care Plan (a mandatory county), the member may leave the Partnership In Care SNP and join another health plan at any time during the first 90 days of enrollment. If the member does not disenroll in the first 90 days, she/he must stay in the SNP for nine more months, unless she/he wants to join another SNP or has good cause. Some examples of good cause include:

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

To disenroll or change plans, the member calls New York Medicaid CHOICE (**1.800.505.5678**). New York Medicaid CHOICE counselors can help the member to change health plans or disenroll. If the member must be in a Medicaid Managed Care plan, the member will have to choose another health plan. The member should inform New York Medicaid CHOICE that she/he is disenrolling from the Partnership In Care SNP and wants to re-enroll in a new Plan. The member will get a notice that the change will take place by a certain date. In most cases, the Plan will provide all medically necessary care until the disenrollment process is completed.

It will take between two and six weeks to process, depending on when the member's request is received. The member can ask for faster action if the member believes the timing of the regular process will cause added damage to her/his health. The member can also ask for faster action if she/he has

complained because the member did not agree to the enrollment. The member can call New York City Human Resources Administration (LDSS) or New York Medicaid CHOICE.

9.14.2. Member Becomes Ineligible for Medicaid Managed Care and Special Needs Plans:

A member (and/or her/his child) may have to leave the Partnership In Care SNP if the member (or the child):

- moves out of the County, the service area, or New York City;
- changes to another managed care plan;
- joins an HMO or other insurance plan through work;
- joins a long-term Home Health Care Program;
- is incarcerated for one or more months
- becomes a permanent resident of a nursing home

A child may have to leave the SNP if she/he:

- joins a Physically Handicapped Children's Program, or
- is placed in foster care (voluntarily by parent/guardian or by a decision of the local Social Services Commissioner)

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

9.14.3. Disenrollment

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

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

9.15. DISCHARGE PLAN

Each member disenrolled from the Plan will receive a written discharge plan to assist the member to obtain needed services and ensure continuity of care.

9.15.1. HIV Uninsured Care Programs

If a member loses Medicaid coverage, she/he may be eligible for the New York State Department of Health, HIV Uninsured Care Programs (also known as ADAP). The programs provide limited coverage for the care and treatment of HIV. If the member has private health insurance, she/he also may be able to get help paying for insurance premiums. The member can call **1.800.542.AIDS (2437)** for more information.

9.16. QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM

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

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

10. QUALITY MANAGEMENT

10.1. QUALITY MANAGEMENT PROGRAM, IMPROVEMENT PLAN AND EVALUATION

10.1.1 Quality Management Program

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

The MetroPlusHealth Quality Assurance Committee (QAC) of the Board of Directors maintains ultimate accountability for the Quality Management Program. The QAC includes Participating Provider representatives active in making decisions regarding all aspects of MetroPlusHealth' Quality Management Program.

10.1.2 Quality Management Program Description

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

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

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

10.1.3 Quality Management Program Evaluation

MetroPlusHealth's Quality Management Program is essential to ensure our members' medical and service needs are being met, and the quality of care and services are continuously improved. The Quality Management Program continues to address issues related to quality management, utilization management customer service, provider credentialing and recredentialing, and patient safety. The Quality Management Program Evaluation provides a mechanism for determining the extent to which the annual quality improvement activities have contributed to the quality of care and service provided to our members. A summary of this evaluation is available to Participating Providers and members upon request.

10.2. PARTICIPATING PROVIDERS AND IMPROVEMENT PLANS

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

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

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

10.3. INVESTIGATION AND REPORTING OF QUALITY OF CARE COMPLAINTS

If a Quality of Care (QOC) issue has been identified either during the course of Care Management, Utilization Review, Provider Relations, Regulatory Affairs or through Customer Services, then MetroPlusHealth staff will communicate this directly to the Quality Management (QM) Department for review and investigation. Upon receipt of a QOC complaint, the Quality Risk Reviewer will conduct an initial investigation. The purpose of the initial investigation is to review the care that was rendered and to ascertain the provider's policies and procedures or medical protocols regarding the type of situation and whether or not the provider appears to have followed those policies and procedures or medical protocols in the case of the given incident/concern.

The Quality Risk Reviewer will send the summary of the QOC complaint and any supporting documentation to the Medical Director for review and approval. Complaints pertaining to clinical matters shall be reviewed by one or more licensed, certified or registered health care professionals. Medical Director(s) may ask for additional information as needed to reach a determination. This may include additional medical records and/or expert opinion. The Quality Risk Reviewer will obtain the requested information if needed. The Medical Director will make a final determination on the QOC complaint and provide sign-off on the case. The Quality Risk Reviewer will provide Member Services with a copy of the QOC complaint review and Customer Service will write the resolution letter to

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

On a quarterly basis, the Quality Assurance Committee (QAC) will review provider performance related to quality of care complaints. If the QAC committee finds that the Provider has failed to complete the corrective action plan (CAP) within the agreed timeframe and/or has repeatedly failed to meet the established performance standard, then the QAC committee Chairperson will refer the case to the Credentialing Committee. The Credentialing Committee will further review the Provider's performance and will determine next steps, which may include enacting provider disciplinary action and/or termination. (CAPs process described below).

10.4. CORRECTIVE ACTION PLANS

When a provider's performance does not meet established clinical practice guidelines, the QM Department will request a corrective action plan (CAP) from the Provider. The purpose of requesting the corrective action plan is to ensure that the Provider takes steps to address the issues underlying poor performance to attain performance compliance/improvement going forward. When a Provider does not make sufficient progress on a corrective action plan, continues to be non-complaint with performance standards, or has required corrective action plans in multiple areas over the course of time the Medical Director will review the Provider's performance and determines next steps.

If the QAC committee finds that the Provider has failed to complete the CAP within the agreed timeframe and/or has repeatedly failed to meet the established performance standard, then the QAC committee Chairperson will refer the case to the Credentialing Committee. The Credentialing Committee will further review the Provider's performance and will determine next steps, which may include enacting provider disciplinary action and/or termination.

All documents related to corrective action plans, including the request, the plan and subsequent communications and progress reports will be forwarded to Member Services, Provider Relations and Contracting Department for inclusion in the Providers' file.

10.5. PROVIDER PERFORMANCE PROFILE

MetroPlusHealth publishes monthly Provider performance profiles which are based on administrative (claim) and supplemental data. PCPs and PCP locations are compared statistically on a range of indicators contained in Value Based Contacting, the MetroPlusHealth Pay-for-Performance Program and the HEDIS/QARR Reportable dataset. Participating Provider sites are also given their results on the final reported HEDIS/QARR indicators on an annual basis. It is anticipated that this data will be applied to each site's quality management programs to improve performance over time. Each time the Provider is presented with this data, MetroPlusHealth will give Participating Providers the opportunity to discuss the unique nature of their patient population, which may account for variation in the statistics, and to work collaboratively with MetroPlusHealth to improve performance.

10.6. QUALITY MEASUREMENT RESULTS AND CONTINUED PROVIDER PARTICIPATION

Quality measurement results for individual Participating Providers consisting of, at minimum, member complaints incidents, and quality of care concerns will be placed in Participating Provider files for

consideration during recredentialing. When recredentialing for an individual Participating Provider has been delegated, quality measurement information will be forwarded to the delegated entity for inclusion in their individual Provider files. During the recredentialing decision making process, MetroPlusHealth or its delegate will look for trends over time in the occurrence of incidents or quality of care issues or in performance standard compliance. Participating Providers are expected to have successfully improved their level of care and services and/or completed corrective action plans.

10.7. CLINICAL FOCUS STUDIES, IMPROVEMENT PROGRAMS AND HEDIS/QARR

Each year, MetroPlusHealth, alone or in conjunction with the NYSDOH or other entities, conducts clinical focus studies. These studies target a specific aspect of care or a specific clinical population and often address Participating Providers' adherence to clinical treatment or preventive health guidelines. The study results are used to establish a baseline for future quality improvement initiatives or to assess the success of implemented improvement interventions.

For its Medicare product lines, MetroPlusHealth maintains a Chronic Care Improvement Program (CCIP). A member health risk assessment and claims data are used to identify members for this program whereby members may have received various levels of care and care management. Member participation in the program is monitored throughout the year.

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

10.8. MEDICAL RECORDS

10.8.1 Medical Record Availability and Record Keeping Systems

Upon request, Participating Providers are required to submit medical records for review by MetroPlusHealth or government oversight agencies as required for quality and utilization management, complaint investigation and program oversight. At minimum, Participating Providers will be given two business days to submit requested records. Participating Providers are responsible for obtaining patient consent to release medical records for MetroPlusHealth and government agency reviews and to adhere to all state and federal regulations regarding the confidentiality of medical records. Medical records of members shall be confidential and shall be disclosed to and by other persons within MetroPlusHealth, including Participating Providers, only as necessary to provide medical care, to conduct quality assurance functions and peer review functions, or as necessary to respond to a complaint and appeals.

Participating Providers are required to maintain organized medical record keeping systems. Such systems should ensure that records could be retrieved using more than one-member identifier. Participating Provider medical record keeping systems should ensure that member records could be retrieved immediately for both individual Provider review in caring for members and, as needed, for health plan review. The actual content of medical records should be organized to ensure that critical medical information could be gleaned quickly by Providers in the event of a medical emergency. Records should contain sections appropriate to the practice type and information within those sections should be filed in chronological order. Medical records should include the following:

- Maintain a separate medical record for each member;
- Verification that the PCP coordinates and manages care;
- The medical record is required to be retained for a period of six years after date of service rendered to members and for a minor, six (6) years after majority;
- For prenatal care, a centralized medical record is required for the provision of prenatal care and all other services.

10.9. PREVENTIVE HEALTH GUIDELINES

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

- Preventive care for infants up to 24 months old.
- Preventive care for children and adolescents 3 to 19 years old.
- Preventive care for adults 20 to 64 years old.
- Preventive care for adults age 65 and older.
- Perinatal care.

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

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

10.10. CLINICAL GUIDELINES

MetroPlusHealth adopts and disseminates Evidence-Based Guidelines for the provision of acute and chronic care services that are relevant to our population up to and including: Medicaid, Child Health Plus, Medicaid HIV Special Needs Plan(s), MetroPlusHealth Managed Long Term Care, HARP, Essential Plan, Marketplace, Medicare, MetroPlusHealth Gold, and MetroPlusHealth GoldCare I & II. Clinical Practice Guidelines serve as a decision support tool for providers and members. These guidelines aid in establishing practices consistent with national standards of care, and standardization of these practices network-wide, thereby reducing unnecessary variation in care. MetroPlusHealth

ensures that all utilization management policies and procedures, benefit coverage and member educational materials are consistent with the guidelines. Adopted guidelines are regularly reviewed and updated whenever national guidelines change, but no less than every two years. When the guidelines change, they are redistributed to providers. Practitioners and members may refer to the guidelines via MetroPlusHealth's Internet site. They are also available in print form upon request. MetroPlusHealth measures performance against several important aspects of the guidelines annually. Clinical Practice Guidelines are not intended as a substitute for the professional assessment of the practitioner but are to be used as a tool to assist in the management of certain types of preventive and clinical care. Individual patient treatment may vary. Guidelines are in place for:

- Acquired Pneumonia in Adults
- ADHD
- Adult Preventive Health (Immunizations, PCP visit, alcohol, Cancer screenings, stroke, tobacco)
- Alcohol & Substance Abuse
- Asthma
- Aspirin Use
- Behavioral Health Screening
- Bipolar Adolescent
- Bipolar Adult
- Child Preventive Health
- Coronary Artery Disease
- Congestive Heart Failure
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Depression Screening in Children, Adolescents and Adults
- Diabetes
- Diabetic Retinopathy
- Fall Prevention
- Family Abuse/Violence
- HIV/AIDS
- Hypertension in Adults
- Hypertension in Children and Adolescents
- Immunizations
- Infectious Disease (HPV, STIs, TB, Viral Hepatitis A, B, C, D, E), Hep C
- Menopause Management
- Obesity in Adults
- Obesity in Children
- Preconception Care
- Prenatal & Postpartum
- Smoking/Vaping Cessation
- Suicide Prevention
- Cholesterol Management
- Glaucoma
- STD's
- Gonorrhea
- Upper Respiratory Infection
- Urinary Incontinence
- Vision
- Preventive Services for Adults and Children
- Partner Violence & Abuse of Elderly
- Lead exposure
- Opioids for Chronic pain
- Osteoporosis

Guidelines are available on the provider website and are available in print form upon request. Updated CPGs are communicated to the providers through provider newsletters and are posted onto the provider website. The plan monitors compliance with clinical practice and preventive health guidelines through HEDIS® measure medical record review.

To access the clinical practice guidelines please see *Appendix V* or log onto the MetroPlusHealth Provider Portal.

MetroPlusHealth has adopted guidelines for HIV treatment in the following areas:

- Adult and adolescent care.
- Pediatric care.
- Perinatal care.
- Health-care worker exposure.
- Non-occupational exposure.
- Prevention of opportunistic infection.
- Prevention and treatment of tuberculosis.

Copies of the current guidelines are available, upon request, from the Partnership in Care program. HIV treatment guidelines are updated frequently, and providers are encouraged to access www.aidsinfo.nih.gov and www.hivguidelines.org for updates.

Participating Providers from the appropriate medical specialties review all proposed guidelines prior to adoption. This review includes consideration of the appropriateness of the guidelines for the specific population served by MetroPlusHealth and the local service delivery system. MetroPlusHealth also conducts a review to ensure that utilization management decisions, member educational materials and interpretations of covered benefits are consistent with the proposed guidelines.

All guidelines are approved by the QAC. When national clinical guidelines change, or at least every two years, all guidelines are reviewed and revised as needed by appropriate Participating Providers and the QAC prior to distribution to Participating Providers. Participating Providers are required to adhere to adopted guidelines when rendering care to our members.

10.11. COMMUNICABLE DISEASES AND PUBLIC HEALTH GUIDELINES

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

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

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

- Infants and toddlers suspected of having developmental delay or disability. Providers may contact 311 and ask for Early Intervention to refer members to early intervention programs. The provider will be asked to complete an Early Intervention Program referral form and fax the form to the regional office in the child's borough of residence. The Early Intervention Program is available to all eligible New York City babies, young children, and their families, regardless of race, ethnicity, income, disability or immigration status. Please visit the Early Intervention provider information website at

https://www1.nyc.gov/site/doh/providers/resources/early-intervention-information-for-providers.page to learn more about the early intervention program.

- Suspected instances of child abuse.
- All Participating Providers have the responsibility to report tuberculosis (TB) cases to the local Public Health Agency.
- Participating Providers will screen and treat members for STDs and report cases of STD to the LPHA and cooperate in contact investigation, in accordance with existing state and local laws and regulations.
- Participating Providers will comply with lead poisoning screening and follow-up as specified in 10 NYCRR Sub-part 67-1. Participating Providers will coordinate with the LPHA to assure appropriate follow-up in terms of environmental investigation, risk management and reporting requirements.
- **Immunizations** – Providers are required to report all immunizations given to members to the New York City Immunization Registry. Additionally, Participating Providers may obtain member immunization histories from the Registry.
- **Lead poisoning prevention** – Providers are required to report all lead test results to the New York City Lead Registry.

Public Health Guidelines encompass communications regarding the following:

- **Maternal health**
- **Adolescent preventive health services**
- **Foster child health care**
- **Smoking/Vaping cessation** – NYC DOHMH has protocols for referring members to the State's Smokers Quitline and for assessing and referring members for smoking/vaping cessation services. Most members are also eligible for smoking/vaping cessation related medications and aids through their pharmacy benefit.
- **Family violence prevention** – Providers should screen all new patients, at annual exams and when family violence is suspected
- **Injury prevention** – providers are expected to implement recommendations from the American Academy of Pediatrics for injury and violence prevention among children.
- **Informed consent for hysterectomy and sterilization** – Providers must have a signed consent form on file which indicates the member understands the sterilization must be considered permanent and not reversible. Participating Providers will comply with the informed consent procedures for Hysterectomy and sterilization specified in 42 CFR Part 441, sub-part F, and 18 NYCRR § 505.13
- **Severe Acute Respiratory Syndrome (SARS)** – Providers are expected to report any suspect cases within 24 hours to the Bureau of Communicable Diseases, as per Section 2.1 of the New York State Sanitary Code.

10.12. COMMUNICABLE DISEASE PROTOCOLS AND REGULATIONS

HIV/AIDS

In New York City in 2016, there were more than 300 people first identified with a diagnosis of AIDS, an advanced stage of HIV disease. It takes an average of 10 years from the time someone is infected with HIV before she or he develops AIDS. People infected with HIV who are not aware of their diagnosis cannot benefit from medications that could keep them healthy and prevent death or serious illness associated with AIDS. Another benefit of earlier diagnosis of HIV infection is the potential of improved immune recovery once treatment is started especially for those individuals over the age of 50 years.

Someone with HIV who is not diagnosed may spread the infection to others without their knowledge. Per the CDC, people who have HIV but are in care, taking HIV medicines, and have a very low or undetectable viral load are much less likely to transmit HIV than people who have HIV and do not have a low viral load (www.cdc.gov/hiv/basics/transmission.html).

Delayed diagnosis of HIV is harmful to both the person living with HIV and the community.

The number of new HIV infections per year has not declined in the last several years in the United States. Currently there are more people living with HIV in the US than ever before, and we are falling behind in our efforts to contain the spread of HIV. The only way to get ahead of the epidemic is to identify the estimated one-quarter of all infected people that are unaware of their HIV diagnosis. The CDC, NYSDOH and CDOH agree that promotion of HIV testing in health care settings is a critical component of the fight against HIV and AIDS.

HIV/AIDS Testing, Reporting and Confidentiality of HIV-Related Information

(Effective Date: May 17, 2017)

SUMMARY

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

Effective April 1, 2015, amendments contained in the 2015-16 enacted New York State budget authorized the elimination of the requirement of written consent for HIV testing in New York State correctional facilities.

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

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

Key provisions of these regulation amendments implementing the legislation include:

- Removing the requirement for informed consent prior to ordering an HIV-related test, including elimination of written consent for HIV testing in New York State correctional facilities, and removing references to consent forms.
- Adding a provision stating that performing an HIV test as part of routine medical care requires at a minimum advising that an HIV-related test is being performed, prior to ordering an HIV-related test.
- Removing the reference to expiration of an individual's informed consent.
- Adding a provision authorizing local and state health departments to share HIV surveillance information with health care providers, including entities engaged in care coordination, for purposes of patient linkage and retention in care.
- Clarifying language pertaining to reporting by blood and tissue banks.
- Inserting updates to the list of reportable HIV-related test results that need to be reported. These updates are consistent with CDC and Association of Public Health Laboratories guidance related to the diagnosis of HIV infection. Additionally, reporting of results for NYS residents and NYS-located clinicians is explicitly required. This change was designed to address known gaps in reporting.
- Including language specifically stating that reports must include the requesting provider and facility. The requirement is expected to improve the quality of provider data and lead to more complete data. This should improve accuracy of the Department's surveillance data and, consequently, the National HIV/AIDS Strategy retention and care measures.
- Removing the requirement that the information on HIV provider reporting forms associated with newly diagnosed cases of HIV infection be reported within 60 days.
- Adding individuals who were previously diagnosed as HIV positive, and who are at elevated risk of transmitting HIV to others, to the contact notification prioritization process.
- Removing the requirement that data on the partners of HIV cases be destroyed after three years and stating that the Department will establish a policy for "record retention and schedule for disposition."
- Eliminating the upper age limit of 64 for the offering of HIV testing.
- Allowing the disclosure of HIV-related information to qualified researchers in compliance with State and Federal law.

All pregnant women should be tested for HIV infection as early in pregnancy as possible. Retesting in the third trimester (i.e., preferably before 36 weeks' gestation) is recommended for women at high risk for acquiring HIV infection (i.e., women who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, or have HIV-infected partners). Pregnant women found to be HIV positive should be referred to an HIV specialist and subsequent care should be carefully coordinated between the HIV specialist and an obstetrician experienced in the care of HIV and pregnancy.

All patients seeking treatment for STDs, including all patients attending STD clinics, should be screened routinely for HIV during each visit for a new complaint, regardless of whether the patient is known or suspected to have specific behavior risks for HIV infection.

Free Confidential or Anonymous HIV Rapid HIV Testing/Counseling is also available at the NYC Department of Health Clinics in all five boroughs for persons seeking these routes for testing. Providers and members can call NYC 311, the New York City government information and non-emergency services line, for days and hours of operation.

For additional information about HIV counseling and testing and the changes to the law, please visit the New York State Department of Health website (www.nyhealth.gov) or the New York City Health Department website (www1.nyc.gov/site/doh/health/health-topics/aids-hiv.page). Questions not addressed here or on the websites may be sent to hivtestlaw@health.state.ny.us.

STDs

Providers must educate members about the risk and prevention of STDs. Providers are required to screen and treat members for STDs and report cases of STDs to the LPHA and cooperate in contact investigation in accordance with existing state and local regulations. MetroPlusHealth endorses the CDC guidelines that a serologic test for syphilis should be performed on all pregnant women at the first prenatal visit. In addition, all pregnant women should be routinely tested for Chlamydia trachomatis and Neisseria gonorrhoeae at the first prenatal visit. Regarding Chlamydia trachomatis, asymptomatic infection is common among both men and women, and to detect chlamydial infections, healthcare providers frequently rely on screening tests.

Annual screening of all sexually active women aged <25 years is recommended, as is screening of older women with risk factors (e.g., those who have a new sex partner or multiple sex partners). Similarly, gonococcal infections among women frequently are asymptomatic. Therefore, MetroPlusHealth recommends that providers screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk. Women aged <25 years are at highest risk for gonorrhea infection. Other risk factors for gonorrhea include a previous gonorrhea infection, other sexually transmitted infections, new or multiple sex partners, inconsistent condom use, commercial sex work, and drug use.

A comprehensive guide to STDs can be accessed at: www.cdc.gov/std/treatment

Tuberculosis

Participating providers must educate members about the risk and prevention of Tuberculosis and report cases of Tuberculosis to the LPHA.

Participating Providers are responsible for reporting diseases specified in the New York State Sanitary Code and diseases specified in the New York City Health Code.

Additionally, Participating Providers are responsible for reporting, or be associated with a lab that reports, communicable diseases to the LPHA. MetroPlusHealth will periodically monitor Participating Provider adherence to communicable disease protocols, regulations and reporting as well as compliance with Public Health Guidelines.

10.13. STERILIZATION CONSENT

MetroPlusHealth Medicaid members have family planning coverage that includes sterilization.

In addition to provision of information at the initial counseling session, the physician who performs the sterilization must review important information with the patient prior to the procedure. Reimbursement is only available if the requirements are met.

Sterilization of a mentally competent individual aged 21 or older:

(a) The individual is at least 21 years old at the time consent is obtained;

(b) The individual is not a mentally incompetent individual;

(c) The individual has voluntarily given informed consent in accordance with all the requirements described under "Informed Consent" below; and

(d) At least 30 days, but not more than 180 days have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Informed Consent:

(a) Informing the individual. An individual has given informed consent only if:

1. The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have concerning the procedure, provided a copy of the consent form and provided orally all of the following information:
    i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.
    ii. A description of available alternative methods of family planning and birth control.
    iii. Advice that the sterilization procedure is considered irreversible.
    iv. A thorough explanation of the specific sterilization procedure to be performed.
    v. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
    vi. A full description of the benefits or advantages that may be expected as a result of the sterilization.
    vii. Advice that the sterilization will not be performed for at least 30 days, except for premature delivery or emergency abdominal surgery
2. Suitable arrangements were made to ensure that the information specified in paragraph (a)(1) of this section was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;
3. An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.

4. The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained.;
5. The consent form requirements of § 441.258 were met; and
6. Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent, was followed.

(b) When informed consent may not be obtained. Informed consent may not be obtained while the individual to be sterilized is:

1. In labor or childbirth
2. Seeking to obtain or obtaining an abortion; or
3. Under the influence of alcohol or other substances that affect the individual's state of awareness.

To access the Sterilization Consent Form, visit our website and select "Forms" under the "Provider" tab.

10.14. EARLY PERIODIC SCREENING DIAGNOSIS (EPSDT) SERVICES THROUGH THE CHILD TEEN HEALTH PROGRAM (C/THP) AND ADOLESCENT PREVENTATIVE SERVICES

Child/Teen Health Program (C/THP) is a package of early and periodic screening, including inter-periodic screens and, diagnostic and treatment services that New York State offers all Medicaid eligible children under twenty-one (21) years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the New York State Department of Health. The care includes necessary health care, diagnostic services, treatment and other measures (described in §1905[a] of the Social Security Act) to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services (regardless of whether the service is otherwise included in the New York State Medicaid Plan). The package of services includes administrative services designed to assist families obtain services for children including outreach, education, appointment scheduling, administrative case management and transportation assistance.

11. CHILDREN'S SPECIAL SERVICES PROGRAM

11.1. PROVIDER RESPONSIBILITIES

11.1.1 Children's Special Services Program

NYS is partnering with Medicaid Managed Care Organizations (MMCO) to manage the delivery of the expanded Medicaid-covered services for all Medicaid enrolled children. The goal is to fundamentally restructure and transform the health care delivery system for individuals under 21 that have medically complex conditions and/or behavioral health needs.

The goals of the NYS Medicaid redesign for children is to improve health outcomes, control Medicaid costs and provide care management for all Medicaid members that aligns incentives for the provision of high quality. A key feature of the model is to create a community-based Medicaid managed care model where there is "no wrong door" for children/youth experiencing complex needs, including children with complex medical and behavioral health needs. NYS envisions a cross-system approach that diminishes silos of care and improves health outcomes for children well into adulthood.

MetroPlusHealth and its behavioral health partner, Beacon Health Options (Beacon), have joined together to offer the integrated physical health and behavioral health components of these programs.

To support integration and create better health outcomes for children and youth, NYS has taken the following key policy steps to stimulate the transformation:

- NYS will make available, via Medicaid State Plan Amendment (SPA), six new services that were previously not available or were only available to children who met narrow eligibility criteria.
- NYS is establishing level of care (LOC) and level of need (LON) criteria to identify subpopulations of children who are likely to benefit from an array of home- and community-based services (HCBS). The LON subpopulation will identify children prior to needing institutional care or as a step down from LOC. This population is at risk by virtue of exposure to adverse events or symptoms leading to functional impairments in their home, school or community
- NYS is consolidating six existing children's 1015(c) waivers into one integrated array of HCBS for an expanded number of Medicaid eligible children allowing them to stay in their home communities to avoid residential and inpatient care.
- MetroPlusHealth complies with all State Medicaid guidance including:
    1. OMH Clinic Standards of Care: (www.omh.ny.gov/omhweb/clinic_standards/care_anchors.html)
    2. OASAS Clinical Guidance: (https://www.oasas.ny.gov/AdMed/recommend/recommendations.cfm)
    3. OHIP, Policy and Proposed Changes to Transition Children in Direct Placement Foster Care into Medicaid Managed Care, April 2013(https://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_and_proposed_changes_fc.pdf)
    4. OCFS Working Together: Health Services for Children/Youth in Foster Care Manual (http://ocfs.ny.gov/main/sppd/health_services/manual.asp)

5. OHIP Principles for Medically Fragile Children

11.1.2 Health Home Care Management for Children

Concurrent with managed care carve-in, children eligible for HCBS will be enrolled in Health Homes. The care coordination of service of the children's HCBS will transition to Health Home unless the child ops out of the Health Home. For members who opt out of Health Home, an Independent Entity (IE), Maximus, will coordinate care. Health Homes will administer all assessments through the Uniform Assessment System which will have algorithms (except for the foster care developmentally disabled (DD) and OPWDD care at home medical fragile developmentally disabled (CAH MF) populations) to determine functional eligibility criteria for HCBS.

To facilitate a smooth transition of HCBS: for children in receipt of HCBS, MetroPlusHealth will begin accepting Plans of Care (POCs):

a. For 1) their enrolled population or 2) a child for whom the Health Home Care Manager or Independent Entity has obtained consent to share the POC with the Plan and the family has indicated that the Plan selection process has been completed;
   i. Each transitioning child must have an updated POC completed by March 31, 2019. POCs may be forwarded to the Plan in advance of the formal transition, though POCs will be required starting September 1, 2019, pending federal approval for 10/1/19 go-live date.

b. The anticipated transition of children in the care of LDSS/licensed VFCAs to managed care is 2/1/2020, pending federal approval. The Plan will continue to accept POCs for children in receipt of HCBS in advance of the effective date of enrollment when the Plan is notified by another Plan, a Health Home Care Manager or the Independent Entity that there is consent to share the POC with the Plan and the family has demonstrated the Plan selection process has been completed, or for a child in the care of a LDSS/licensed VFCA, Plan selection has been confirmed by the LDSS/VFCA.

Transition of Populations into Medicaid Managed Care

Beginning April 1, 2019 statewide, the State will remove the exemptions from Medicaid Managed Care enrollment for children in the following HCBS waivers with a physical, emotional or developmental disabilities diagnosis:

- OMH Serious Emotional Disturbance (SED) 1915(c) waiver (NY.0296)
- Bridges to Health (B2H) SED 1915(c) waiver (NY.0469)
- Bridges to Health (B2H) Medically Fragile 1915(c) waiver (NY.0471)
- Bridges to Health (B2H) DD 1915(c) waiver (NY.0470)
- DOH Care at Home (CAH) I/II 1915(c) waiver (NY.4125)
- Office for People with Developmental Disabilities (OPWDD) Care at Home (CAH) waiver

Beginning no earlier than October 1, 2019, the following will occur:

- 1915(c) Children's Consolidated Waiver Services carved-in to Managed Care
- The State will remove the exclusion from Medicaid Managed Care enrollment for children in Voluntary Foster Care Agencies. This transition is expected to occur on 2/1/2020.

- SSI children begin receiving State Plan behavioral health services in managed care.
- Children residing in a Voluntary Foster Care Agency will be mandatorily enrolled in managed care. This transition is expected to occur on 2/1/2020
- Implement Family Peer Support Services as State Plan Services in managed care and fee-for-service
- BH services already in managed care for adults 21 and older are available in managed care for individuals 19-21 (e.g. PROS, ACT, etc.)
- The three-year phase in of Level of Care (LOC) expansion started on October 1, 2019.
- Effective October 1, 2019, Medicaid-eligible children, who meet at-risk LON criteria may receive HCBS.
- On October 1, 2019, Medicaid eligibility was expanded to children who meet at-risk LON criteria and are determined Medicaid eligible through Family of One and receive HCBS.

Children/youth who continue to be excluded from enrollment in a managed care plan or who are exempt and choose not to enroll will continue to receive benefits via the fee-for-service (FFS) delivery system.

Participating Providers in the Children's Physical and Behavioral Health program must comply with appointment availability standard by Service Type and Foster Care Initial Health Services listed in the tables below.

Network Standards: Appointment Availability Standard by Service Type

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
MH Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request	Within 5 business days of request
IPRT			2 – 4 weeks	Within 24 hours	
Partial Hospitalization				Within 5 business days of request	
Inpatient Psychiatric Services	Upon presentation				
CPEP	Upon presentation				
OASAS Outpatient Clinic		Within 24 hours	Within 1 week or request	Within 5 business days of request	Within 5 business days of request
Detoxification	Upon presentation				
SUD Inpatient Rehab	Upon presentation	Within 24 hours			

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge	Follow-up to residential services, detention discharge, or discharge from justice system placement
OTP		Within 24 hours	Within 1 week or request	Within 5 business days of request	Within 5 business days of request
Crisis Intervention	Within 1 hour			Within 24 hours of Mobile Crisis Intervention response	
CPST		Within 24 hours (for intensive in home and crisis response services under definition)	Within 1 week of request	Within 72 hours of discharge	Within 72 hours
OLP		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Family Peer Support Services		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
Youth Peer Support and Training		Within 24 hours of request	Within 1 week of request	Within 72 hours of request	Within 72 hours of request
PSR		Within 72 hours of request	Within 5 business days of request	Within 72 hours of request	Within 72 hours of request
Caregiver/ Family Supports and Services			Within 5 business days of request	Within 5 business days of request	
Crisis Respite	Within 24 hours of request	Within 24 hours of request		Within 24 hours of request	
Planned Respite			Within 7 days of request	Within 7 days of request	
Prevocational Services			Within 2 weeks of request		
Supported Employment			Within 2 weeks of request		
Community Self-Advocacy Training and Support			Within 5 business days of request		
Habilitation			Within 2 weeks of request		
Adaptive and Assistive Equipment		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Accessibility Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request	Within 24 hours of request
Palliative Care			Within 2 weeks of request	Within 24 hours of request	

Network Standards: Foster Care Initial Health Services

Initial Health Services Time Frames				
Time Frame	**Activity**	**Mandated Activity**	**Mandated Time Frame**	**Who Performs**
24 Hours	Initial screening/screening for abuse/neglect	✓	✓	Health practitioner (preferred) or caseworker/health staff
5 Days	Initial determination of capacity to consent for HIV risk assessment & testing	✓	✓	Caseworker or designated staff
5 Days	Initial HIV risk assessment for child without capacity to consent	✓	✓	Caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	✓	✓	Caseworker or health staff
30 Days	Initial medical assessment	✓	✓	Health practitioner
30 Days	Initial dental assessment	✓	✓	Health practitioner
30 Days	Initial mental health assessment	✓		Mental health practitioner
30 Days	Family Planning Education and Counseling and follow-up health care for youth age 12 and older (or younger as appropriate)	✓	✓	Health practitioner
30 Days	HIV risk assessment for child with possible capacity to consent	✓	✓	Caseworker or designated staff
30 Days	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	✓	✓	Caseworker or health staff
45 Days	Initial developmental assessment	✓		Health practitioner
45 Days	Initial substance abuse assessment			Health practitioner
60 Days	Follow-up health evaluation			Health practitioner
60 Days	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection	✓	✓	Caseworker or health staff
60 Days	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	✓	✓	Caseworker or health staff

11.2 COVERED AND NON-COVERED SERVICES

Services	MMCO Benefits
Assertive Community Treatment (minimum age is 18 for medical necessity for this adult-oriented service)	July 2019
CFCO State Plan Services for children meeting eligibility criteria	October 2019
Children's Crisis Intervention	October 2020
Comprehensive psychiatric emergency program (CPEP) including Extended Observation Bed	July 2019
Continuing day treatment (minimum age is 18 for medical necessity for this adult-oriented service)	July 2019
Community Psychiatric Treatment and Supports (CPST)	January 2019
Crisis Intervention Demonstration Project	January 2019
Family Peer Support Services	July 2019
Health Home Care Management	October 2019
Inpatient psychiatric services	Current
Intensive Psychiatric Rehabilitation Treatment (IPRT)	Current
Medically Managed Detoxification (hospital based)	Current
Medically supervised inpatient detoxification	Current
Medically supervised outpatient withdrawal	Current
OASAS Inpatient Rehabilitation Services	Current
OASAS opioid treatment program (OTP) services	July 2019
OASAS Outpatient and Residential Addiction services	Current
OASAS Outpatient Rehabilitation Programs	July 2019
OASAS Outpatient Services	July 2019
Other Licensed Practitioner (OLP)	January 2019
Partial hospitalization	July 2019
Personalized Recovery Oriented Services (minimum age is 18 for medical necessity for this adult oriented service)	July 2019
Psychosocial Rehabilitation (PSR)	January 2019
Youth Peer Support and Training	January 2020
Rehabilitation Services for residents of community residences	TBD
Residential Rehabilitation Services for Youth (RRSY)	TBD
Residential Supports and Services (New Early and Periodic Screening, Diagnostic and Treatment [EPSDT] Prevention, formerly known as foster care Medicaid Per Diem)	February 2020
Residential Treatment Facility (RTF)	TBD
Teaching Family Home	TBD

11.3 ACCESS TO SPECIALTY CARE

Members who are eligible for waiver services are assigned health homes. Once these members enroll in a health home, they receive an HCBS eligibility assessment. The health homes create a Plan of Care (POC) based on the findings of the eligibility assessment. The health homes then submit the POC, the assessment results and request for HCBS services for the Plan's approval. The Plan's Care Managers assess the POC and the request for HCBS services against the eligibility findings. If the request for HCBS services matches the assessment findings, the Plan sends the health homes an initial approval for HCBS and contact information of at least 2 HCBS providers.

If the requested HCBS does not match the assessment findings, the Plan's Care Managers will work with the health home Care Coordinators to adjust the POCs.

Members who refuse enrollment in the Health Homes are managed directly by the Plan's Care Managers who will refer the members to a contracted State Designated entity called C-YES (Children and Youth Evaluation Services) through Maximus for HCBS eligibility assessment. Based on the assessment findings, the Plan's care managers will refer the member to an appropriate HCBS provider.

The Health Homes and/or C-YES, the independent NYS designated entity is responsible to conduct the CANS-NY assessment which determines the need for HCBS services. MetroPlusHealth ensures that all members who received waiver services are enrolled in health homes or C-YES and are assessed for HCBS services on a timely basis. MetroPlusHealth also runs a monthly report identifying members who may need Health Homes and HCBS services. The identified children are referred to Health Homes.

MetroPlusHealth follows up on members receiving services with Health Homes and/or HCBS services by conducting monthly and quarterly follow up assessments with the Health Home or C-YES care coordinator and members' caretaker or LDSS/VCFA care manager.

If an enrolled child in foster care is placed in another county, and the Plan in which he or she is enrolled operates in the new county, the Plan must allow for the child to transition to a new primary care provider and other healthcare providers without disrupting the care plan that is in place.

If an enrolled child in foster care is placed outside of the Plan's service area, the plan must permit the enrollee to access providers with expertise treating children involved in foster care as necessary to ensure continuity of care and the provision of all medically necessary benefit package services.

The Health Home sends members' Plans of Care (POCs) with the HCBS assessment results to the Plan for HCBS approval

If the Plan has no information about members' HCBS assessment and/or members' POCs, the Plan's Care Managers will call the members' Health Home or Independent Entity to request this information.

The Plan care managers will keep a data base with information about the assessments, assessment results, POCs, requested and delivered HCBS. This data base will be used to ensure that members served by the Children's Special Services Program receive appropriate care.

11.4 UTILIZATION REVIEW/ACTIONS

Below includes MetroPlusHealth's review process for HCBS review and approval of a POC inclusive of HCBS.

- HCBS will be managed in compliance with CMS HCBS Final Rule and any applicable State guidance.
- MetroPlusHealth will ensure that the POC is developed in a person-centered manner, compliant with federal regulations and state guidance, and meets individual needs.
- MetroPlusHealth will ensure HCBS is authorized pursuant to a POC.
- MetroPlusHealth has a data driven approach to identify service utilization patterns that deviate from any approved POC, conducts outreach to review such deviations, and requires appropriate adjustments to either the service delivery or the POC.

For children transitioning from a 1915(c) waiver, MetroPlusHealth will continue to authorize covered HCBS and LTSS in accordance with the most recent POC for at least 180 days following the date of transition of children's specialty services newly carved into managed care. Service frequency, scope, level, quantity and existing providers at the time of the transition will remain unchanged (unless such changes are requested by the enrollee or the provider refuses to work with the plan) for no less than 180 days, during which time, a new POC is to be developed.

During the initial 180 days of the transition, MetroPlusHealth will authorize any children's specialty services newly carved into managed care that are added to the POC under a person-centered process without conducting utilization review.

MetroPlusHealth has an authorization process for member transitioning from a 1915 c waiver. During the initial 180 days of the transition, the Plan will authorize any children's specialty services newly carved into managed care that are added to the POC under a person-centered process without conducting utilization review. MetroPlusHealth authorization process ensures that HCBS services are authorized pursuant to a POC. The Plan follows up on members' progress by a monthly and quarterly calls to Health Home care coordinators, member's care taker or LDSS/VCFA care manager.

11.5 QUALITY ASSURANCE

The Quality Assurance Program will be a separate document and will be addended to the MetroPlusHealth Quality Management Program Description.

The purpose of the Children's Advisory Subcommittee (CAS) is to advise and assist MetroPlusHealth in identifying and resolving issue related to the management of children's health and behavioral health benefits.

Representatives on the CAS providers who have expertise in children's services and familiarity with children eligible for home and community-based services (HCBS), including medically fragile children, medically fragile developmentally disabled, seriously emotionally disturbed, and children with diagnoses across multiple HCBS categories. The committee representatives include members/families and providers who are chosen to reflect the entire geographic service area of the Plan.

The CAS reports directly to the MetroPlusHealth Quality Management Committee (QMC). The QMC provides oversight, leadership and direction for quality improvement.

When contracting with NYS-designated providers, MetroPlusHealth will not separately credential individual staff members in their capacity as employees of these programs. MetroPlusHealth must still conduct program integrity reviews to ensure that provider staff are not disbarred from Medicaid or any other way excluded from Medicaid reimbursement. MetroPlusHealth shall still collect and accept program integrity related information from these providers, as required in the Medicaid Managed Care Model Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

MetroPlusHealth will expand its current provider training curriculum to reflect the expanded children's benefit and populations. MetroPlusHealth will collaborate with NYS and Regional Planning Consortiums (RPCs) to develop a uniform provider training curriculum that addresses the clinical components necessary to meet the needs of the expanded populations transitioning to managed care.

MetroPlusHealth will educate and train all participating providers on children's benefit and population policies and procedures regarding care and ensure providers are trained in cultural competency when delivering services to members.

MetroPlusHealth requires that all providers meet applicable State minimum training requirements:

- Training is available at alternate times and days of the week and sufficient opportunities are made available to reach all new Plan providers working with the expanded children benefit and populations. Providers may access the training document on the MetroPlusHealth website or contact their respective Provider Services Representative to schedule a training session.
- The training plan reflects member and family involvement in the development and delivery of any new trainings relevant to the expanded children benefit and populations.
- The Network Relations Department will distribute and post on the MetroPlusHealth website updated documentation to medical, behavioral, community-based and facility-based providers on the following topics:
    - Billing
    - Coding
    - Data interfaces
    - Claiming resources/contacts
    - Provider profiling programs
    - UM requirements for the Medically Fragile population
        - This population will be served by MetroPlusHealth's Children's Special Services Department
    - Plan of Care development
    - Child evidence-based/promising practices, including: trauma-focused cognitive behavioral therapy, trauma informed child-parent psychotherapy, multi-systemic therapy, functional

family therapy, multi-dimensional treatment foster care, dialectical behavior therapy, multidimensional family therapy, seven challenges, adolescent community reinforcement, and assertive continuing care

- Unique needs of special populations including SED, SUD, TAY, EI, medically fragile and children involved with child welfare
- Cultural competency
- HCBS and all its related requirements
- Family-driven, youth guided, person-centered treatment planning and service provision
- Recovery and resilience principles
- Multidisciplinary teams with member/family member/caregiver engagement and meaningful participation and member choice
- Trauma informed care
- Requirements of EPSDT and completion of required foster care initial health assessments
- Common medical conditions and medical challenges in the medically fragile population
- For PCPs and Health Homes – children's BH service array and application for children's clinical practice guidelines and EPBs for BH conditions

MetroPlusHealth Behavioral Health partner, Beacon Health Options ensures that its providers have access to rapid consultation from a child and adolescent psychiatrist as well access to training, referral and support.

11.6 PROVIDER PAYMENT

MetroPlusHealth shall execute Single Case Agreements (SCAs) with non-participating providers to meet clinical needs of children when in-network services are not available. The Plan will reimburse at the FFS fee schedule for 24 months for all SCAs.

MetroPlusHealth will reimburse at the Medicaid FFS fee schedule for 24 months or as long as New York State mandates (whichever is longer) for the following services/providers:

1. New EPSDT Child and Family Treatment and Support Services (CFTSS) including OLP; Crisis Intervention; CPST; PSR; Family Peer Support Services and Youth Peer Support and Training; and Preventive Residential Supports
2. OASAS clinics (Article 32 certified programs)
3. All OMH Licensed Ambulatory Programs (Article 31 licensed programs)
4. Hospital-based and free-standing clinics dually (Article 28 licensed and/or certified programs)

MetroPlusHealth will reimburse transitional rates for Providers who historically delivered Care Management services under one of the 1915(c) waivers being eliminated, and who will provide Care Management services that are being transitioned to Health Home for no more than 24 months. The

transitional rates will be as financially equivalent as practical to the interim rates (and as reconciled) established under the former waivers and in place immediately prior to their transition to Health Home.

MetroPlusHealth will contract with OASAS residential programs and pay their allied clinical service providers on a single case or contracted basis for members who are placed in an OASAS certified residential program to ensure access to and continuity of care for patients placed outside of the Plan's service area.

MetroPlusHealth will ensure that all HCBS services costs will be paid according to the NYS fee schedule without risk to the Plan for 24 months from the date of inclusion in the MMCP benefit package or until HCBS services are included in the capitated rates.

APPENDICES

IA OUTPATIENT MEDICAL RECORD DOCUMENTATION STANDARDS

Concise medical record documentation is critical to providing patients with quality care as well as to receiving accurate and timely reimbursement for furnished services. It chronologically documents the care of the patient and is required to record pertinent facts, findings, and observations about the patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. Medical record documentation also assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring his or her health care over time.

Payers may require reasonable documentation that services are consistent with the insurance coverage provided in order to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services furnished have been accurately reported.

In alignment with NCQA's Guidelines for Medical Record Documentation, to ensure that medical record documentation is accurate, the following principles should be followed:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - Significant illnesses and medical conditions are indicated on the problem list
  - Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record
  - Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses
  - Working diagnoses are consistent with findings
  - Treatment plans are consistent with diagnoses
  - There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure
  - Date and legible identity of the observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented. The Current Procedural Terminology (CPT) and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

The following requirements apply to all outpatient medical records:

- A separate medical record is maintained for each patient.
- Every page in the medical record contains the patient's name or identification number.
- Each medical record contains personal biographical data including:
  - Address
  - Date of birth
  - Gender
  - Marital status,
  - Next of kin or emergency contact
  - Employer and work or school telephone number (as applicable)
  - Home telephone number (if patient has one)
  - Medicaid or Member identification number
  - Consent and guardian information (as applicable)
- All entries in the medical record contain identification of the author. Author identification may be a handwritten signature, unique electronic identifier or initials. A supervising Participating Provider countersigns all entries by a resident.
- All entries in the medical record are dated.
- The record is legible to someone other than the writer.
- Significant illness and medical conditions are indicated on a problem list. A complete, up to date problem list should be maintained in the medical record for patients with multiple/chronic conditions.
- Medication allergies and adverse drug reactions are noted in the record in a clearly identifiable location. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- A medication list includes the patient's medication history as well as current medications.
- Past medical history is easily identified for any patient seen three or more times, and includes documentation of serious accidents, operations, and illnesses. For children and adolescents (up to 18 years of age), documentation of past medical history includes prenatal care, birth, operations and childhood illnesses.
- For patients 12 years and older who are seen for a routine evaluation, notation concerning the use of tobacco, alcohol and other substances is present in the record. For patients seen three or more times, substance abuse history is queried.
- • Progress Notes should be in S.O.A.P. format as follows:
  - S: The patient's (or caretaker's) subjective statement about the primary problem for which the Physician was consulted.
  - O: The Provider's objective observation of the patient's condition. Any pertinent history or physical examination data relating to chief complaints.
  - A: The Provider's assessment of the patient's condition or their diagnosis impressions.
  - P: The treatment plan, including medications, diagnostic testing and return date.
- For diabetic patients who are seen for routine evaluation, notation concerning results of A1C, Diabetic Eye Exam, Blood Pressure, and Pedal Examination is present in the record.

- Laboratory and other studies are ordered, as appropriate.
- The working diagnosis is consistent with the findings from the history taking, physical examination and/or studies or tests performed.
- The treatment plan is consistent with the working diagnosis.
- Encounter forms or progress notes contain a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return should be noted in weeks, months or as needed (PRN).
- The medical record contains documentation indicating that unresolved problems from previous office visits are addressed in subsequent visits.
- The record contains documentation, which supports the use of consultants to address patient complaints/findings.
- When a consultation is ordered, a note from the consultant is present in the record or there is evidence of coordination of care between primary and specialty (consulting) Provider.
- When the patient is referred to a behavioral health Provider or a history of behavioral health treatment is noted, evidence of the coordination of care between the primary care and behavioral health Provider is present in the medical record.
- Consultations, laboratory and x-ray reports filed in the medical record are initialed by the Provider who ordered them to signify review.
- Consultations and abnormal laboratory and imaging study results have an explicit notation in the record with regard to follow-up plans and patient notification.
- The record contains evidence that care is medically appropriate and that the risks of diagnostic or therapeutic procedures versus no diagnosis/treatment for specific problems has been explained to the patient.
- For children, the immunization record is up to date and for adults an appropriate history of immunizations has been taken.
- The record contains evidence that preventive health screening and services have been offered to the patient in accordance with the plan's preventive health guidelines, including the growth and BMI chart.

For Evaluation and Management Services documentation it is recommended that providers refer to the following publications:

- *1995 Documentation Guidelines for Evaluation and Management Services*, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf on the Centers for Medicare & Medicaid Services (CMS) website;
- *1997 Documentation Guidelines for Evaluation and Management Services*, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf on the CMS website;
- Medicare Claims Processing Manual (Pub. 100-4), available at www.cms.hhs.gov/Manuals/ on the CMS website; and
- *Current Procedural Terminology* book, available from the American Medical Association (800.621.8335 or www.amapress.org on the Web).

IB OUTPATIENT BEHAVIORAL HEALTH TREATMENT RECORD DOCUMENTATION STANDARDS

The following requirements apply to all Outpatient Behavioral Health Treatment records:

- A separate treatment record is maintained for each patient.
- Every page in the treatment record contains the patient's name or identification number.
- Every medical record contains personal biographical data including:
  - Address
  - Date of birth
  - Gender
  - Marital or legal status
  - Next of kin or emergency contact
  - Employer and work telephone number, or school telephone number (as applicable)
  - Home telephone number (if patient has one)
  - Medicaid or Member identification number
  - Consent and guardian information, if applicable
- All entries in the treatment record are dated.
- The responsible clinician's name, professional degree and relevant identification number, if applicable. A supervising Participating Provider countersigns all entries by a resident or intern.
- The record is legible to someone other than the writer.
- Medication allergies, adverse reactions and relevant medical conditions are clearly documented, dated and recorded in an easily identifiable location.
- Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
- The results of a mental status exam are documented.
- Special status situations, when present, such as imminent risk of harm to self or others are prominently noted, documented and revised overtime as appropriate.
- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- Time element (duration), (where time is an element of the face-to-face contact for the service rendered).
- A medical and psychiatric history is documented including:
  - Previous treatment dates
  - Provider identification
  - Therapeutic interventions and responses
  - Sources of clinical data
  - Relevant family information

For interactive therapy, medical record should indicate the adaptations utilized in the session and the rationale for employing these interactive techniques.

For services that include a medical evaluation and management component, documentation of the medical evaluation or management component of the treatment, including prescriptions, monitoring of medication effects and results of clinical tests.

Group therapy session notes must also be prepared within a reasonable time period after the rendering of professional services consistent with accepted practice, and can be organized according to the general session note guidelines for individual therapy or the clinician may elect to use the following group note format.

One group note that is common to all patients, documenting date, length of time for each session, along with key issues presented. Names of the patients in the group should not appear in this group note.

An additional notation, or addendum to the group note, for each patient's record, commenting on that particular patient's participation in the group process and any significant changes in patient status. As outlined in HIPAA regulations above, the note should exclude content of the patient conversation.

CMS State Medicaid Manual Section 4221:

D. Documentation. – The outpatient program should develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, should consist of material which includes:

1. the specific services rendered;
2. the date and actual time the services were rendered;
3. who rendered the services;
4. the setting in which the services were rendered;
5. the amount of time it took to deliver the services;
6. the relationship of the services to the treatment regimen described in the PoC, and
7. updates describing the patient's progress.

For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

IC PERINATAL MEDICAL RECORD DOCUMENTATION STANDARDS

The following components of prenatal and postpartum care documentation guidelines, in addition to the Outpatient Medical Record Standards, should be reflected in all medical records.

Initial Prenatal Care Visit

1. Date of First Prenatal Visit
2. Gestational age at first visit
3. Expected Delivery Date
4. Physical Examination.
   Note height, pre-pregnancy weight, initial visit weight, blood pressure, head, neck and mouth, breasts, heart, lungs, abdomen, pelvis, uterus, vagina, cervix, rectum, extremities.
   "PE =WNL" is not considered acceptable documentation.
5. Comprehensive Risk Assessment performed during the first 2 visits with the Member (regardless of the stage of pregnancy), the assessment should focus on an analysis of individual characteristics affecting pregnancy including:
   - Medical/health history
     Note review of systems, previous and current medical/surgical problems, list of all medications taken within the past 12 months and family history of disease.
   - Obstetric history
     Note menstrual history, past pregnancies, number of full term pregnancies, premature deliveries, spontaneous and induced abortions, number of living children, spacing of previous pregnancies, length of each gestation, route of each delivery, sex and weight of each newborn, exposure to group B strep, and any complications, particularly those that resulted in fetal or neonatal death.
   - Prenatal Risk Assessment, Screening and Referral for Care
     Prenatal care (PNC) providers shall conduct a comprehensive prenatal care risk assessment for both maternal and fetal risks, at the earliest prenatal care visit, on all pregnant women. The risk assessment shall include but not be limited to an analysis of individual characteristics affecting pregnancy, such as genetic, nutritional, environmental, behavioral health, psychosocial and history of previous and current obstetrical/fetal and medical/surgical risk factors.
   - Nutritional Screening, Counseling and Referral for Care
     Note eating habits and screening for specific nutritional risk conditions. A notation of "diet adequate", 24-hour diet recall, or similar statement are acceptable forms of documentation. Documentation that simply notes prescription/advice for prenatal vitamins is not acceptable.
   - Psychosocial Risk Assessment, Screening, Counseling And Referral For Care
     The assessment shall include a broad range of social, economic, psychological and emotional problems. Note assessment of barriers to care, unstable housing, communication barriers (i.e. language and /or cultural barriers), nutrition, tobacco use, substance use, depression or other psychiatric illness, safety, domestic violence, sexual abuse, and stress. Listing of demographic information alone is not acceptable documentation.

- Genetic risk factors
  Note that the history obtained during the initial evaluation was reviewed to detect risk factors for genetic disorders. The assessment should be comprehensive and consistent with current standards of practice.
- Home/work environment
  Note exposure to second hand smoke, lead, chemicals and toxoplasmosis.
- History and current use of tobacco, alcohol and drugs
  Use of prescribed and over-the-counter medications should be included in the history.
- Infectious disease screening
  Note exposure to HIV, rubella, tuberculosis and sexually transmitted diseases.

6. Care Plan which addresses the problems identified as a result of the initial risk assessment. The care plan shall describe the implementation and coordination of all services required by the pregnant woman, be routinely updated and implemented jointly by the pregnant woman, her family and the appropriate members of the health care team.

Care Plan Development and Care Coordination

1. A problem list with the care plan.
2. Evidence of ongoing assessment of risk factors throughout pregnancy including review of symptoms, awareness of fetal movements, occurrence of contractions or rupture of membranes, review of laboratory data, emerging nutritional, medical and psychosocial factors, with appropriate documentation that symptoms, findings or changes in patient status are being addressed in the care plan.
3. Regular care plan updates.
4. Referrals and assessments including, when appropriate, evidence of social work referral and assessment, referral to a nutritionist and nutrition assessment, and referral to high risk care.

Prenatal Care Visits

All lab tests are conducted on a risk-appropriate basis, except for syphilis and hepatitis B testing mandated by law. Indication that the test was performed and the results of the test should be present in the record.

Initial Testing:

1. Hemoglobin electrophoresis with documentation of the women's ethnicity. HgB electrophoresis is strongly recommended by NYSDOH rather than the sickle prep test.
2. Hemoglobin/hematocrit
3. Hepatitis B Surface Antigen
4. Blood Type
5. Rh Type
6. Antibody Screen
7. Rubella
8. VDRL or RPR

9. PPD
10. Chlamydia
11. GC Screen
12. Vaginal/cervical cytology: document if testing was done within one year and the results were negative.
13. Urine screen

Additional Testing:

1. Maternal Serum AFP (14-18 weeks)
2. Glucose Challenge (24-28 weeks)
3. Hemoglobin/Hematocrit (third trimester)
4. Group B Strep (35-37 weeks)
5. HbsAg (28-36 weeks)
6. VDRL (28-36 weeks
7. Chlamydia (third trimester)
8. GC Screen (third trimester)
9. Ultrasound
10. Amniocentesis

Rhogam: Given at 28 weeks, when indicated.

HIV Counseling/testing, document if the Member's HIV status is known prior to testing or if the Member refused the test.

Patient Education

Documentation in the medical record should include the specific health education topics covered. If the patient attended prenatal or childbirth classes, document if the course was completed. If a woman had previous deliveries, document assessment of her level of knowledge (e.g. signs and symptoms of labor). Specific patient education topics must be covered:

1. Basic nutrition, including dietary intake and weight gain
2. Avoidance of harmful practices/substances, including alcohol, non-prescription medications, nicotine and other drugs
3. Risk of HIV infection/risk reduction behavior
4. Signs/symptoms of pregnancy complications
5. Signs/symptoms of labor
6. Relaxation techniques in labor
7. Childbirth education/class attendance
8. Labor and delivery process
9. OB anesthesia and analgesia

10. Breastfeeding/infant feeding choices
11. Preparation for parenting, including infant development, care and safety
12. Family planning, including methods of contraception
13. Pediatric care, including infant care education (e.g. immunization and well child visit schedule)

Postpartum Care

Documentation of the visit scheduled between 21 and 56 days after delivery should include:

1. Information such as delivery date, type of delivery, number of infant(s) delivered, sex(es), birth weight(s), and gestational age(s).
2. Cesarean wound check, if applicable.
3. A physical check up after delivery including breasts, blood pressure, abdomen, external and internal genitalia, and weight.
4. Depression screening – Screening should be coupled with appropriate follow-up and treatment when indicated.
5. Family planning services provided or referrals made.
6. Preconception counseling on improving nutritional status, genetic counseling, and correction of chronic health problems that could lead to poor future pregnancy outcomes.
7. Postnatal needs assessment of nutritional factors, medical issues, psychosocial factors, breast-feeding, smoking/vaping, alcohol and substance abuse treatment needs.
8. Referrals as needed.

IIA RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE

Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

Bright Futures/American Academy of Pediatrics

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Bright Futures

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	⟶		★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	⟵	⟵	⟵	●[10]	⟶	⟵	●	⟶	⟵	●	⟶
DEVELOPMENTAL/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●			●		●																		
Autism Spectrum Disorder Screening[12]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																						●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																								
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20]	⟶																											
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	⟵	●	⟶	★	★	★	★	★	⟵	⟵	⟵	●	⟶
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	⟵	⟵	●	⟶	★	★	★
Cervical Dysplasia[31]																															●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★														
Fluoride Varnish[34]							⟵	⟵	⟵	⟵	●	⟵	⟵	⟵	⟶																
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://crafft.org.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ⟵ ● ⟶ = range during which a service may be provided

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(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/home) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (http://pediatrics.aappublications.org/content/138/1/e20161493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.*
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Oral-Health/Pages/Oral-Health-Practice-Tools.aspx) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment
See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This schedule reflects changes approved in December 2018 and published in March 2019.
For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

- Footnote 6 has been updated to read as follows: "Screening should occur per 'Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents' (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years."

ANEMIA

- Footnote 24 has been updated to read as follows: "Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter)."

LEAD

- Footnote 25 has been updated to read as follows: "For children at risk of lead exposure, see 'Prevention of Childhood Lead Toxicity' (http://pediatrics.aappublications.org/content/138/1/e20161493) and 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention' (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)."

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications' (http://pediatrics.aappublications.org/content/124/4/1193)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf). See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (http://pediatrics.aappublications.org/content/134/3/626)."

Adult Preventive Health Care Schedule: Recommendations from the USPSTF (as of June 1, 2018)

To be used in conjunction with USPSTF recommendation statements for additional details (see accompanying tables and references)

Only grade A/B recommendations are shown

Age	*18*	*21*	*24*	*25*	*35*	*40*	*45*	*50*	*55*	*59*	*65*	*70*	*74*	*75*	*80*
USPSTF screening recommendations															
Alcohol misuse[1]	(B)														
Depression[2]	(B)														
Hypertension[3]	(A)														
Obesity[4]	(B)														
Tobacco use and cessation[5]	(A)														
HIV infection[6]	(A)											(A) if at increased risk			
Hepatitis B virus infection[7]	(B) if at increased risk														
Syphilis[8]	(A) if at increased risk														
Tuberculosis[9]	(B) if at increased risk														
BRCA gene screening[10]	(B) if appropriate family history														
Chlamydia and gonorrhea[11]	(B) if sexually active			(B) if at increased risk											
Intimate partner violence[12]	(B) childbearing-aged women														
Cervical cancer[13]		(A) Pap smear every 3 years, or every 5 years with human papillomavirus cotesting starting at age 30													
Abnormal glucose/diabetes[14]						(B) if overweight or obese									
Hepatitis C virus infection[15]	(B) if at high risk							(B) birth years 1945-1965					(B) if at high risk		
Colorectal cancer[16]								(A)							
Breast cancer[17]								(B) biennial screening							
Lung cancer[18]									(B) if 30 pack-years and current or former smoker (quit in past 15 years)						
Osteoporosis[19]							(B) if ≥ 9.3% 10-year fracture risk				(B)				
Abdominal aortic aneurysm[20]											(B) if an "ever smoker"				
USPSTF preventive therapies recommendations															
Primary prevention of breast cancer[21]	(B) if at increased risk and only after shared decision making														
Folic acid supplementation[22]	(A) if capable of conceiving														
Statins for primary prevention of CVD[23]						(B) see criteria on p. 6									
Aspirin for primary prevention of CVD and colorectal cancer[24]								(B) if ≥ 10% 10-year CVD risk							
Fall prevention in community-dwelling older adults[25]											(B) exercise interventions if at increased fall risk				
USPSTF counseling recommendations															
Sexually transmitted infection prevention[26]	(B) if at increased risk														
Diet/activity for CVD prevention[27]	(B) if overweight or obese and with additional CVD risk														
Skin cancer prevention[28]	(B) if fair skinned														

Legend

Recommendation for men and women

Recommendation for men only

Recommendation for women only

Normal risk / *With specific risk factor*

Recommendation grades

A	Recommended (likely significant benefit)
B	Recommended (likely moderate benefit)
C	Do not use routinely (benefit is likely small)
D	Recommended against (likely harm or no benefit)
I	Insufficient evidence to recommend for or against

CHD = coronary heart disease; CVD = cardiovascular disease; HIV = human immunodeficiency virus; USPSTF = U.S. Preventive Services Task Force.

Visual adaptation from recommendation statements by Swenson PF, Lindberg C, Carrilo C, and Clutter J.

HIV RISK FACTORS

- IV drug use
- Men who have sex with men
- Other STI
- Requesting STI testing
- Sex exchanged for drugs or money
- Sex with individuals who are IV drug users, bisexual, or HIV positive
- Unprotected sex, including anal intercourse

HIV = human immunodeficiency virus; IV = intravenous; STI = sexually transmitted infection.

HEPATITIS B INFECTION RISK FACTORS

- Human immunodeficiency virus infection
- Infected sex partner
- Intravenous drug use
- Living with an infected individual
- Men who have sex with men
- Origin from regions* with prevalence ≥ 2%
- U.S.-born children of immigrants from regions* with prevalence ≥ 8%, if unvaccinated

**—Risk of regions can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5708a1.htm.*

SYPHILIS RISK FACTORS

- High-risk sexual behaviors
- Incarceration
- Local prevalence
- Men who have sex with men
- Sex exchanged for money for drugs

TUBERCULOSIS RISK FACTORS

- Health professionals*
- Homelessness, including former
- Immunosuppression*
- Prisoners, including former
- Residents of high-risk regions, including former

**—Evidence for screening not reviewed by the USPSTF because this is standard practice in public health and standard of care for patients with immunosuppression, respectively.*

BRCA MUTATION RISK FACTORS

Family history of breast cancer:
- Bilateral
- Diagnosed before 50 years of age
- Diagnosed in multiple family members
- In one or more male family members
- With a family history of ovarian cancer

Family member with two *BRCA*-related cancers

NOTE: *Consider use of validated risk assessment tools to identify patients with pertinent family history.*

CHLAMYDIA AND GONORRHEA RISK FACTORS

- New or multiple sex partners
- Other STI, including history of STI
- Partner with STI
- Partners who have multiple sex partners
- Sex exchanged for drugs or money
- Sexually active adolescents
- Unprotected sex or inconsistent condom use

STI = sexually transmitted infection.

CARDIOVASCULAR DISEASE RISK FACTORS

- Diabetes mellitus
- Dyslipidemia
- Family history
- Hypertension
- Metabolic syndrome
- Obesity
- Tobacco use

HEPATITIS C INFECTION RISK FACTORS

- Blood transfusion before 1992
- Chronic hemodialysis
- High-risk sexual behaviors
- Incarceration
- Intravenous or intranasal drug use
- Maternal infection (concern for vertical transmission)
- Unregulated tattoo

BREAST CANCER RISK FACTORS

Consider use of a risk-assessment model for patients with a history of biopsy or positive family history

SEXUALLY TRANSMITTED INFECTION RISK FACTORS

Similar to those risk factors listed previously for sexually transmitted infections; consider local and population-based prevalence in individual risk assessment

Adult Preventive Health Care Schedule: Recommendations from the USPSTF

Grade A/B Recommendations (with Associated Grade C/D/I Recommendations):

Alcohol misuse screening[1] (UIP)

(B) Screen adults and provide brief behavioral interventions for risky alcohol use

Depression screening[2]

(B) Screen adults with systems for evaluation and management

Hypertension screening[3]

(A) Screen adults; exclude white coat hypertension before starting therapy

Obesity screening[4] (UIP)

(B) Screen adults and offer or refer patients with body mass index ≥ 30 kg per m^2 to intensive behavioral interventions

Tobacco use screening[5] (UIP)

(A) Screen adults and provide behavioral and U.S. Food and Drug Administration–approved intervention therapy for cessation

(I) IETRFOA electronic nicotine delivery systems for tobacco cessation

Human immunodeficiency virus screening[6] (UIP)

(A) Screen individuals 15 to 65 years of age

(A) Screen older and younger persons who are at increased risk

Hepatitis B virus infection screening[7]

(B) Screen adolescents and adults at high risk

Syphilis screening[8]

(A) Screen individuals at increased risk

Tuberculosis screening[9]

(B) Screen individuals at increased risk

***BRCA* screening[10] (UIP)**

(B) Screen women with appropriate family history

(D) Recommend against screening patients without appropriate family history

Chlamydia and gonorrhea screening[11]

(B) Screen sexually active women 24 years and younger, and women at increased risk who are 25 years and older

(I) IETRFOA screening sexually active males

Intimate partner violence screening[12] (UIP)

(B) Screen women of childbearing age and refer to appropriate services

(I) IETRFOA screening all vulnerable and elderly patients for abuse or neglect

Cervical cancer screening[13] (UIP)

(A) Screen women 21 to 65 years of age

- Papanicolaou smear every three years
- Women 30 to 65 years of age may increase screening interval to five years with cytology and human papillomavirus cotesting

(D) Recommend against screening in women

- Age 20 years and younger
- Older than 65 years if adequately screened previously and no increased risk of cervical cancer
- With hysterectomy (including cervix) without history of cervical intraepithelial neoplasia grade 2 or 3 or cervical cancer
- Younger than 30 years with human papillomavirus testing alone or in combination with cytology

Abnormal glucose and diabetes mellitus type 2 screening[14]

(B) Screen overweight or obese adults 40 to 70 years of age and refer patients with abnormal glucose levels for intensive counseling for healthy diet and exercise

Hepatitis C virus infection screening[15] (UIP)

(B) Offer one-time screening of patients born between 1945 and 1965

(B) Screen high-risk patients

Colorectal cancer screening[16]

(A) Screen patients 50 to 75 years of age with fecal occult blood (or immunochemical) test, sigmoidoscopy, colonoscopy, computed tomography colonography, or multitargeted stool DNA test

(C) Recommend against routine screening of patients 76 to 85 years of age

Breast cancer screening[17]

(B) Biennial screening mammography in women 50 to 74 years of age

(C) Screening is an individualized decision for women 40 to 49 years of age

(I) IETRFOA

- Mammography after 75 years of age
- Screening with digital breast tomosynthesis
- Adjunctive screening in women with dense breast tissue and negative screening mammogram

Lung cancer screening[18] (UIP)

(B) Screen annually with low-dose computed tomography for individuals 55 to 80 years of age with a 30 pack-year history who currently smoke or quit within the past 15 years; consider overall health in decision to screen

Osteoporosis screening[19] (UIP)

(B) Screen women 65 years and older

(B) Screen women if fracture risk equal to that of a 65-year-old white woman without other risk factors (9.3% in 10 years by U.S. FRAX [Fracture Risk Assessment] tool)

(I) IETRFOA screening men

Abdominal aortic aneurysm screening[20] (UIP)

(B) Screen men 65 to 75 years of age who ever smoked (100 or greater lifetime cigarettes) with one-time abdominal aortic aneurysm ultrasonography

(C) Recommend selective screening of never-smoking men 65 to 75 years of age

(I) IETRFOA women 65 to 75 years of age who ever smoked

(D) Recommend against routine screening in never-smoking women 65 to 75 years of age

Primary prevention of breast cancer[21] (UIP)

(B) Recommend shared decision making for medications (such as tamoxifen and raloxifene) that reduce risk of breast cancer in women at increased risk

(D) Recommend against routine use if no increased risk

Folic acid supplementation[22]

(A) 0.4 to 0.8 mg daily for women capable of conception

continues

CHD = coronary heart disease; CVD = cardiovascular disease; IETRFOA = insufficient evidence to recommend for or against; UIP = update in progress; USPSTF = U.S. Preventive Services Task Force.

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(continued)*

Grade A/B Recommendations (with Associated Grade C/D/I Recommendations): *(continued)*

Statins for primary prevention of CVD[23]

(B) Recommend low- to moderate-dose statin therapy in patients meeting all three criteria:
  (1) 40 to 75 years of age
  (2) Dyslipidemia, diabetes, hypertension, or smoker
  (3) 10-year CVD risk of 10% or greater

(C) Consider low- to moderate-dose statin therapy in appropriate candidates meeting the first two criteria but with a 10-year CVD risk of 7.5% to 10%

(I) IETRFOA initiating statin therapy after 75 years of age for primary prevention

Aspirin for primary prevention of CVD and colorectal cancer[24]

(B) Recommend low-dose aspirin for patients 50 to 59 years of age with a 10-year CVD risk of 10% or greater, appropriate bleeding risk, and life expectancy of at least 10 years

(C) Recommend individualized decision making for patients 60 to 69 years of age who meet the same criteria

(I) IETRFOA low-dose aspirin for patients younger than 50 years or 70 years or older

Fall prevention in community-dwelling older adults[25]

(B) Recommend exercise interventions for individuals 65 years and older at increased risk of falls

(C) Recommend multifactorial interventions for appropriate individuals 65 years and older; see Clinical Considerations in original recommendation statement for patient selection

(D) Recommend against vitamin D supplementation for fall prevention

Counseling to prevent sexually transmitted infection[26] (UIP)

(B) Recommend counseling to prevent sexually transmitted infection for adolescents and adults at increased risk

Counseling to promote healthy diet and physical activity[27]

(B) Recommend that overweight or obese patients with other CVD risk factor(s) be offered or referred for intensive behavioral counseling

Counseling for skin cancer prevention[28]

(B) Recommend counseling fair-skinned patients six months to 24 years of age about minimizing ultraviolet light exposure

(C) Recommend selectively counseling fair-skinned patients older than 24 years about minimizing exposure to UV radiation

(I) IETRFOA counseling adults about skin self-examination

Grade C Recommendations:

Physical activity and healthy diet counseling to reduce cardiovascular risk in adults without obesity or known CVD risk factors[29]

Prostate cancer screening with prostate-specific antigen in men 55 to 69 years of age after shared decision making[30]

Grade D Recommendations:

Bacteriuria (asymptomatic) screening in men and nonpregnant women[31] (UIP)

Beta carotene or vitamin E supplementation for CVD or cancer risk reduction[32]

Carotid artery stenosis screening[33]

CHD screening with resting or exercise electrocardiography in low-risk patients[34] (UIP)

Chronic obstructive pulmonary disease screening with spirometry[35]

Combined estrogen-progesterone for prevention of chronic conditions or estrogen for the same in patients with hysterectomy[36]

Genital herpes screening[37]

Ovarian cancer screening[38]

Pancreatic cancer screening[39] (UIP)

Prostate cancer screening with prostate-specific antigen for men 70 years and older[30]

Testicular cancer screening[40]

Thyroid cancer screening[41]

Vitamin D (≤ 400 IU) and calcium (≤ 1,000 mg) supplementation daily for primary prevention of fracture in postmenopausal women[42]

Grade I Statements:

Bladder cancer screening[43]

Celiac disease screening[44]

CHD screening with nontraditional risk factors[45] (UIP)

CHD screening with resting or exercise electrocardiography in intermediate- to high-risk patients[34] (UIP)

Chronic kidney disease screening[46]

Cognitive impairment screening in older adults[47] (UIP)

Gynecologic condition screening with pelvic examination[48]

Hearing loss screening in older adults[49]

Illicit drug use screening[50] (UIP)

Impaired visual acuity screening in older adults[51]

Multivitamin, single nutrient, or paired nutrients for CVD or cancer risk reduction (beta carotene and vitamin E, as above)[32]

Obstructive sleep apnea screening[52]

Oral cancer screening[53]

Peripheral artery disease and CVD risk screening with ankle-brachial index[54] (UIP)

Primary open-angle glaucoma screening[55]

Primary prevention of fractures with vitamin D and calcium supplementation (alone or combined; dose unspecified) in men or premenopausal women, and in postmenopausal women with daily dosages > 400 IU of vitamin D and > 1,000 mg of calcium[42]

Skin cancer screening[56]

Suicide risk screening[57]

Thyroid dysfunction screening[58]

Vitamin D deficiency screening in community-dwelling nonpregnant adults[59]

CHD = coronary heart disease; CVD = cardiovascular disease; IETRFOA = insufficient evidence to recommend for or against; UIP = update in progress; USPSTF = U.S. Preventive Services Task Force.

Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(continued)*

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Adult Preventive Health Care Schedule: Recommendations from the USPSTF *(continued)*

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III CHILD VACCINE SCHEDULE

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES 2019

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccines	Abbreviations	Trade names
Diphtheria, tetanus, and acellular pertussis vaccine	**DTaP**	Daptacel Infanrix
Diphtheria, tetanus vaccine	**DT**	No Trade Name
Haemophilus influenzae type b vaccine	**Hib (PRP-T)** **Hib (PRP-OMP)**	ActHIB Hiberix PedvaxHIB
Hepatitis A vaccine	**HepA**	Havrix Vaqta
Hepatitis B vaccine	**HepB**	Engerix-B Recombivax HB
Human papillomavirus vaccine	**HPV**	Gardasil 9
Influenza vaccine (inactivated)	**IIV**	Multiple
Influenza vaccine (live, attenuated)	**LAIV**	FluMist
Measles, mumps, and rubella vaccine	**MMR**	M-M-R II
Meningococcal serogroups A, C, W, Y vaccine	**MenACWY-D**	Menactra
	MenACWY-CRM	Menveo
Meningococcal serogroup B vaccine	**MenB-4C**	Bexsero
	MenB-FHbp	Trumenba
Pneumococcal 13-valent conjugate vaccine	**PCV13**	Prevnar 13
Pneumococcal 23-valent polysaccharide vaccine	**PPSV23**	Pneumovax
Poliovirus vaccine (inactivated)	**IPV**	IPOL
Rotavirus vaccine	**RV1** **RV5**	Rotarix RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	**Tdap**	Adacel Boostrix
Tetanus and diphtheria vaccine	**Td**	Tenivac Td vaccine
Varicella vaccine	**VAR**	Varivax
Combination Vaccines *(Use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	**DTaP-HepB-IPV**	Pediarix
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	**DTaP-IPV/Hib**	Pentacel
DTaP and inactivated poliovirus vaccine	**DTaP-IPV**	Kinrix Quadracel
Measles, mumps, rubella, and varicella vaccines	**MMRV**	ProQuad

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child/adolescent immunization schedule

1 Determine recommended vaccine by age **(Table 1)**

2 Determine recommended interval for catch-up vaccination **(Table 2)**

3 Assess need for additional recommended vaccines by medical condition and other indications **(Table 3)**

4 Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), and American College of Obstetricians and Gynecologists (www.acog.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or (800-822-7967)

Download the CDC Vaccine Schedules App for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information

- Complete ACIP recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- General Best Practice Guidelines for Immunization: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Outbreak information (including case identification and outbreak response), see Manual for the Surveillance of Vaccine-Preventable Diseases: www.cdc.gov/vaccines/pubs/surv-manual

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger United States, 2019

These recommendations must be read with the Notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Table 1. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.

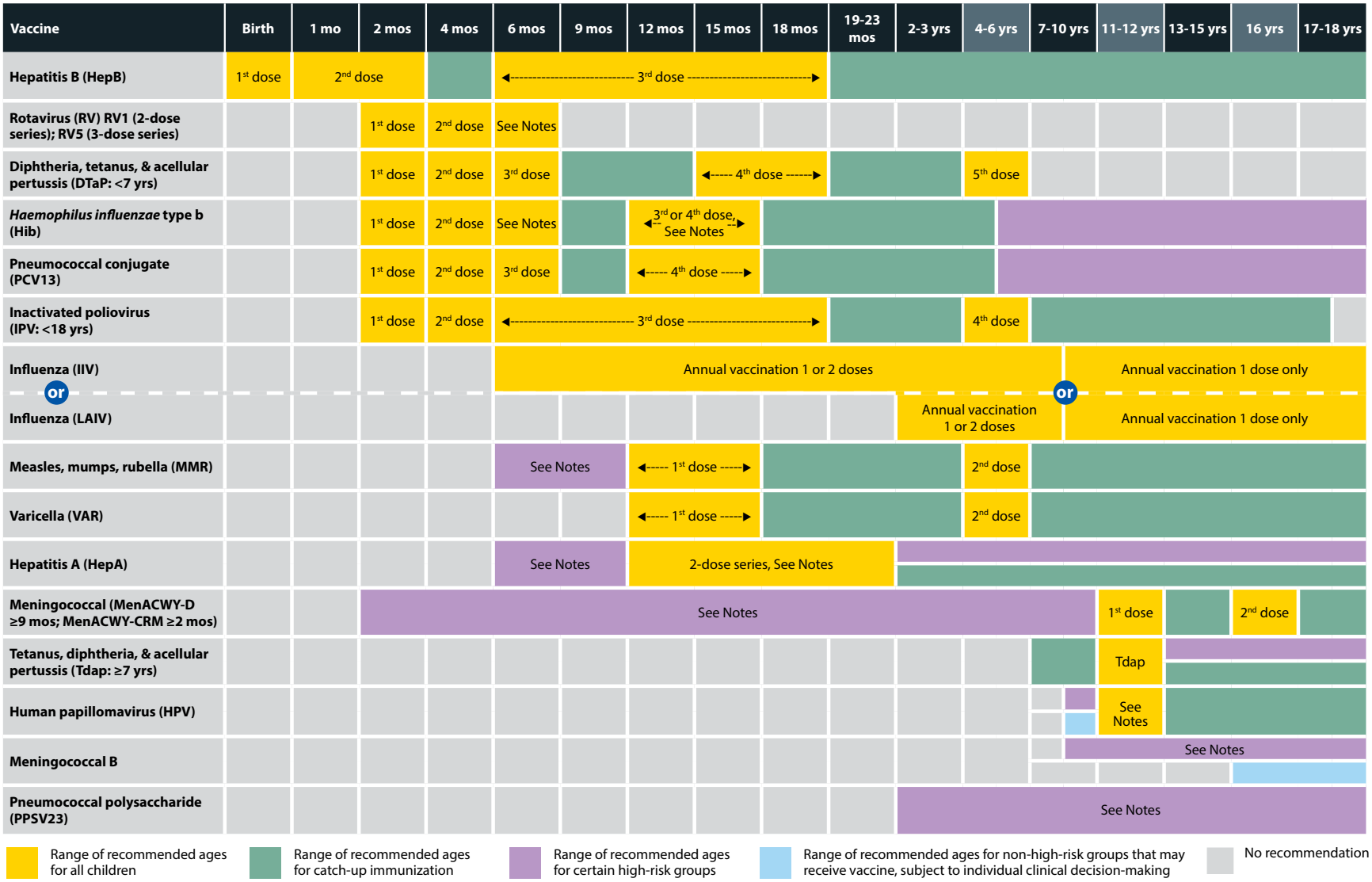


Table 2 Catch-up immunization schedule for persons aged 4 months—18 years who start late or who are more than 1 month behind, United States, 2019

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Table 1 and the notes that follow.

Children age 4 months through 6 years					
Vaccine	**Minimum Age for Dose 1**	**Minimum Interval Between Doses**			
		Dose 1 to Dose 2	**Dose 2 to Dose 3**	**Dose 3 to Dose 4**	**Dose 4 to Dose 5**
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.** Minimum age for the final dose is 24 weeks.		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days	**4 weeks**	**4 weeks** Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older. **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months, ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday, ***and*** second dose administered at younger than 15 months; OR if both doses were PRP-OMP (PedvaxHIB; Comvax) ***and*** were administered before the 1st birthday.	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older. **4 weeks** if first dose administered before the 1st birthday. **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after.	**No further doses needed** for healthy children if previous dose administered at age 24 months or older. **4 weeks** if current age is younger than 12 months and previous dose given at <7 months old. **8 weeks (as final dose for healthy children)** if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months.	**8 weeks (as final dose)** This **dose** only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	**4 weeks**	4 weeks if current age is < 4 years. 6 months (as final dose) if current age is 4 years or older.	**6 months** (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal	2 months MenACWY-CRM 9 months MenACWY-D	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal	Not Applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday. **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	**6 months** if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and*** at least 16 weeks after first dose.		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older.			

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication United States, 2019

VACCINE	INDICATION										
	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection CD4+ count[1]		Kidney failure, end-stage renal disease, on hemodialysis	Heart disease, chronic lung disease	CSF leaks/ cochlear implants	Asplenia and persistent complement component deficiencies	Chronic liver disease	Diabetes
			<15% and total CD4 cell count of <200/mm3	≥15% and total CD4 cell count of ≥200/mm3						
Hepatitis B										
Rotavirus		SCID[2]								
Diphtheria, tetanus, & acellular pertussis (DTaP)										
Haemophilus influenzae type b										
Pneumococcal conjugate										
Inactivated poliovirus										
Influenza (IIV)										
or										
Influenza (LAIV)						Asthma, wheezing: 2-4yrs[3]				
Measles, mumps, rubella										
Varicella										
Hepatitis A										
Meningococcal ACWY										
Tetanus, diphtheria, & acellular pertussis (Tdap)										
Human papillomavirus										
Meningococcal B										
Pneumococcal polysaccharide										

Vaccination according to the routine schedule recommended

Recommended for persons with an additional risk factor for which the vaccine would be indicated

Vaccination is recommended, and additional doses may be necessary based on medical condition. See Notes.

Contraindicated or use not recommended—vaccine should not be administered because of risk for serious adverse reaction

Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction

Delay vaccination until after pregnancy if vaccine indicated

No recommendation

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization "Altered Immunocompetence" at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Table 4-1 (footnote D) at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

2 Severe Combined Immunodeficiency

3 LAIV contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months.

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2019

For vaccine recommendations for persons 19 years of age and older, see the Recommended Adult Immunization Schedule.

Additional information

- Consult relevant ACIP statements for detailed recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For information on contraindications and precautions for the use of a vaccine, consult the General Best Practice Guidelines for Immunization and relevant ACIP statements at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at wwwnc.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).
- For information regarding vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series at 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be given as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently given as early as 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older.
- For other catch-up guidance, see Table 2.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, 12–15 months
- **PedvaxHIB:** 3-dose series at 2, 4, 12–15 months

Catch-up vaccination

- **Dose 1 at 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before 12 months and dose 2 before 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **Unvaccinated at 15–59 months:** 1 dose
- For other catch-up guidance, see Table 2.

Special situations

- **Chemotherapy or radiation treatment:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  12–59 months
  - Unvaccinated or only 1 dose before 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before 12 months:1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5 years or older*
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated persons age 15 months or older*
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5–18 years*
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

**Unvaccinated* = Less than routine series (through 14 months) OR no doses (14 months or older)

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2019

Hepatitis A vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series (**Havrix** 6–12 months apart or **Vaqta** 6–18 months apart, minimum interval 6 months); a series begun before the 2nd birthday should be completed even if the child turns 2 before the second dose is administered.

Catch-up vaccination

- Anyone 2 years of age or older may receive HepA vaccine if desired. Minimum interval between doses: 6 months
- Adolescents 18 years and older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (0, 7, and 21–30 days, followed by a dose at 12 months).

International travel

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (wwwnc.cdc.gov/travel/):
  - **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses, separated by 6–18 months, between 12 to 23 months of age.
  - **Unvaccinated age 12 months and older**: 1st dose as soon as travel considered

Special situations

At risk for hepatitis A infection: 2-dose series as above

- **Chronic liver disease**
- **Clotting factor disorders**
- **Men who have sex with men**
- **Injection or non-injection drug use**
- **Homelessness**
- **Work with hepatitis A virus** in research laboratory or nonhuman primates with hepatitis A infection
- **Travel** in countries with high or intermediate endemic hepatitis A
- **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)

Hepatitis B vaccination (minimum age: birth)

Birth dose (monovalent HepB vaccine only)

- **Mother is HBsAg-negative:** 1 dose within 24 hours of birth for **all** medically stable infants ≥2,000 grams. Infants <2,000 grams: administer 1 dose at chronological age 1 month or hospital discharge.
- **Mother is HBsAg-positive:**
  - Administer **HepB vaccine** and **0.5 mL of hepatitis B immune globulin (HBIG)** (at separate anatomic sites) within 12 hours of birth, regardless of birth weight. For infants <2,000 grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, administer **0.5 mL of HBIG** in addition to HepB vaccine within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **0.5 mL of HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine series

- 3-dose series at 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations)

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents 18 years and older may receive a 2-dose series of HepB **(Heplisav-B)** at least 4 weeks apart.
- Adolescents 18 years and older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (0, 7, and 21–30 days, followed by a dose at 12 months).
- For other catch-up guidance, see Table 2.

Human papillomavirus vaccination (minimum age: 9 years)

Routine and catch-up vaccination

- HPV vaccination routinely recommended for all adolescents **age 11–12 years (can start at age 9 years)** and through age 18 years if not previously adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9 through 14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- If completed valid vaccination series with any HPV vaccine, no additional doses needed

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series as above
- **History of sexual abuse or assault:** Start at age 9 years
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Inactivated poliovirus vaccination (minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after the 4th birthday and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before the 4th birthday when a combination vaccine containing IPV is used. However, a dose is still recommended after the 4th birthday and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- IPV is not routinely recommended for U.S. residents 18 years and older.

Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w.

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2019

- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Influenza vaccination (minimum age: 6 months [IIV], 2 years [LAIV], 18 years [RIV])

Routine vaccination

- 1 dose any influenza vaccine appropriate for age and health status annually (2 doses separated by at least 4 weeks for **children 6 months–8 years** who did not receive at least 2 doses of influenza vaccine before July 1, 2018)

Special situations

- **Egg allergy, hives only**: Any influenza vaccine appropriate for age and health status annually
- **Egg allergy more severe than hives** (e.g., angioedema, respiratory distress): Any influenza vaccine appropriate for age and health status annually in medical setting under supervision of health care provider who can recognize and manage severe allergic conditions
- **LAIV should not be used for** those with a history of severe allergic reaction to any component of the vaccine (excluding egg) or to a previous dose of any influenza vaccine, children and adolescents receiving concomitant aspirin or salicylate-containing medications, children age 2 through 4 years with a history of asthma or wheezing, those who are immunocompromised due to any cause (including immunosuppression caused by medications and HIV infection), anatomic and functional asplenia, cochlear implants, cerebrospinal fluid-oropharyngeal communication, close contacts and caregivers of severely immunosuppressed persons who require a protected environment, pregnancy, and persons who have received influenza antiviral medications within the previous 48 hours.

Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 4 weeks after dose 1.

Catch-up vaccination

- Unvaccinated children and adolescents: 2 doses at least 4 weeks apart
- The maximum age for use of *MMRV* is 12 years.

Special situations

International travel

- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2 doses at 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months and older:** 2-dose series at least 4 weeks apart before departure

Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra])

Routine vaccination

- 2-dose series: 11–12 years, 16 years

Catch-up vaccination

- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, eculizumab use:

- **Menveo**
  - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after the 1st birthday)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
  - **Persistent complement component deficiency:**
    - Age 9–23 months: 2 doses at least 12 weeks apart
    - Age 24 months or older: 2 doses at least 8 weeks apart
  - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
    - **Age 9–23 months**: Not recommended
    - **24 months or older**: 2 doses at least 8 weeks apart
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (wwwnc.cdc.gov/travel/)**:**

- Children age less than 24 months:
  - **Menveo (age 2–23 months):**
    - Dose 1 at 8 weeks: 4-dose series at 2, 4, 6, 12 months
    - Dose 1 at 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after the 1st birthday)
  - **Menactra (age 9–23 months):**
    - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose **Menveo** or **Menactra**

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:

- 1 dose **Menveo** or **Menactra**

Note: Menactra should be administered either before or at the same time as DTaP. For MenACWY booster dose recommendations for groups listed under "Special situations" above and additional meningococcal vaccination information, see meningococcal *MMWR* publications at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba])

Clinical discretion

- MenB vaccine may be administered based on individual clinical decision to **adolescents not at increased risk** age 16–23 years (preferred age 16–18 years):
- **Bexsero:** 2-dose series at least 1 month apart
- **Trumenba:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, eculizumab use:

- **Bexsero:** 2-dose series at least 1 month apart
- **Trumenba:** 3-dose series at 0, 1–2, 6 months

Bexsero and **Trumenba** are not interchangeable; the same product should be used for all doses in a series.
For additional meningococcal vaccination information, see meningococcal *MMWR* publications at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2019

Pneumococcal vaccination
(minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13
- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV13
- 1 dose for healthy children age 24–59 months with any incomplete* PCV13 series
- For other catch-up guidance, see Table 2.

Special situations
High-risk conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during same visit.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral corticosteroids); diabetes mellitus:

Age 2–5 years
- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Cerebrospinal fluid leak, cochlear implant:

Age 2–5 years
- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13, 8 weeks after the most recent dose and administered 8 weeks apart
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years
- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years
- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later

Age 6–18 years
- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Chronic liver disease, alcoholism:

Age 6–18 years
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

*An incomplete series is defined as not having received all doses in either the recommended series or an age-appropriate catch-up series. See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

Rotavirus vaccination
(minimum age: 6 weeks)

Routine vaccination
- **Rotarix:** 2-dose series at 2 and 4 months.
- **RotaTeq:** 3-dose series at 2, 4, and 6 months.

If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination
- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

Tetanus, diphtheria, and pertussis (Tdap) vaccination
(minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination
- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination
- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td booster every 10 years
- **Persons age 7–18 years not fully immunized with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td.
- **Children age 7–10 years** who receive Tdap inadvertently or as part of the catch-up series should receive the routine Tdap dose at 11–12 years.
- **DTaP inadvertently given after the 7th birthday:**
  - **Child age 7–10 years**: DTaP may count as part of catch-up series. Routine Tdap dose at 11–12 should be administered.
  - **Adolescent age 11–18 years**: Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.
- For information on use of Tdap or Td as tetanus prophylaxis in wound management, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Varicella vaccination
(minimum age: 12 months)

Routine vaccination
- 2-dose series: 12–15 months, 4–6 years
- Dose 2 may be administered as early as 3 months after dose 1 (a dose administered after a 4-week interval may be counted).

Catch-up vaccination
- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2-dose series:
  - **Ages 7–12 years**: routine interval: 3 months (minimum interval: 4 weeks)
  - **Ages 13 years and older**: routine interval: 4–8 weeks (minimum interval: 4 weeks).
  - The maximum age for use of *MMRV* is 12 years.

IV ADULT VACCINE SCHEDULE

Recommended Adult Immunization Schedule
for ages 19 years or older

UNITED STATES 2019

How to use the adult immunization schedule

1 Determine recommended vaccinations by age **(Table 1)**

2 Assess need for additional recommended vaccinations by medical condition and other indications **(Table 2)**

3 Review vaccine types, frequencies, and intervals, and considerations for special situations **(Notes)**

Vaccines in the Adult Immunization Schedule*

Vaccines	Abbreviations	Trade names
Haemophilus influenzae type b vaccine	Hib	ActHIB Hiberix
Hepatitis A vaccine	HepA	Havrix Vaqta
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix
Hepatitis B vaccine	HepB	Engerix-B Recombivax HB Heplisav-B
Human papillomavirus vaccine	HPV vaccine	Gardasil 9
Influenza vaccine, inactivated	IIV	Many brands
Influenza vaccine, live attenuated	LAIV	FluMist Quadrivalent
Influenza vaccine, recombinant	RIV	Flublok Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY	Menactra Menveo
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero Trumenba
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax
Tetanus and diphtheria toxoids	Td	Tenivac Td vaccine
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	Adacel Boostrix
Varicella vaccine	VAR	Varivax
Zoster vaccine, recombinant	RZV	Shingrix
Zoster vaccine live	ZVL	Zostavax

*Administer recommended vaccines if vaccination history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American College of Physicians (www.acponline.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), and American College of Nurse-Midwives (www.midwife.org).

Report
- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System at www.vaers.hhs.gov or 800-822-7967

Injury claims
All vaccines included in the adult immunization schedule except pneumococcal 23-valent polysaccharide and zoster vaccines are covered by the Vaccine Injury Compensation Program. Information on how to file a vaccine injury claim is available at www.hrsa.gov/vaccinecompensation or 800-338-2382.

Questions or comments
Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.

Download the CDC Vaccine Schedules App for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information
- Complete ACIP recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- General Best Practice Guidelines for Immunization (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine Information Statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual
- Travel vaccine recommendations: www.cdc.gov/travel
- Recommended Child and Adolescent Immunization Schedule, United States, 2019: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Table 1 Recommended Adult Immunization Schedule by Age Group United States, 2019

Vaccine	19–21 years	22–26 years	27–49 years	50–64 years	≥65 years
Influenza inactivated (IIV) or **Influenza recombinant** (RIV)	1 dose annually				
or					
Influenza live attenuated (LAIV)	1 dose annually				
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap, then Td booster every 10 yrs				
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)				
Varicella (VAR)	2 doses (if born in 1980 or later)				
Zoster recombinant (RZV) *(preferred)*				2 doses	
or					
Zoster live (ZVL)				1 dose	
Human papillomavirus (HPV) **Female**	2 or 3 doses depending on age at initial vaccination				
Human papillomavirus (HPV) **Male**	2 or 3 doses depending on age at initial vaccination				
Pneumococcal conjugate (PCV13)	1 dose				
Pneumococcal polysaccharide (PPSV23)	1 or 2 doses depending on indication				1 dose
Hepatitis A (HepA)	2 or 3 doses depending on vaccine				
Hepatitis B (HepB)	2 or 3 doses depending on vaccine				
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, then booster every 5 yrs if risk remains				
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication				
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication				

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

No recommendation

Table 2 Recommended Adult Immunization Schedule by Medical Condition and Other Indications United States, 2019

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 count <200	HIV infection CD4 count ≥200	Asplenia, complement deficiencies	End-stage renal disease, on hemodialysis	Heart or lung disease, alcoholism[1]	Chronic liver disease	Diabetes	Health care personnel[2]	Men who have sex with men
IIV or RIV	1 dose annually										
or										or	
LAIV	CONTRAINDICATED						PRECAUTION			1 dose annually	
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td booster every 10 yrs									
MMR	CONTRAINDICATED			1 or 2 doses depending on indication							
VAR	CONTRAINDICATED			2 doses							
RZV *(preferred)*	DELAY			2 doses at age ≥50 yrs							
or											
ZVL	CONTRAINDICATED			1 dose at age ≥60 yrs							
HPV Female	DELAY	3 doses through age 26 yrs		2 or 3 doses through age 26 yrs							
HPV Male		3 doses through age 26 yrs		2 or 3 doses through age 21 yrs							2 or 3 doses through age 26 yrs
PCV13		1 dose									
PPSV23		1, 2, or 3 doses depending on age and indication									
HepA	2 or 3 doses depending on vaccine										
HepB	2 or 3 doses depending on vaccine										
MenACWY	1 or 2 doses depending on indication, then booster every 5 yrs if risk remains										
MenB	PRECAUTION	2 or 3 doses depending on vaccine and indication									
Hib		3 doses HSCT[3] recipients only		1 dose							

- Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
- Recommended vaccination for adults with an additional risk factor or another indication
- Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction
- Delay vaccination until after pregnancy if vaccine is indicated
- Contraindicated—vaccine should not be administered because of risk for serious adverse reaction
- No recommendation

1. Precaution for LAIV does not apply to alcoholism. **2.** See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. **3.** Hematopoietic stem cell transplant.

Notes

Recommended Adult Immunization Schedule United States, 2019

Haemophilus influenzae type b vaccination

Special situations

- **Anatomical or functional asplenia (including sickle cell disease)**: 1 dose Hib if previously did not receive Hib; if elective splenectomy, 1 dose Hib, preferably at least 14 days before splenectomy
- **Hematopoietic stem cell transplant** (HSCT): 3-dose series Hib 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history

Hepatitis A vaccination

Routine vaccination

- **Not at risk but want protection from hepatitis A** (identification of risk factor not required): 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2, 5 months between doses 2 and 3])

Special situations

- **At risk for hepatitis A virus infection**: 2-dose series HepA or 3-dose series HepA-HepB as above
  - **Chronic liver disease**
  - **Clotting factor disorders**
  - **Men who have sex with men**
  - **Injection or non-injection drug use**
  - **Homelessness**
  - **Work with hepatitis A virus** in research laboratory or nonhuman primates with hepatitis A virus infection
  - **Travel in countries with high or intermediate endemic hepatitis A**
  - **Close personal contact with international adoptee** (e.g., household, regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)

Hepatitis B vaccination

Routine vaccination

- **Not at risk but want protection from hepatitis B** (identification of risk factor not required): 2- or 3-dose series HepB (2-dose series Heplisav-B at least 4 weeks apart [2-dose series HepB only applies when 2 doses of Heplisav-B are used at least 4 weeks apart] or 3-dose series Engerix-B or Recombivax HB at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2, 8 weeks between doses 2 and 3, 16 weeks between doses 1 and 3]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: 4 weeks between doses 1 and 2, 5 months between doses 2 and 3])

Special situations

- **At risk for hepatitis B virus infection**: 2-dose (Heplisav-B) or 3-dose (Engerix-B, Recombivax HB) series HepB, or 3-dose series HepA-HepB as above
  - **Hepatitis C virus infection**
  - **Chronic liver disease** (e.g., cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice upper limit of normal)
  - **HIV infection**
  - **Sexual exposure risk** (e.g., sex partners of hepatitis B surface antigen (HBsAg)-positive persons; sexually active persons not in mutually monogamous relationships, persons seeking evaluation or treatment for a sexually transmitted infection, men who have sex with men)
  - **Current or recent injection drug use**
  - **Percutaneous or mucosal risk for exposure to blood** (e.g., household contacts of HBsAg-positive persons; residents and staff of facilities for developmentally disabled persons; health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids; hemodialysis, peritoneal dialysis, home dialysis, and predialysis patients; persons with diabetes mellitus age younger than 60 years and, at discretion of treating clinician, those age 60 years or older)
  - **Incarcerated persons**
  - **Travel in countries with high or intermediate endemic hepatitis B**

Human papillomavirus vaccination

Routine vaccination

- **Females through age 26 years and males through age 21 years:** 2- or 3-dose series HPV vaccine depending on age at initial vaccination; males age 22 through 26 years may be vaccinated based on individual clinical decision (HPV vaccination routinely recommended at age 11–12 years)
- **Age 15 years or older at initial vaccination**: 3-dose series HPV vaccine at 0, 1–2, 6 months (minimum intervals: 4 weeks between doses 1 and 2, 12 weeks between doses 2 and 3, 5 months between doses 1 and 3; repeat dose if administered too soon)
- **Age 9 through 14 years at initial vaccination and received 1 dose, or 2 doses less than 5 months apart**: 1 dose HPV vaccine
- **Age 9 through 14 years at initial vaccination and received 2 doses at least 5 months apart**: HPV vaccination complete, no additional dose needed
- If completed valid vaccination series with any HPV vaccine, no additional doses needed

Special situations

- **Immunocompromising conditions (including HIV infection) through age 26 years**: 3-dose series HPV vaccine at 0, 1–2, 6 months as above
- **Men who have sex with men and transgender persons through age 26 years**: 2- or 3-dose series HPV vaccine depending on age at initial vaccination as above
- **Pregnancy through age 26 years**: HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Notes

Recommended Adult Immunization Schedule United States, 2019

Influenza vaccination

Routine vaccination

- **Persons age 6 months or older**: 1 dose IIV, RIV, or LAIV appropriate for age and health status annually
- For additional guidance, see www.cdc.gov/flu/professionals/index.htm

Special situations

- **Egg allergy, hives only**: 1 dose IIV, RIV, or LAIV appropriate for age and health status annually
- **Egg allergy more severe than hives** (e.g., angioedema, respiratory distress): 1 dose IIV, RIV, or LAIV appropriate for age and health status annually in medical setting under supervision of health care provider who can recognize and manage severe allergic conditions
- **Immunocompromising conditions (including HIV infection), anatomical or functional asplenia, pregnant women, close contacts and caregivers of severely immunocompromised persons in protected environment, use of influenza antiviral medications in previous 48 hours, with cerebrospinal fluid leak or cochlear implant**: 1 dose IIV or RIV annually (LAIV not recommended)
- **History of Guillain-Barré syndrome within 6 weeks of previous dose of influenza vaccine**: Generally should not be vaccinated

Measles, mumps, and rubella vaccination

Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella**: 1 dose MMR
  - Evidence of immunity: Born before 1957 (except health care personnel [see below]), documentation of receipt of MMR, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

Special situations

- **Pregnancy with no evidence of immunity to rubella**: MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose MMR
- **Non-pregnant women of childbearing age with no evidence of immunity to rubella**: 1 dose MMR
- **HIV infection with CD4 count ≥200 cells/μL for at least 6 months and no evidence of immunity to measles, mumps, or rubella**: 2-dose series MMR at least 4 weeks apart; MMR contraindicated in HIV infection with CD4 count <200 cells/μL
- **Severe immunocompromising conditions**: MMR contraindicated
- **Students in postsecondary educational institutions, international travelers, and household or close personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella**: 1 dose MMR if previously received 1 dose MMR, or 2-dose series MMR at least 4 weeks apart if previously did not receive any MMR
- **Health care personnel born in 1957 or later with no evidence of immunity to measles, mumps, or rubella**: 2-dose series MMR at least 4 weeks apart for measles or mumps, or at least 1 dose MMR for rubella; if born before 1957, consider 2-dose series MMR at least 4 weeks apart for measles or mumps, or 1 dose MMR for rubella

Meningococcal vaccination

Special situations for MenACWY

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, eculizumab use**: 2-dose series MenACWY (Menactra, Menveo) at least 8 weeks apart and revaccinate every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, microbiologists routinely exposed to *Neisseria meningitidis***: 1 dose MenACWY and revaccinate every 5 years if risk remains
- **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) and military recruits**: 1 dose MenACWY

Special situations for MenB

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, eculizumab use, microbiologists routinely exposed to *Neisseria meningitidis***: 2-dose series MenB-4C (Bexsero) at least 1 month apart, or 3-dose series MenB-FHbp (Trumenba) at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series)
- **Pregnancy**: Delay MenB until after pregnancy unless at increased risk and vaccination benefit outweighs potential risks
- **Healthy adolescents and young adults age 16 through 23 years (age 16 through 18 years preferred) not at increased risk for meningococcal disease**: Based on individual clinical decision, may receive 2-dose series MenB-4C at least 1 month apart, or 2-dose series MenB-FHbp at 0, 6 months (if dose 2 was administered less than 6 months after dose 1, administer dose 3 at least 4 months after dose 2); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series)

Notes Recommended Adult Immunization Schedule United States, 2019

Pneumococcal vaccination

Routine vaccination

- **Age 65 years or older** (immunocompetent): 1 dose PCV13 if previously did not receive PCV13, followed by 1 dose PPSV23 at least 1 year after PCV13 and at least 5 years after last dose PPSV23
  - Previously received PPSV23 but not PCV13 at age 65 years or older: 1 dose PCV13 at least 1 year after PPSV23
  - When both PCV13 and PPSV23 are indicated, administer PCV13 first (PCV13 and PPSV23 should not be administered during same visit)

Special situations

- **Age 19 through 64 years with chronic medical conditions (chronic heart [excluding hypertension], lung, or liver disease; diabetes), alcoholism, or cigarette smoking**: 1 dose PPSV23
- **Age 19 years or older with immunocompromising conditions (congenital or acquired immunodeficiency [including B- and T-lymphocyte deficiency, complement deficiencies, phagocytic disorders, HIV infection], chronic renal failure, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, iatrogenic immunosuppression [e.g., drug or radiation therapy], solid organ transplant, multiple myeloma) or anatomical or functional asplenia (including sickle cell disease and other hemoglobinopathies)**: 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later, then another dose PPSV23 at least 5 years after previous PPSV23; at age 65 years or older, administer 1 dose PPSV23 at least 5 years after most recent PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)
- **Age 19 years or older with cerebrospinal fluid leak or cochlear implant**: 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later; at age 65 years or older, administer another dose PPSV23 at least 5 years after PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)

Tetanus, diphtheria, and pertussis vaccination

Routine vaccination

- **Previously did not receive Tdap at or after age 11 years**: 1 dose Tdap, then Td booster every 10 years

Special situations

- **Previously did not receive primary vaccination series for tetanus, diphtheria, and pertussis**: 1 dose Tdap followed by 1 dose Td at least 4 weeks after Tdap, and another dose Td 6–12 months after last Td (Tdap can be substituted for any Td dose, but preferred as first dose); Td booster every 10 years thereafter
- **Pregnancy**: 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- For information on use of Tdap or Td as tetanus prophylaxis in wound management, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm

Varicella vaccination

Routine vaccination

- **No evidence of immunity to varicella**: 2-dose series VAR 4–8 weeks apart if previously did not receive varicella-containing vaccine (VAR or MMRV [measles-mumps-rubella-varicella vaccine] for children); if previously received 1 dose varicella-containing vaccine: 1 dose VAR at least 4 weeks after first dose
  - Evidence of immunity: U.S.-born before 1980 (except for pregnant women and health care personnel [see below]), documentation of 2 doses varicella-containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease

Special situations

- **Pregnancy with no evidence of immunity to varicella**: VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose VAR if previously received 1 dose varicella-containing vaccine, or dose 1 of 2-dose series VAR (dose 2: 4–8 weeks later) if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **Health care personnel with no evidence of immunity to varicella**: 1 dose VAR if previously received 1 dose varicella-containing vaccine, or 2-dose series VAR 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **HIV infection with CD4 count ≥200 cells/μL with no evidence of immunity**: Consider 2-dose series VAR 3 months apart based on individual clinical decision; VAR contraindicated in HIV infection with CD4 count <200 cells/μL
- **Severe immunocompromising conditions**: VAR contraindicated

Zoster vaccination

Routine vaccination

- **Age 50 years or older**: 2-dose series RZV 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon) regardless of previous herpes zoster or previously received ZVL (administer RZV at least 2 months after ZVL)
- **Age 60 years or older**: 2-dose series RZV 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon) or 1 dose ZVL if not previously vaccinated (if previously received ZVL, administer RZV at least 2 months after ZVL); RZV preferred over ZVL

Special situations

- **Pregnancy**: ZVL contraindicated; consider delaying RZV until after pregnancy if RZV is otherwise indicated
- **Severe immunocompromising conditions (including HIV infection with CD4 count <200 cells/μL)**: ZVL contraindicated; recommended use of RZV under review

V CLINICAL PRACTICE GUIDELINES

TOPIC	SOURCE/TITLE/VERSION	WEB SITE
Acquired Pneumonia in Adults	Infectious Diseases Society of America/ American Thoracic Society Consensus Guidelines on the Management of Community-Acquired Pneumonia in Adults; 2007	https://www.thoracic.org/statements/resources/mtpi/idsaats-cap.pdf
	Management of Adults With Hospital-acquired and Ventilator-associated Pneumonia: 2016 Clinical Practice Guidelines by the Infectious Diseases Society of America and the American Thoracic Society	https://www.thoracic.org/statements/resources/tb-opi/hap-vap-guidelines-2016.pdf
Adult PCP Checkup	Healthcare.gov – Preventive Care Benefits for Adults	https://www.healthcare.gov/preventive-care-adults/
Alcohol Misuse: Screening	USPSTF: Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions; 2018	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions
Aspirin Use	USPSTF: Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication; 2016	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer?ds=1&s=aspirin to prevent cardiovascular disease
Asthma	2019 GINA Report, Global Strategy for Asthma Management and Prevention	https://ginasthma.org/reports/
Attention Deficit Disorder	American Academy of Pediatrics – ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents; 2011	http://pediatrics.aappublications.org/content/128/5/1007
Behavioral Health	American Psychiatric Association – Clinical Practice Guidelines	https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines
Bipolar Disorder	NCBI – The Clinical Management of Bipolar Disorder: A Review of Evidence-Based Guidelines; 2011	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3219517/
Cancer Screenings	American Cancer Society Guidelines for the Early Detection of Cancer	https://www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html
Cancer, Breast	USPSTF – Breast Cancer: Screening; 2016	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/brca-related-cancer-risk-assessment-genetic-counseling-and-genetic-testing1
Cancer, Cervical	USPSTF – Cervical Cancer: Screening; 2018	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2
	CDC: Cervical Cancer Screening	https://www.cdc.gov/cancer/cervical/basic_info/screening.htm

TOPIC	SOURCE/TITLE/VERSION	WEB SITE
Cancer, Colon	USPSTF – Colorectal Cancer: Screening; 2016	https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/colorectal-cancer-screening2
Cardiovascular Disease	American College of Cardiology/American Heart Association: Guideline on the Primary Prevention of Cardiovascular Disease, 2019	http://www.onlinejacc.org/content/early/2019/03/07/j.jacc.2019.03.010?_ga=2.198142182.874047990.1560792755-1540079517.1551298868
Children Health	World Health Organization: Guidelines for Children	http://www.who.int/publications/guidelines/child_health/en/
Cholesterol Management	USPSTF – High Blood Pressure in Adults: Screening; 2015	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/high-blood-pressure-in-adults-screening
	2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults Endorsed by the American College of Cardiology/American Heart Association Task Force: Guideline on the Management of Blood Cholesterol, 2018	http://www.onlinejacc.org/content/early/2019/03/07/j.jacc.2019.03.010?_ga=2.13212919.1365767720.1561032471-1540079517.1551298868
Chronic Kidney Disease	National Kidney Foundation – Guidelines	https://www.kidney.org/professionals/guidelines/guidelines_commentaries
Chronic Obstructive Pulmonary Disease	Global Initiative for Chronic Obstructive Lung Disease: Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease; 2019	https://goldcopd.org/gold-reports/
Depression Screening	USPSTF – Depression in Adults: Screening; 2016	https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1
	USPSTF – Depression in Children and Adolescents: Screening; 2016	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1?ds=1&s=Depression in Children and
	American Academy of Pediatrics – Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management; 2018	http://pediatrics.aappublications.org/content/early/2018/02/22/peds.2017-4081
Diabetes	ADA Diabetes Care: Standards of Medical Care In Diabetes; 2019	https://professional.diabetes.org/content-page/standards-medical-care-diabetes/
	USPSTF – Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening; 2015	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes
	ADA Diabetes Care: Diabetic Retinopathy: A Position Statement by the American Diabetes Association; 2017	http://care.diabetesjournals.org/content/40/3/412

TOPIC	SOURCE/TITLE/VERSION	WEB SITE
Drug Use	NIH – Resource Guide: Screening for Drug Use in General Medical Settings; 2012	https://www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen
Falls Prevention: Interventions	USPSTF – Falls Prevention in Community-Dwelling Older Adults: Interventions; 2018	https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/falls-prevention-in-older-adults-interventions1
Glaucoma	National Institute for Health and Care Excellence – Glaucoma: diagnosis and management; 2009	https://www.nice.org.uk/guidance/CG85
	International Council of Opthalmology – ICO Guidelines for Glaucoma Eye Care	http://www.icoph.org/enhancing_eyecare/glaucoma.html
Gonorrhea	USPST – Chlamydia and Gonorrhea: Screening; 2014	http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/chlamydia-and-gonorrhea-screening?ds=1&s=gonorrhea
Heart Failure	American College of Cardiology – 2017 ACC/AHA/HFSA Focused Update Guideline for the Management of Heart Failure	https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/04/27/15/50/2017-acc-aha-hfsa-focused-update-of-hf-guideline
Hepatitis C	USPSTF – Hepatitis C: Screening; 2013	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/hepatitis-c-screening
HIV/AIDS	US Department of Health and Human Services: AIDS Info	http://www.aidsinfo.nih.gov/
	New York State Department of Health AIDS Institute: Clinical Guidelines Program	http://www.hivguidelines.org/
	Current U.S. Public Health Service treatment guidelines for HIV/AIDS and hepatitis B and C treatment, exposure management, and prevention, plus additional treatment protocol resources; (Reviewed and Updated 2016)	http://nccc.ucsf.edu/clinical-resources/hiv-aids-resources/hiv-aids-guidelines/
	Current U.S. Public Health Service treatment guidelines for HIV/AIDS and hepatitis B and C treatment, exposure management, and prevention, plus additional treatment protocol resources; (Reviewed and Updated 2016)	http://nccc.ucsf.edu/clinical-resources/hiv-aids-resources/hiv-aids-guidelines/
	Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV; 2019	https://aidsinfo.nih.gov/contentfiles/lvguidelines/AA_Recommendations.pdf
	USPSTF - Human Immunodeficiency Virus (HIV) Infection: Screening; 2019	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening1
	PrEP for the Prevention of HIV Infection in the US – 2017.	https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf
	Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV; 2019	https://aidsinfo.nih.gov/contentfiles/lvguidelines/AA_Recommendations.pdf
	Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States.	http://www.cdcnpin.org/scripts/hiv/index.asp

TOPIC	SOURCE/TITLE/VERSION	WEB SITE
Human Papillomavirus Vaccine	CDC: Human Papillomavirus Vaccine	http://www.cdc.gov/std/hpv/
Hypertension	2017 ACC/AHA/AAPA/ABC/ACPM/AGS/ APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines	https://www.sciencedirect.com/science/article/pii/S0735109717415191?via%3Dihub#tbl6
Immunization Schedule	CDC: Recommended Adult Immunization Schedule for ages 19 years or older, United States, 2019	https://www.cdc.gov/vaccines/schedules/hcp/adult.html
	Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger; 2019	http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
	CDC: Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2019	https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Screening	USPSTF – Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening; 2018	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening
Lead Exposure for Children	NYC DOHMH – Lead Exposure in Children; 2018	https://www1.nyc.gov/assets/doh/downloads/pdf/lead/lead-guidelines-children.pdf
Management of Overweight and Obesity In Adults	2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society	https://www.ncbi.nlm.nih.gov/pubmed/24222017
Menopause Management	AACE Protocol for Standardized Production of Clinical Practice Guidelines, Algorithms, and Checklists – 2017 Update	https://www.aace.com/files/menopause.pdf
TOPIC	**SOURCE/TITLE/VERSION**	**WEB SITE**
Obesity	NHLBI: Managing Overweight and Obesity in Adults: Systematic Evidence Review from the Obesity Expert Panel; 2013	https://www.nhlbi.nih.gov/health-topics/managing-overweight-obesity-in-adults
	USPSTF – Final Recommendation Statement Obesity in Children and Adolescents: Screening; 2017	https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-children-and-adolescents-screening1#Pod8.com
	USPSTF – Obesity in Adults: Screening	https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/obesity-in-adults-screening-and-management-2012

TOPIC	SOURCE/TITLE/VERSION	WEB SITE
Opioids For Chronic Pain	CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016	https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf
Osteoporosis	USPSTF – Screening Osteoporosis to Prevent Fractures; 2018	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/osteoporosis-screening1
Pediatric PCP Checkup	Bright Futures/American Academy of Pediatrics – Recommendations for Preventive Pediatric Health Care; 2018	https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
Perinatal Care	March of Dimes: Prenatal and Postpartum Care	https://www.marchofdimes.org/pdf/california/CA_Prenatal_and_Postpartum_Care.pdf
Post-Partum Care	ACOG – Optimizing Postpartum Care; 2018	https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co736.pdf?dmc=1&ts=20181108T1408167947
Preconception Care	USPSTF – Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication; 2017	https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication
	One key Question Initiative – The Preconception Resource Guide is designed to help primary care providers meet their patient's needs based on the response to this "vital sign" question: "Would you like to become pregnant in the next year?" Her answer will allow you and your colleagues to individualize her primary care to best meet her overall and reproductive health needs.	https://beforeandbeyond.org/toolkit/
Preventive Services for Children and Adolescents	MQIC: Routine Preventive Services for Children and Adolescents (Ages 2-21)	http://www.mqic.org/pdf/mqic_routine_preventive_services_for_children_and_adolescents_ages_2_to_21_cpg.pdf
Sexually Transmitted Disease	CDC Resource: Sexually Transmitted Disease	https://www.cdc.gov/std/
	USPSTF – Syphilis Infection in Nonpregnant Adults and Adolescents: Screening; 2016	https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/syphilis-infection-in-nonpregnant-adults-and-adolescents#Pod8
Smoking/ Vaping Cessation	AHRQ: Treating Tobacco Use and Dependence: 2008 Update – Overview	http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/presentations/2008update-overview/index.html
	USPSTF – Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions; 2015	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1
	Electronic Cigarettes, Vaping, Product use associated lung injury (EVALI)	https://www.cdc.gov/mmwr/volumes/68/wr/mm6841e3.htm?s_cid=mm6841e3_w

TOPIC	SOURCE/TITLE/VERSION	WEB SITE
Stroke	Primary Prevention of Ischemic Stroke; 2006 *A Guideline From the American Heart Association/American Stroke Association Stroke Council: Cosponsored by the Atherosclerotic Peripheral Vascular Disease Interdisciplinary Working Group; Cardiovascular Nursing Council; Clinical Cardiology Council; Nutrition, Physical Activity, and Metabolism Council; and the Quality of Care and Outcomes Research Interdisciplinary Working Group: The American Academy of Neurology affirms the value of this guideline.*	http://stroke.ahajournals.org/cgi/reprint/37/6/1583
	Guidelines for the Prevention of Stroke in Patients With Stroke and Transient Ischemic Attack; 2014 *A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association*	http://stroke.ahajournals.org/content/45/7/2160
Suicide Prevention	Suicide Risk in Adolescents, Adults and Older Adults: Screening; 2014	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/suicide-risk-in-adolescents-adults-and-older-adults-screening?ds=1&s=suicide
	American Psychiatric Association – Suicide Prevention	https://www.psychiatry.org/patients-families/suicide-prevention
Tuberculosis	CDC: Tuberculosis Resources	http://www.cdc.gov/tb/pubs/mmwr/Maj_guide/List_date.htm
	USPSTF – Tuberculosis, Latent: Screening; 2016	https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/latent-tuberculosis-infection-screening
Upper Respiratory Tract Infections	AAFP – Antibiotic Use in Acute Upper Respiratory Tract Infections; 2012	http://www.aafp.org/afp/2012/1101/p817.html
	CDC – Antibiotic Prescribing and Use in Doctor's Offices	https://www.cdc.gov/antibiotic-use/community/for-hcp/outpatient-hcp/adult-treatment-rec.html
Urinary Incontinence	AAFP – Nonsurgical Management of Urinary Incontinence in Women; 2015	https://annals.org/aim/fullarticle/1905131/nonsurgical-management-urinary-incontinence-women-clinical-practice-guideline-from-american
Viral Hepatitis	CDC – Viral Hepatitis Guidelines and Recommendations; 2015	https://npin.cdc.gov/pages/viral-hepatitis-guidelines-and-recommendations
Vision	American Academy of Opthalmology – Resources	http://www.aao.org/guidelines-browse

2020 FREE PREVENTIVE HEALTH CARE SERVICES

At MetroPlus, we always want you to be at your best. That's why we encourage you and your family to take advantage of preventive care services available to you at **no cost.** We've listed dozens of FREE preventive services here for adults, women and children that just may help you be your healthiest yet…

WHAT ARE PREVENTIVE CARE SERVICES?

Preventive care helps your doctor find potential health problems before you feel sick. By finding medical problems early, your doctor can see you get the care you need to stay healthy.

Be sure to visit your doctor regularly to get preventive care.

Preventive care includes some:

Immunizations

Physical exams

Lab tests

Prescriptions

The free preventive care services we list in these guidelines are based on recommendations from the U.S. Preventive Services Task Force, Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA) and the latest medical research from organizations like the American Medical Association.

DO YOU KNOW THE DIFFERENCE BETWEEN PREVENTIVE AND DIAGNOSTIC SERVICES?

The same service could be preventive (free) or diagnostic (copayments, coinsurance or deductibles apply).

- A list of free preventive care services can be found in our online guide at **metroplus.org/KnowYourBenefits**.
- Preventive care services are free when provided by an in-network doctor. Go to **metroplus.org/FindADoctor** and use our Find a Doctor tool to find in-network doctors.

	REASON FOR SERVICE	WHAT YOU'LL PAY
Preventive care	To prevent health problems. You don't have symptoms.	You won't pay anything.
Diagnostic care	You have a symptom, or you're being checked because of a known health issue.	This is a medical claim. Your deductible, copayments and coinsurance may apply.

7 in 10 American deaths each year result from chronic diseases like heart disease and diabetes. Did you know many of these deaths can be prevented through early detection and the right care?

Source: CDC

Questions about preventive care?
Find more information at **metroplus.org/KnowYourBenefits** or call Member Services at the number on the back of your member ID card.

HOW DO I KNOW IF A SERVICE IS PREVENTIVE OR DIAGNOSTIC?

A service is diagnostic when it's done to monitor, diagnose or treat health problems. That means:

- If you have a chronic disease like diabetes, your doctor may monitor your condition with tests. Because the tests manage your condition, they're diagnostic.
- If you have a preventive screening and a health problem shows up, your doctor may order follow-up tests. In this case, the follow-up tests are diagnostic.
- If your doctor orders tests based on symptoms you're having, like a stomachache, these tests are diagnostic.

If you receive services listed in this guide for a diagnostic reason, there may be a cost to you.

COMPARE COSTS AND QUALITY FOR DIAGNOSTIC SERVICES

Did you know that the cost of medical tests and procedures can vary 300% or more depending on where you have these performed. Compare costs and quality for 200+ health services at **http://marketplustcc.metroplus.org**.

SERVICE	IT'S PREVENTIVE (FREE) WHEN...	IT'S DIAGNOSTIC WHEN...
DIABETES SCREENING	A blood glucose test is used to detect problems with your blood sugar, even though you don't have symptoms.	You're diagnosed with diabetes and your doctor checks your A1c.
OSTEOPOROSIS SCREENING	Your doctor recommends a bone density test based on your age or family history.	You've had a health problem, or your doctor wants to determine the success of a treatment.
COLON CANCER SCREENING	Your doctor wants to screen for signs of colon cancer based on your age or family history. If a polyp is found and removed during your preventive colonoscopy, the colonoscopy and polyp removal are preventive. If the polyp is sent for lab testing, the testing is considered diagnostic.	You're having a health problem, like bleeding or irregularity, or if the polyp you have removed is sent to a lab to be tested, the lab test is diagnostic.
COMPLETE BLOOD COUNT (CBC)	Never preventive.	Always diagnostic. Studies show there's no need for this test unless you have symptoms.
METABOLIC PANELS	Never preventive.	Always diagnostic. Studies show that a metabolic panel isn't the best test for detecting or preventing illnesses.
URINALYSIS	Never preventive.	Always diagnostic. National Guidelines say there's no need for this test unless you have symptoms.
PROSTATE EXAM (PSA)	Never preventive.	Always diagnostic. National Guidelines have changed recently because this test gives many false results.

2020 FREE PREVENTIVE HEALTH CARE SERVICES

GENERAL ADULT HEALTH

CARE FOR ALL ADULTS

You can keep track of services by completing the "Date Received" column.

PHYSICAL EXAMS

AGE	RECOMMENDATION	DATE RECEIVED
19 – 21 years	Once every 2 – 3 years; annually if desired	
22 – 64 years	Once every 1 – 3 years; annually if desired	
65 and older	Once every year	

IMMUNIZATIONS

Doses, ages and recommendations vary.

VACCINE	RECOMMENDATION	DATE RECEIVED
Chickenpox (varicella)	2 doses, 28 days apart, for those with no history of the vaccination or disease.	
Flu (influenza)	1 dose annually.	
Hepatitis A	2 doses, 6 months apart, for those at high risk.	
Hepatitis B	3 doses over 6 months.	
HPV (human papillomavirus)	2 – 3 doses over a 6 month period up to age 26.	
Measles, mumps, rubella (MMR)	1 – 2 doses if no history of the vaccination or disease.	
Meningitis (meningococcal)	1 dose if no history of vaccination. Booster doses can be given if at high risk.	
Pneumonia (Pneumococcal)	1 dose for those 65 and older. Those at high risk or with a history of asthma or smoking should have 1 dose between ages 19 and 64 with a booster 5 years later.	
Shingles (herpes zoster)	1 dose for those 60 and older.	
Tetanus, diphtheria and whooping cough (pertussis)	1 dose if no history of pertussis vaccine regardless of interval since last tetanus vaccine, followed by tetanus every 10 years.	

DOCTOR VISITS AND TESTS

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Abdominal aortic aneurysm screening	Once for men ages 65 – 75 with a history of smoking.	
Alcohol misuse screening and counseling	At physical exam.	
Preventive guidance for family and intimate partner violence, breast self- exam, menopause counseling, safety, falls and injury prevention	At doctor's discretion.	
Blood pressure screening	At EVERY wellness visit.	
Cholesterol test	For men 35 and older, and men and women over age 20 who are at increased risk for coronary heart disease.	
Colon cancer screening	Starting age 50 – 75 years. Colonoscopy every 10 years is HIGHLY recommended.	
Depression screening	Every year, during physical exam. For pregnant women, during prenatal and postpartum visits.	
Diabetes screening	For adults with high blood pressure and those, ages 40 – 70, who are overweight or obese.	
Diet/nutrition counseling	At your doctor's discretion if you're at high risk for heart and diet related chronic diseases.	
Hepatitis B screening	Adults at high risk and pregnant women.	
Hepatitis C screening	Adults at high risk and a one-time screening for adults born between 1945 and 1965.	
HIV screening	Routine for all individuals 18 years of age and older and annual testing for those at increased risk.	
Lung cancer screening	Annual screening (including CT) for adults ages 55 – 80 who have a 30-pack-a-year smoking history and currently smoke or quit smoking within the past 15 years.	
Obesity screening and counseling	Every year during physical exam.	
Sexually transmitted infection (STI) counseling and screening	Every year for adults at increased risk.	
Tobacco–use screening and counseling	At each visit. Includes counseling on quitting (see tobacco cessation products in the "Drugs" section). Expanded counseling for pregnant women.	

DRUGS

Prescription required.

PRESCRIPTION	RECOMMENDATION	DATE RECEIVED
Tobacco cessation products	FDA-approved tobacco cessation prescription medications and OTC nicotine replacement therapy (NRT) covered at 100%. NRT is available only with a prescription.	

2020 FREE PREVENTIVE HEALTH CARE SERVICES

WOMEN'S HEALTH

CARE THAT'S RECOMMENDED FOR WOMEN

You can keep track of the services you've had by completing the "Date Received" column. See the "Adult Health" section for more care that's recommended for all adults.

DOCTOR VISITS AND TESTS

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
BRCA risk assessment and genetic counseling/testing	For women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	
Breast cancer screening (mammogram)	Once every 2 years for women over age 40.	
Contraceptive counseling and contraception methods	FDA-approved contraceptive methods, sterilization procedures, education and counseling.	
Domestic violence and intimate partner violence screening and counseling	Annually.	
HIV counseling and screening	Adults up to age 65. Screen older adults if at high risk.	
Osteoporosis screening (bone density testing)	Women 65 and older.	
Pap and HPV test (cervical cancer screening)	Pap test once every 3 years for women 21 – 65 years old or a Pap test with an HPV test every 5 years for women ages 30 – 65.	
Sexually transmitted infection (STI) prevention counseling and screening	Screening and counseling for gonorrhea and syphilis for women who are at high risk. For chlamydia screening and counseling is to be completed annually for all females under age 25, and annually for ages 25 and over if at high risk.	
Well-woman visits (physical exams)	Annually.	

DRUGS

Prescription required.

PRESCRIPTION	RECOMMENDATION	DATE RECEIVED
Breast cancer prevention medication	Risk-reducing medications for women 35 and older with an increased risk of breast cancer who have never been diagnosed with breast cancer.	
Folic acid supplements	Women planning to become or who are pregnant: 0.4 to 0.8 MG.	

CONTRACEPTIVES

Prescription required.

TYPE	METHOD	BENEFIT LEVEL
Hormonal	• Oral contraceptives • Injectable contraceptives • Patch • Ring	Generic contraceptive methods and the ring methods for women are covered at 100% (free). Your deductible and/or prescription copayment applies for brand-name contraceptives when there is a generic available.
Barrier	• Diaphragms • Condoms • Contraceptive sponge • Cervical cap • Spermicide	
Implantable	• IUDs • Implantable rod	
Emergency	• Ella® • Next Choice® • Next Choice® One Dose • My Way™	Covered at 100%
Permanent	• Tubal ligation	Covered 100% at outpatient facilities. If received during an inpatient stay, only the services related to the tubal ligation are covered in full.

2020 FREE PREVENTIVE HEALTH CARE SERVICES

PREGNANT WOMEN'S HEALTH

CARE THAT'S RECOMMENDED FOR PREGNANT WOMEN

If you're pregnant, plan to become pregnant or recently had a baby, we recommend the preventive care that's listed here. You can keep track of the services you've had by completing the "Date Received" column.

DOCTOR VISITS AND TESTS

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Bacteriuria screening with urine culture	Between 12 – 16 weeks gestation or during first prenatal visit if later.	
Breastfeeding support, supplies and counseling	Lactation support and counseling to pregnant and postpartum women, including costs for breastfeeding equipment.	
Gestational diabetes screening	Women 24 – 28 weeks pregnant or at the first prenatal visit for those identified as high risk for gestational diabetes.	
Hematocrit or hemoglobin screening	During the first prenatal visit.	
Hepatitis B screening	During the first prenatal visit.	
HIV screening	All pregnant women during each pregnancy.	
Iron-deficient anemia screening	On a routine basis.	
Rh incompatibility screening	All pregnant women and follow-up testing for women at high risk.	
Routine maternity care	Routine prenatal and postpartum visits for all pregnant women.	
Sexually transmitted infection (STI) screening	Screening and counseling for chlamydia, gonorrhea, and syphilis.	

IMMUNIZATIONS

Doses, ages and recommendations vary.

VACCINE	BEFORE PREGNANCY	DURING PREGNANCY	AFTER PREGNANCY	DATE RECEIVED
Chickenpox (varicella)	Yes; avoid getting pregnant for 4 weeks	No	Yes, immediately postpartum	
Hepatitis A	Yes, if at risk	Yes, if at risk	Yes, if at risk	
Hepatitis B	Yes, if at risk	Yes, if at risk	Yes, if at risk	
HPV (human papillomavirus)	Yes, if between ages 9 and 26	No	Yes, if between ages 9 and 26	
Flu nasal spray	Yes, if less than 50 years of age and healthy. Avoid getting pregnant for 4 weeks.	No	Yes, if less than 50 years of age and healthy. Avoid getting pregnant for 4 weeks.	
Flu shot	Yes	Yes	Yes	
Measles, mumps, rubella (MMR)	Yes; avoid getting pregnant for 4 weeks	No	No	
Meningococcal	If indicated	If indicated	If indicated	
Pneumococcal	If indicated	If indicated	If indicated	
Tetanus	Yes (Tdap preferred)	If indicated	Yes (Tdap preferred)	
Tetanus, diphtheria, whooping cough (1 dose only)	Yes	Yes	Yes	

2020 FREE PREVENTIVE HEALTH CARE SERVICES

CHILDREN'S HEALTH

CARE FOR NEWBORNS THROUGH AGE 18

You can keep track of services by completing the "Date Received" column.

PHYSICAL EXAMS (WELL-CHILD VISITS)

AGE	RECOMMENDATION	DATE RECEIVED
Newborn	1 visit 3 – 5 days after discharge	
0 – 2 years	1 visit at 2, 4, 6, 9, 12, 15, 18 and 24 months	
3 – 6 years	1 visit at 30 months and 1 visit every year for ages 3 – 6	
7 – 10 years	1 visit every year	
11 – 18 years	1 visit every year	

IMMUNIZATIONS

VACCINE	RECOMMENDATION	DATE RECEIVED
Chickenpox (varicella)	First dose between 12 – 15 months old. Second dose between 4 – 6 years old. For kids 13 and older with no history of the vaccination or disease, 2 doses 28 days apart.	
Diphtheria, tetanus, whooping cough (pertussis)	There are four combination vaccines available, talk to your child's doctor about the right choice. **DTaP and DT:** 5 doses (1 dose at 2, 4, 6 and 18 months old, 1 dose between ages 4 – 6 years). **Tdap and Td:** 1 dose of Tdap between 11 and 12 years with a Td booster every 10 years after. Those older than 7 years and not previously immunized can get a single dose of Tdap.	
Flu (influenza)	Children over 6 months should receive the flu vaccine annually.	
Haemophilus influenza type b	1 dose at 2, 4 and 6 months and once between 12 – 15 months old.	
Hepatitis A	2 doses at least 6 months apart starting at 12 – 23 months old. For children not previously immunized, 2 doses can be given at least 6 months apart at your doctor's discretion.	
Hepatitis B	1 dose at birth, 2 doses before 18 months. All children should receive vaccine if not immunized as a baby.	
HPV (human papillomavirus)	2 – 3 doses over a 6 month period starting at age 11 for boys and girls. Your doctor may give the vaccine as early as age 9 if your child is at high risk.	

VACCINE	RECOMMENDATION	DATE RECEIVED
Polio	1 dose at 2 and 4 months and between 6 – 18 months (3 doses total). 1 booster dose between 4 – 6 years old.	
Measles, mumps, rubella (MMR)	1 dose between 12 –15 months and a second between 4 – 6 years. Can be given to older children if no history of vaccination or the disease.	
Meningitis (meningococcal)	1 dose between 11 – 12 years, with a booster dose at 16 years. If the first dose is done between 13 – 15 years, then give the booster between 16 – 18 years. Doctors may give vaccine as early as age 2 if your child is at high risk.	
Pneumonia (Pneumococcal)	1 dose at 2, 4 and 6 months and again at 12 to 15 months. Children at high risk can be vaccinated after age 6.	
Rotavirus	1 dose at 2, 4 and 6 months old.	

DRUGS

Prescription required.

PRESCRIPTION	RECOMMENDATION	DATE RECEIVED
Iron supplements	Children ages 6 – 12 months at risk for iron deficiency.	
Oral fluoride supplements	Children 6 months through age 5 without fluoride in their primary water source.	

DOCTOR VISITS AND TESTS

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Alcohol and drug use assessment	Ages 11 – 18 during each visit. Counseling to those at risk.	
Autism screening	At 18 and 24 months.	
Blood pressure	Every year starting at age 3.	
Congenital hypothyroidism screening	Once at birth.	
Dental Visits	Annually starting at age 1.	
Cavity prevention	Doctors should apply fluoride varnish to teeth as part of a wellness office visit for children 6 months to 5 years.	
Dental sealants	For permanent molars (the most likely to benefit from sealants). Best if applied as soon as molars appear: first molars at about 6 years; second at about age 12.	
Depression screening and behavioral assessments	At doctor's visit for ages 12 – 18.	
Developmental screening	Beginning at 9 months of age to 24 – 30 months.	
Dyslipidemia screening	Screening for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.	

ASSESSMENTS, SCREENINGS AND COUNSELING	RECOMMENDATION	DATE RECEIVED
Gonorrhea preventive medication	Once at birth.	
Hearing loss screening	For all newborns.	
Height, weight and body mass percentile	At each visit.	
Hematocrit or hemoglobin screening	For all children.	
Hepatitis B screening	Adolescents at high risk.	
HIV screening	Adolescents starting at age 15. Children under 15 if they're at high risk.	
Lead screening	Ages 1 and 2 and children ages 3 – 6 years who have not been previously screened.	
Medical history	At each well-child visit.	
Newborn screenings as identified by the Federal Health Resources and Services Administration	Once at birth.	
Obesity screening and physical activity and nutrition counseling	YEARLY screening for children starting age 6.	
Oral health risk assessment	At wellness visits for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.	
Sexually transmitted infection (STI) prevention, screening and counseling	At your doctor's discretion for all sexually active adolescents.	
Tobacco-use screening and counseling	During each visit. Includes cessation interventions for tobacco users and expanded counseling for pregnant tobacco users.	
Tuberculosis (TB) testing	At your doctor's discretion for children at high risk.	
Vision screening	Screening for all children at least once between the ages of 3 and 5 years.	

VII COMMUNICABLE DISEASE REPORTING REQUIREMENTS

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10). Although physicians have primary responsibility for reporting, school nurses, laboratory directors, infection control practitioners, daycare center directors, health care facilities, state institutions and any other individuals/locations providing health care services are also required to report communicable diseases.

Reports should be made to the local health department in the county in which the patient resides and need to be submitted within 24 hours of diagnosis. However, some diseases warrant prompt action and should be reported immediately to local health departments by phone. A list of diseases and information on properly reporting them can be found under Communicable Disease Reporting Requirements.

For more information on communicable disease reporting, call your local health department or the New York State Department of Health's Bureau of Communicable Disease Control at **518.473.4439** or, after hours, at **1.866.881.2809**; to obtain reporting forms (DOH-389), call **518.402.5012**. In New York City, call **1.866.NYC.DOH1** (**1.866.692.3641**) for additional information. Health care personnel in New York City should use the downloadable Universal Reporting Form (PD-16) ; those belonging to NYC MED can complete and submit the form online.

NEW YORK STATE DEPARTMENT OF HEALTH

Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

Anaplasmosis
Amebiasis
Animal bites for which rabies prophylaxis is given[1]
Anthrax[2]
Arboviral infection[3]
Babesiosis
Botulism[2]
Brucellosis[2]
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
Cholera
Cryptosporidiosis
Cyclosporiasis
Diphtheria
E.coli O157:H7 infection[4]
Ehrlichiosis
Encephalitis
Foodborne Illness
Giardiasis
Glanders[2]
Gonococcal infection
Haemophilus influenzae[5] (invasive disease)
Hantavirus disease
Hemolytic uremic syndrome
Hepatitis A
Hepatitis A in a food handler
Hepatitis B (specify acute or chronic)
Hepatitis C (specify acute or chronic)
Pregnant hepatitis B carrier
Herpes infection, infants aged 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory-confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
Measles
Melioidosis[2]
Meningitis
Aseptic or viral
Haemophilus
Meningococcal
Other (specify type)
Meningococcemia
Monkeypox
Mumps
Pertussis
Plague[2]
Poliomyelitis
Psittacosis
Q Fever[2]
Rabies[1]
Rocky Mountain spotted fever
Rubella (including congenital rubella syndrome)
Salmonellosis
Severe Acute Respiratory Syndrome (SARS)
Shigatoxin-producing E.coli[4] (STEC)
Shigellosis[4]
Smallpox[2]
Staphylococcus aureus[6] (due to strains showing reduced susceptibility or resistance to vancomycin)
Staphylococcal enterotoxin B poisoning[2]
Streptococcal infection (invasive disease)[5]
Group A beta-hemolytic strep
Group B strep
Streptococcus pneumoniae
Syphilis, specify stage[7]
Tetanus
Toxic shock syndrome
Transmissable spongiform encephalopathies[8] (TSE)
Trichinosis
Tuberculosis current disease (specify site)
Tularemia[2]
Typhoid
Vaccinia disease[9]
Vibriosis[6]
Viral hemorrhagic fever[2]
Yersiniosis

WHO SHOULD REPORT?

Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

WHERE SHOULD REPORT BE MADE?

Report to local health department where patient resides.

Contact Person _____

Name _____

Address _____

_____

Phone _____ Fax _____

WHEN SHOULD REPORT BE MADE?

Within 24 hours of diagnosis:

- Phone diseases in bold type,
- Mail case report, DOH-389, for all other diseases.
- In New York City use form PD-16.

SPECIAL NOTES

- Diseases listed in **bold type** warrant prompt action and should be reported **immediately** to local health departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- **Cases of HIV infection, HIV-related illness and AIDS are reportable on form DOH-4189 which may be obtained by contacting:**

  Division of Epidemiology, Evaluation and Research
  P.O. Box 2073, ESP Station
  Albany, NY 12220-2073
  (518) 474-4284

  In NYC: New York City Department of Health and Mental Hygiene
  For HIV/AIDS reporting, call:
  (212) 442-3388

1. Local health department must be notified prior to initiating rabies prophylaxis.
2. Diseases that are possible indicators of bioterrorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nile virus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatoxin test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test ≥1:16 or any positive prenatal or delivery test regardless of titer or any primary or secondary stage disease, should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, cases should also be reported to the NYCDOHMH.
9. Persons with vaccinia infection due to contact transmission and persons with the following complications from vaccination; eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the infection site, and any other serious adverse events.

ADDITIONAL INFORMATION

For more information on disease reporting,
call your local health department or the
New York State Department of Health
Bureau of Communicable Disease Control at
(518) 473-4439
or (866) 881-2809 after hours.
In New York City, 1 (866) NYC-DOH1.
To obtain reporting forms (DOH-389), call (518) 402-5012.

PLEASE POST THIS CONSPICUOUSLY

DOH-389 (2/11) p2 of 2

VIII COORDINATING TREATMENT WITH A MEMBER'S PRIMARY CARE AND BEHAVIORAL HEALTH PROVIDER

Coordinating Treatment with a Member's **Primary Care** *Provider*

1. Initial Evaluation Meeting

Written consent is **not required** when communicating within or between facilities licensed by the New York State Office of Mental Health.

If consent is needed, ask each MetroPlusHealth Member or the Member's guardian for written consent to allow you to share basic clinical information such as the diagnosis and initial treatment plan with the PCP. A sample consent form is attached (Side 1 – Attachment A.) Members should be encouraged to provide consent for this collaboration using the rationale that such coordination of care is essential to effective treatment. If the Member refuses to provide consent to release information to his/her PCP, document the refusal on the Refusal to Consent Form (Side 2 – Attachment A) and place the form in the Member's medical record.

2. Complete the Release of Information Form

Attachment A is a recommended consent form for your use. You are not required to use Attachment A. You may use an appropriate release form of your choice. However, under state and federal regulation, behavioral health information may only be exchanged between Providers with the expressed consent of the Member or the Member's legal guardian.

- For Members referred by their PCP location: the PCP's name, address and phone number should be present on the referral form provided at the outset of treatment.
- For self-referred Members: the name of the Member's PCP and the PCP location should be printed on the Member's MetroPlusHealth enrollment card.

3. Communication with the Primary Care Provider:

A. Initial Communication

Attachment B is a recommended communication form for your use. You are not required to use Attachment B. You may use an appropriate communication form of your choice. Once a signed consent form is obtained, send the Member's PCP the following information via mail or fax:

- Your name, address and phone number
- Date of first encounter
- Initial diagnosis
- Initial treatment plan, including a list of psychotherapeutic medications, and
- Reason for Referral/Request for any information needed from the PCP regarding the Member.

The Member's PCP is expected to send you:

- Results of Member's recent history and physical examination
- A list of Member's current medications
- A response to your request for information.

B. Ongoing Communication

As treatment progresses, you and the Member's PCP should inform each other of the following:

- Any medical, psychiatric or substance use hospitalizations
- Addition or changes to medication regimes
- Identification of substance use problems and
- Any condition or proposed treatment that may impact a Member's medical or behavioral health care

At minimum, annual communication with the PCP is required.

C. Final Communication

When the treatment is completed, a clinical disposition note should be forwarded to the PCP. The note should include a summary of treatment and any further treatment that the PCP should consider for the Member.

D. Documentation

Documentation of all attempts at communication with the PCP should be documented in the Member's behavioral health record.

Coordinating Treatment with a Member's **Behavioral Health** *Provider (a provider who treats members with mental health conditions and/or substance use disorders)*

1. Initial Evaluation Meeting

Written consent is **not required** when communicating within or between facilities licensed by the New York State Office of Mental Health.

If consent is needed, ask each MetroPlusHealth Member or the Member's guardian for written consent to allow you to share basic clinical information with the Behavioral Health Provider such as the results of Member's recent history and physical examination and a list of Member's current medications. A sample consent form is attached (Side 1 – Attachment A.) Members should be encouraged to provide consent for this collaboration using the rationale that such coordination of care is essential to effective treatment. If the Member refuses to provide consent to release information to his/her behavioral health Provider, document the refusal on the Refusal to Consent Form (Side 2 – Attachment A) and place the form in the Member's medical record.

2. Complete the Release of Information Form

Attachment A is a recommended consent form for your use. You are not required to use Attachment A. You may use an appropriate release form of your choice. However, under state and federal regulation, behavioral health information may only be exchanged between Providers with the expressed consent of the Member or the Member's legal guardian.

- Members may receive services from more than one behavioral health Provider (e.g., psychotherapist, psychiatrist, substance use provider). Ask the Member to identify the name and location of the behavioral health Provider with whom they have the most frequent contact or with whom they have the most contact regarding their treatment planning.

3. Communication with the Behavioral Health Provider:

A. Initial Communication

Attachment B is a recommended communication form for your use. You are not required to use Attachment B. You may use an appropriate communication form of your choice. Once a signed consent form is obtained, send the Member's Behavioral Health Provider the following information via mail or fax:

- Your name, address and phone number
- Results of Member's recent history and physical examination
- A list of Member's current medications
- Reason for referral/Request for information needed from the Behavioral Health Provider.

(Note: MetroPlusHealth can assist in providing mailing addresses for behavioral health Providers, if needed.)

The Member's Behavioral Health Provider is expected to send you:

- Date of first encounter
- Initial diagnosis
- Initial treatment plan, including a list of psychotropic medications, and
- A response to your request for information

B. Ongoing Communication

As treatment progresses, you and the Member's Behavioral Health Provider should inform each other of the following:

- Any medical, psychiatric or substance abuse hospitalizations
- Addition or changes to medication regimens
- Identification of substance use problems and
- Any condition or proposed treatment that may impact a Member's medical or behavioral health care

At minimum, annual communication with the Behavioral Health Provider is required.

C. Documentation

Documentation of all attempts at communication with Behavioral Health Providers should be documented in the Member's behavioral health record.

Attachment IV, A

Information for the Primary Care Provider:

_____
PCP Name

_____
Office Location/ Address

_____
Street Address

_____
City, State, Zip Code

(____)_____
Fax Number

(____)_____
Phone Number

_____
Today's Date

_____
Behavioral Health Provider's Name

_____
Office Location/Address

_____
Street Address

_____
City, State, Zip Code

(____)_____
Fax Number

(____)_____
Phone Number

- ❑ **Signed copy of Member Release of Information Form attached. (Not required if communicating within or between facilities licensed by the New York State Office of Mental Health.)**

Behavioral Health Provider's List:

1. Date of First Contact with Member:_____
2. Initial Diagnoses:

_____ _____
_____ _____
_____ _____

3. Initial Treatment Plan:

_____
_____
_____
_____

4. Current Medications (including dosage and frequency):

_____ _____
_____ _____
_____ _____

5. Reason for Referral to the PCP/Request for Information from the PCP:

_____

_____

PROHIBITION OF REDISCLOSURE

To the person receiving this release of information: This information has been disclosed to you from records protected by federal confidentiality rules or state confidentiality law. These regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical information or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

Information for the Behavioral Health Provider:_____

Behavioral Health Provider's Name

_____

Office Location/ Address

_____

Street Address

_____

City, State, Zip Code

(____)_____

Fax Number

_____ (____)_____

Today's Date Phone Number

_____

Primary Care Provider's Name

_____

Office Location/Address

_____

Street Address

_____

City, State, Zip Code

(____)_____

Fax Number

(____)_____

Phone Number

- ❑ **Signed copy of Member Release of Information Form attached. (Not required if communicating within or between facilities licensed by the New York State Office of Mental Health.)**

Primary Care Provider's List:

1. Date of Most Recent Contact with Member:_____
2. Results of Member's most recent history and physical examination (a copy of the completed history and physical form is acceptable):

_____

_____

_____

3. Current Medical Diagnoses (if applicable):

_____ _____

_____ _____

4. Current Medications (including dosage and frequency):

_____ _____
_____ _____
_____ _____

5. Reason for Referral to /Request for Information from Behavioral Health Provider:

_____
_____

PROHIBITION OF REDISCLOSURE

To the person receiving this release of information: This information has been disclosed to you from records protected by federal confidentiality rules or state confidentiality law. These regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical information or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

IX NYSDOH QUALITY ASSURANCE REPORTING REQUIREMENTS (QARR) GUIDE

The NYSDOH Quality Assurance Reporting Requirements (QARR) are indicators measured annually by health plans throughout the State. The 2019 QARR consists of measures from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), Center for Medicare and Medicaid Services (CMS) QRS Technical Specifications, and New York State-specific measures. The 2019 QARR incorporates measures from HEDIS® 2019. Use of the standardized measurement methodologies enables the NYSDOH to compare the performance of health plans throughout the state, with local and national benchmarks. Moreover, the NYSDOH uses the results to establish quality improvement goals for health plans, set the length of health plan Medicaid contracts, and determine the number of Medicaid Members automatically assigned to the health plan. Health plan results are published in the Medicaid Consumer Health Plan Choice Guide and are made available to the general public.

A health plan's performance is based largely on the performance of the Providers in its network. As such, health plans expect Participating Providers to adhere to the standards of care associated with HEDIS, participate in data collection, and initiate quality improvement activities where necessary. Most health plans report QARR performance back to facilities and individual PCPs. Organizational and PCP QARR results are also used to compare performance across a range of Providers. Organizational and PCP performance on QARR affects the way health care purchasers perceive Providers and can have an impact on a health plan's contracting and re-credentialing decisions. Some health plans, including MetroPlusHealth, offer incentives or financial awards for exemplary performance on QARR indicators.

Every year MetroPlusHealth collects data for two sets of QARR indicators, one for Members in the Managed Medicaid, FHP, & CHP line of businesses, and one for Members in the HIV Special Needs Plan (SNP). Indicators for the SNP QARR were developed by NYSDOH AIDS Institute.

Many of the QARR indicators are measured from claims submitted by Participating Provider sites. It is therefore critical that complete, accurate CPT and ICD-10 codes are entered onto coding sheets in a timely fashion. Other indicators are based on medical record review. Comprehensive, legible, dated and signed documentation is necessary for measurement. Many of the standardized medical record forms have been developed to prompt Providers to document components of these indicators. Providers should complete these forms in their entirety, using the check off boxes and accompanying spaces as much as possible.

The major areas of performance included in the 2019 QARR are:

1. Effectiveness of Care
2. Access/Availability of Care
3. Experience of Care
4. Utilization and Risk Adjusted Utilization
5. Health Plan Descriptive Information
6. NYS-specific measures:
    - Adolescent Preventive Care
    - Viral Load Suppression

- Continuity of Care from Inpatient Detox to Lower Level of Care
- Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care
- Initiation of Pharmacotherapy upon New Episode of Opioid Dependence
- Use of Pharmacotherapy for Alcohol Abuse or Dependence
- Maintaining/Improving Employment or Higher Education Status
- Maintenance of Stable or Improved Housing Status
- No or Reduced Criminal Justice Involvement
- Potentially Preventable Mental Health Related Readmission Rate 30 Days
- Prenatal Care measures from the Live Birth file

For more detailed information, please go to NYS DOH https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2019/docs/qarr_specifications_manual.pdf

XA MEDICAID MANAGED CARE BENEFIT SUMMARY

A comprehensive benefits package is provided to Medicaid Managed Care members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at **1.800.303.9626** with any questions regarding MetroPlusHealth benefits. The following services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services
- Inpatient and outpatient medical and surgical service
- Preventive care, including well-baby care, well-child care, smoking/vaping cessation counseling, HIV education and risk reduction, and early and periodic screening, diagnosis and treatment (EPSDT) services
- Family planning and reproductive health care services, including abortions
- Medically necessary infertility drugs and medical services related to prescribing and monitoring the use of such drugs. This benefit is limited to coverage for three (3) cycles of treatment per lifetime.
    - The infertility benefit includes: infertility drugs, office visits, x-rays of the uterus and fallopian tubes, pelvic ultrasound, and blood testing.
    - In order to be eligible for this benefit, members must meet the following criteria: 21-34 years old and unable to get pregnant after 12 months of regular, unprotected sex or 35-44 years old and unable to get pregnant after 6 months of regular, unprotected sex.
- Maternity care, including pregnancy care, doctors/midwife and hospital services, newborn nursery care, screening for depression during pregnancy and up to a year after delivery
- Smoking/Vaping cessation treatment includes:
    - Smoking cessation treatment includes screening, behavioral interventions and Food Drug and Administration approved pharmacotherapy for adults, and behavioral interventions for school-aged children and adolescents, as appropriate.
    - Treatment for smoking cessation counseling for e-cigarettes and vaping of nicotine products must meet the following criteria:
        - Smoking cessation counseling must be provided face to face by a physician, dentist, registered physician assistant (PA), registered nurse practitioner (RNP), or licensed midwife (LM).
        - Current smoking cessation counseling includes a maximum of two quit attempts per 12 months, which includes up to four face-to-face counseling sessions per quit attempt. Dental practitioners are allowed to provide two smoking cessation face-to-face counseling per 12 months.
        - Smoking cessation counseling may take place during individual or group counseling sessions.
        - Only one procedure code per day may be billed.
        - Claims must include the appropriate ICD-10-CM diagnosis code for nicotine dependence.
    - Medicaid coverage includes all medications to treat smoking cessation listed on the Medicaid Pharmacy List of Reimbursable Drugs found at https://www.emedny.org/info/formfile.aspx.

- Diagnostic and laboratory tests and radiology services, including mammograms
- Vision services, including exams, eyeglasses and medically necessary contact lenses and polycarbonate lenses. One pair of glasses per 24 months. Lost or broken glasses will be replaced with an identical replacement pair.
- Rehabilitation services, including physical, occupational and speech therapy (limited to 20 visits each calendar year).
- Speech therapy is covered for conditions that will likely improve within a two-month period, beginning with the first day of therapy (authorization required for services over ten [10] visits per year)
- Hearing (audiology) services, including hearing aids, ear molds, special fittings and replacement parts
- Durable medical equipment, including orthotics and prosthetics, from a contracted vendor
- Emergency care and post-stabilization services
- Substance use disorder treatment and mental health Services
- Radiation therapy and chemotherapy
- Dialysis
- Skilled nursing facility rehabilitative services
- Skilled home health services
- Dental services
- Prescription drugs
- Personal care services
- Hospice services
- Diabetic supplies and equipment
- Consumer-directed personal assistance services
- Adult day health care
- Aids adult day health care
- Tuberculosis directly observed therapy
- Crisis intervention services

Coverage is provided by Medicaid, not MetroPlusHealth, for the following services:

- Disposable medical supplies and hearing aid batteries
- Residential Health Care Facility (Nursing Home Service)

Non-covered services include:

- Services of a Podiatrist (for those 21 years and older unless you are a diabetic)
- Cosmetic Surgery (if not medically needed)
- Infertility Treatments
- Chiropractor services (except when ordered through EPSDT)

XB CHILD HEALTH PLUS BENEFIT SUMMARY

A comprehensive benefits package is provided to Child Health Plus members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at **1.800.303.9626** with any questions regarding MetroPlusHealth benefits. The following services are covered:

- Well child care visits, including immunizations, health education, developmental screening, lead screening and related services
- Diagnostic and laboratory tests and radiology services
- Reproductive health services
- Maternity care, including pre and post natal services, labor and delivery
- Inpatient and outpatient hospital medical and surgical care including acute rehabilitation services
- Dental services, including emergency, preventive and routine dental care provided through MetroPlusHealth's dental benefit manager
- Vision services, including exams, eyeglasses and medically necessary contact lenses. One pair of glasses per year. Lost or broken glasses will be replaced with an identical replacement pair, including frame selection.
- Hearing services, one examination per year and necessary follow-up, including hearing aids
- Short term inpatient and outpatient physical therapy and occupational therapy (authorization required for services over ten [10] visits per year)
- Speech therapy is covered for conditions that will likely improve within a two-month period, beginning with the first day of therapy (authorization required for services over ten [10] visits per year)
- Durable medical equipment, prosthetic appliances and orthotic devices
- Emergency medical services
- Emergency ambulance services; non-emergent transportation is not a covered benefit
- Outpatient and inpatient mental health and alcohol and substance abuse services
- Prescription drugs, including enteral formulas, vitamins when necessary to treat a diagnosed illness or condition, and certain OTC medications
- Diabetic supplies and equipment
- Skilled home health services (limited to 40 visits per year)
- Hospice services

Non-covered services include:

- Non-emergent transportation
- Orthodontia, private duty nursing, and chiropractic services
- Skilled Nursing Facility rehabilitative services
- Experimental medical or surgical procedures or drugs unless approved by the plan
- Non-prescription drugs, except as described above
- Disposable supplies, except for diabetes and ostomy supplies

XC MEDICAID HIV SPECIAL NEEDS PLAN BENEFIT SUMMARY

A comprehensive benefits package is provided to Medicaid HIV Special Needs Plan members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at **1.800.303.9626** with any questions regarding MetroPlusHealth benefits. These services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services
- Inpatient and outpatient medical and surgical services
- Private duty nursing services when medically necessary
- Well child care
- Family planning and reproductive health care services, including abortions
- Medically necessary infertility drugs and medical services related to prescribing and monitoring the use of such drugs. This benefit is limited to coverage for three (3) cycles of treatment per lifetime.
    - The infertility benefit includes: infertility drugs, office visits, x-rays of the uterus and fallopian tubes, pelvic ultrasound, and blood testing.
    - In order to be eligible for this benefit, members must meet the following criteria: 21-34 years old and unable to get pregnant after 12 months of regular, unprotected sex OR 35-44 years old and unable to get pregnant after 6 months of regular, unprotected sex.
- Maternity care, including pre and postnatal visits, labor and delivery
- Smoking/vaping cessation treatment includes:
    - Smoking cessation treatment includes screening, behavioral interventions and Food Drug and Administration approved pharmacotherapy for adults, and behavioral interventions for school-aged children and adolescents, as appropriate.
    - Treatment for smoking cessation counseling for e-cigarettes and vaping of nicotine products must meet the following criteria:
        - Smoking cessation counseling must be provided face to face by a physician, dentist, registered physician assistant (PA), registered nurse practitioner (RNP), or licensed midwife (LM).
        - Current smoking cessation counseling includes a maximum of two quit attempts per 12 months, which includes up to four face-to-face counseling sessions per quit attempt. Dental practitioners are allowed to provide two smoking cessation face-to-face counseling per 12 months.
        - Smoking cessation counseling may take place during individual or group counseling sessions.
        - Only one procedure code per day may be billed.
        - Claims must include the appropriate ICD-10-CM diagnosis code for nicotine dependence.
    - Medicaid coverage includes all medications to treat smoking cessation listed on the Medicaid Pharmacy List of Reimbursable Drugs found at https://www.emedny.org/info/formfile.aspx.

- Diagnostic and laboratory tests and radiology services, including mammograms
- Vision services, including exams, eyeglasses and medically necessary contact lenses and polycarbonate lenses. One pair of glasses per 24 months. Lost or broken glasses will be replaced with an identical replacement pair, including frame selection.
- Short term inpatient and outpatient physical therapy and occupational therapy (authorization required for services over ten [10] visits per year)
- Hospice services
- Adult day health care
- AIDS adult day health care
- Prescription and non-prescription (OTC) drugs, diabetic supplies and equipment, medical supplies, and enteral formula
- Dental services
- Speech therapy is covered for conditions that will likely improve within a two-month period, beginning with the first day of therapy (authorization required for services over ten [10] visits per year)
- Hearing services, including hearing aids, ear molds, special fittings and replacement parts
- Durable medical equipment, including orthotics and prosthetics
- Emergency room visits
- Inpatient and outpatient substance use disorder treatment
- Inpatient and outpatient mental health services
- Dialysis
- Home health services
- Behavioral health home and community-based services including psychosocial rehabilitation.
- Personal care services
- Tuberculosis directly observed therapy
- Treatment adherence services
- HIV prevention and risk reduction education

Coverage is provided by Medicaid, not MetroPlusHealth, for the following services:

- COBRA case management services
- Emergency and/or non-emergency transportation
- HIV resistance tests
- Long term custodial services in a residential health care facility
- Services rendered by a personal care agency which is approved by the Local Department of Social Services when ordered by an enrollee's PCP. District will determine applicants need for personal care agency services.

XD METROPLUSHEALTH GOLD BENEFIT SUMMARY

A comprehensive benefits package is provided to MetroPlusHealth Gold members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and for authorized out-of-network services. Please call Member Services at **1.877.475.3795** with any questions regarding MetroPlusHealth benefits or refer to the Certificate of Coverage on *www.metroplus.org*. The following services are covered:

- All visits to your Primary Care Provider (PCP)
- Specialty visits referred by your PCP
- Second opinion visits arranged by your PCP or by MetroPlusHealth for medical and surgical conditions
- Initial (baseline) and periodic physical examinations for adults and children
- Gynecological and obstetrical care including maternity and newborn care
- Diagnostic and laboratory tests and radiology services, including mammograms
- Short term inpatient and outpatient occupational therapy and physical therapy (authorization required for services over ten [10] visits per year)
- Speech therapy is covered for conditions that will likely improve within a two month period, beginning with the first day of therapy (authorization required for services over ten [10] visits per year)
- Radiation therapy and chemotherapy
- Dialysis
- Eye examinations and treatments for eye diseases, not including glasses and contact lenses
- Emergency ambulance services; routine transportation is not covered
- Durable medical equipment, including orthotics and prosthetic appliances and devices
- Chiropractic care
- Diabetic medications and supplies
- Inpatient medical and surgical services and related hospital and anesthesia
- Ambulatory surgery
- Inpatient mental health, alcohol and drug detoxification and treatment
- Outpatient mental health (long term mental health services are not covered), alcohol and substance abuse treatment
- Skilled home health services (limited to 40 visits per calendar year)
- Skilled Nursing Facility rehabilitative care (limited to 200 days per calendar year)
- Hospice care (inpatient: 210 days per plan year and five (5) visits for family bereavement counseling)

The following services require a co-payment:

- Prescription drug benefits offered through the Optional Prescription Drug Rider
- Emergency Department – $150 Copayment; waved if admitted to hospital

Non-covered services include:

- Dental care
- Cosmetic surgery, electrolysis, routine foot care
- Infertility services
- Experimental services and treatments, unless approved by MetroPlusHealth or required by the decision of a New York State external appeal agent
- Long term custodial care in a facility
- Private duty nursing

XE METROPLUSHEALTH OUTPATIENT & INPATIENT BEHAVIORAL HEALTH BENEFIT TABLES

*MetroPlusHealth Inpatient Behavioral Health Benefit Table**

Line of Business	Benefit	Authorization Requirement
Medicaid Managed Care & Harp	Unlimited inpatient days	Authorization required for inpatient services
Medicaid Managed Care with SSI	Inpatient detox services are covered; mental health and substance abuse rehab services are covered by Medicaid Fee for Service (except SSI SNP members)	Inpatient Detox and Rehab require notification, not prior authorization
Child Health Plus	Unlimited inpatient days	Authorization required for inpatient services
HIV Special Needs Plan (SNP)	Unlimited inpatient days; mental health and substance abuse services for SSI SNP members are covered by HIV SNP	Authorization required for inpatient services
MetroPlusHealth Gold	Unlimited inpatient mental health; not to exceed 5 days per detox visit; not to exceed 30 days per calendar year for substance abuse rehab services	Authorization required for inpatient services

*MetroPlusHealth Outpatient Behavioral Health Benefit Table**

Line of Business	Benefit	Authorization Requirement
Medicaid Managed Care & Harp	Outpatient detox and behavioral health services – no visit limits	Authorization required after 60 outpatient visits per calendar year
Medicaid Managed Care with SSI	Outpatient detox – no visit limits; outpatient mental health and substance abuse services are covered by Medicaid Fee for Service	None
Child Health Plus	Outpatient behavioral health services – no visit limits	None
HIV Special Needs Plan (SNP)	Outpatient detox and behavioral health services – no visit limits	Authorization required after 60 outpatient visits per calendar year
MetroPlusHealth Gold	Outpatient detox – no limits; outpatient alcohol and substance abuse services – not to exceed 30 days per calendar year; long term outpatient mental health services are not covered	None

*Refer to Medicaid Managed Care Contract for more information.

XF METROPLUSHEALTH MEDICARE ADVANTAGE PLANS: EVIDENCE OF COVERAGE

Evidence of Coverage for each of the MetroPlusHealth Medicare Plans is available on the MetroPlusHealth web site: www.metroplusmedicare.org.

XG QUALIFIED HEALTH PLAN BENEFIT SUMMARY

MetroPlusHealth offers Qualified Health Plans at all standard metal levels and catastrophic cost sharing options, both on the Individual and SHOP (Small Business Health Options) exchanges. For individuals, reduced cost sharing options are available for members with incomes under 250% of the FPL and for American Indians under 300% of the FPL. MetroPlusHealth also offers non-standard plans with adult vision and dental care, bronze level plans with HSA, and silver and gold plans with the first 3 PCP visits not subject to their deductible. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at **1.855.809.4073** with any questions regarding MetroPlusHealth benefits. The following services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services
- Inpatient and outpatient medical and surgical service
- Well baby/well child care
- Family planning and reproductive health care services, including abortions. For members who obtain SHOP coverage through religious employers, this may not be covered.
- Maternity care, including pre and postnatal visits, labor and delivery
- Smoking/vaping cessation drugs
- Diagnostic and laboratory tests and radiology services, including mammograms
- Pediatric vision services, including exams, eyeglasses and medically necessary contact lenses and polycarbonate lenses. One pair of glasses per 12 months.
- Short term inpatient and outpatient physical, occupational and speech therapy (60 visits per year, authorization required for all visits)
- Hearing (audiology) services, including hearing aids, ear molds, special fittings and replacement parts. Hearing aids are covered once every 3 years.
- Durable medical equipment, including orthotics and prosthetics, from a contracted vendor
- Emergency room visits and emergency ambulance services, and non-urgent transport for medically necessary services
- Inpatient drug, alcohol and mental health treatment
- Radiation therapy and chemotherapy
- Dialysis
- Skilled nursing facility rehabilitative services
- Skilled home health services
- Pediatric dental services, including routine exams, x-rays, and preventive care
- Prescription drugs and enteral formulas
- Outpatient alcohol or substance abuse treatment services
- Hospice services
- Diabetic supplies and equipment
- Chiropractor services

Coverage is only provided if the member elects additional coverage for the following services:

- Adult vision care, including exams, eyeglasses, and contact lenses
- Adult dental care, including routine exams, x-rays, and preventive care

Non-covered services include:

- Routine foot care
- Long-term custodial nursing care
- Personal care agency services

XH ESSENTIAL PLAN BENEFIT SUMMARY

MetroPlusHealth offers ten distinct Essential Plans, including four standardized plans, options with additional dental and vision coverage, and plans with reduced cost sharing for American Indians. A comprehensive benefits package is provided to Essential Plan members. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at **1.855.809.4073** with any questions regarding MetroPlusHealth benefits. The following services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services
- Inpatient and outpatient medical and surgical service
- Family planning and reproductive health care services, including abortions
- Diagnostic and laboratory tests and radiology services, including mammograms
- Short term inpatient and outpatient occupational therapy and physical therapy (60 visits per year, authorization required for all visits)
- Hearing (audiology) services, including hearing aids, ear molds, special fittings and replacement parts
- Durable medical equipment, including orthotics and prosthetics, from a contracted vendor
- Emergency room visits and emergency ambulance services, and non-urgent transport for medically necessary services
- Non-emergency transportation services are covered for members of the EP 3 and EP 4 plans
- Inpatient drug, alcohol and mental health treatment
- Radiation therapy and chemotherapy
- Dialysis
- Skilled nursing facility rehabilitative services
- Skilled home health services Prescription drugs and enteral formulas.
- Non-prescription drugs are covered for members of the EP 3 and EP 4 plans.
- Outpatient alcohol or substance abuse treatment services
- Hospice services
- Diabetic supplies and equipment
- Chiropractor services

Coverage is only provided if the member elects additional coverage for the following services:

- Vision care, including exams, eyeglasses, and contact lenses.
- Dental care, including routine exams, x-rays, and preventive care.

Non-covered services include:

- Routine foot care
- Long-term custodial nursing care

XJ GOLDCARE BENEFIT SUMMARY

MetroPlusHealth offers two GoldCare plans, which differ in cost sharing amounts and in breadth of network. Both plans offer a comprehensive benefits package. All services must be medically necessary and must be provided by a MetroPlusHealth Participating Provider, except for emergency services and authorized out-of-network services. Please call Member Services at **1.877.475.3795** with any questions regarding MetroPlusHealth benefits. The following services are covered by MetroPlusHealth:

- Physician, nurse practitioner and midwifery services, including all preventive health, primary care, specialty and surgical services
- Inpatient and outpatient medical and surgical service
- Well baby/well child care
- Family planning and reproductive health care services, including abortions
- Maternity care, including pre and postnatal visits, labor and delivery
- Smoking/vaping cessation drugs
- Diagnostic and laboratory tests and radiology services, including mammograms
- Speech therapy and physical therapy are only covered following a hospital stay or surgery
- Durable medical equipment, including orthotics, from a contracted vendor
- Emergency room visits and emergency ambulance services
- Inpatient drug, alcohol and mental health treatment
- Radiation therapy and chemotherapy
- Dialysis
- Skilled nursing facility rehabilitative services
- Skilled home health services
- Chiropractic care
- Prescription drugs and enteral formulas
- Outpatient alcohol or substance abuse treatment services
- Hospice services
- Diabetic supplies and equipment when obtained from a designated manufacturer

Non-covered services include:

- Vision services
- Dental services
- Hearing aids
- Long-term custodial nursing care
- Personal care agency services
- Routine foot care

XI STATEMENT ON FRAUD AND ABUSE

It is the policy of MetroPlusHealth to comply with all federal and state laws regarding fraud, waste and abuse, to implement and enforce procedures to detect and prevent fraud, waste and abuse regarding claims submitted to federal and state healthcare programs, and to provide protection for those who report in good faith actual or suspected wrongdoing.

MetroPlusHealth is also required to refer potential fraud or misconduct related to the Medicare program to the Health and Human Services Office of the Inspector General Medicaid Fraud Control Unit (OIG MFCU) and the Medicare Drug Integrity Contractor (MEDIC) for fraud or misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste and abuse related to the NY state funded programs are reported to the State Department of Health (SDOH), the Office of the Medicaid Inspector General (OMIG), Health + Hospitals Inspector General, and/or other appropriate law enforcement or regulatory agency.

The Compliance Policy

MetroPlusHealth maintains a strict policy of zero tolerance toward fraud and abuse and other inappropriate activities. Individuals who engage in any inappropriate activity alone or in collaboration with another employee, member, or provider are subject to immediate disciplinary action up to and including termination.

As part of our commitment to this zero-tolerance policy, MetroPlusHealth provides this information to vendors to achieve the following goals:

- Demonstrate its commitment to responsible corporate conduct
- Maintain an environment that encourages reporting of potential problems
- Ensure appropriate investigation of possible misconduct by the company

MetroPlusHealth has adopted organization-wide fraud prevention, detection, and investigation programs for the purpose of protecting the member, the government, and/or MetroPlusHealth from expending money where it should not be expended.

Specifically, MetroPlusHealth has an established Special Investigations Unit (SIU), which ensures that MetroPlusHealth and its providers are in compliance with all applicable state and federal regulations and managed care contract provisions. The SIU is chiefly responsible for accepting referrals from both outside the company and within the company for investigation to determine if provider fraud or abuse has occurred. MetroPlusHealth employees and contracted entities have a responsibility to report any inappropriate provider activities to the SIU.

All concerns about fraud or abuse, including those relating to member, contractor, or employee behavior, can be reported to the MetroPlusHealth Corporate Compliance department.

MetroPlusHealth proactively investigates and resolves all complaints and other reports or findings that raise suspicion of fraud and/or abuse. Members, Providers, employees or the public can report suspected fraudulent or abusive behavior by:

- Calling the **Compliance Hotline** at **1.888.245.7247** or the **Special Investigations Unit** at **212.908.5172**, or
- Emailing *ComplianceOfficer@metroplus.org*, or
- Writing to **MetroPlusHealth Compliance Department, MetroPlusHealth, 160 Water Street, 4th Floor, New York, NY 10038**.

The Member Services Department will also accept verbal or written reports and will ensure proper referral to the Compliance Department. You can contact the **Member Services Department** at **1.800.303.9626**.

Following receipt of the complaint/fraud and abuse referral, the Compliance Department conducts a preliminary investigation to assess the nature and scope of the issue. Based upon the findings of the preliminary investigation, a plan for further investigation and/or resolution of the matter is established.

Fraud, Waste & Abuse – General Information

Definitions

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes enrollee practices that result in unnecessary cost.

Fraud – An intentional, knowing, or willful deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or other person. It includes any act that constitutes fraud under applicable federal or state law.

Waste – The extravagant, careless or needless expenditure of funds resulting from deficient practices, systems, controls or decisions.

Relevant Statutes and Regulations

Stark Law

The Stark law, with several separate provisions, governs physician self-referral for Medicare and Medicaid patients. Physician self-referral is the practice of a physician referring a patient to a medical facility in which he or an immediate family member has a financial interest, be it ownership, investment, or a structured compensation agreement.

The Omnibus Budget Reconciliation Act of 1989 also bars self-referrals for clinical laboratory services under the Medicare program. The law included a series of exceptions to the ban in order to accommodate legitimate business arrangements. The Omnibus Budget Reconciliation Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. The Social Security Act prohibits physicians from referring Medicare patients for certain designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship – unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a health service furnished as a result of a prohibited referral.

Violations of Stark and Physician Self-Referral are to be reported to the Centers for Medicare and Medicaid Services through an established self-disclosure process.

Anti-Kickback Statute

The Medicare and Medicaid Patient Protection Act of 1987, provides the basis for this statute. It provides for criminal penalties for certain acts which impact Medicare and Medicaid or any other Federal or State funded program. If you solicit or receive any remuneration in return for referring an individual to a person (doctor, hospital and provider) for a service for which payment may be made, it can be seen as a potential kickback. Remuneration includes payment, monies, or any other goods or services from any healthcare facilities, programs, and providers.

False Claims Act

The federal government amended the False Claims Act (FCA) to make it a more effective tool. Using the False Claims Act, private citizens (i.e., whistle-blowers) can help reduce fraud against the government. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (the act does not cover tax fraud).

For the purposes of this policy, "knowing and/or knowingly" means that a person has actual knowledge of the information; acts in a deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

Both federal and state False Claims Acts (FCA) apply when a company or person:

- Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment
- Knowingly makes, uses, or causes to be made or used a false record or statement to get a claim paid by the federal government
- Conspires with others to get a false or fraudulent claim paid by the federal government
- Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government

Examples of the type of conduct that may violate the FCA include the following:

- Knowingly submitting premium claims to the Medicaid program for members not actually served by MetroPlusHealth
- Knowingly failing to provide members with access to services for which MetroPlusHealth has received premium payments
- Knowingly submitting inaccurate, misleading or incomplete Medicaid cost reports

False Claims Act Penalties

Those who defraud the government can end up paying triple (or more than) the damage done to the government or a fine (between $5,500 and $11,000) for every false claim, in addition to the claimant's cost and attorneys' fees. These monetary fines are in addition to potential incarceration, revocation of licensures, and/or becoming an "excluded" individual which prevents an individual from being employed in any job that receives monies from the Federal Government, the State Government, or both.

Protections for Whistle Blowers

Whistle-blower protection is provided by federal acts and related State and federal laws, which shield employees from retaliation for reporting illegal acts of employers. An employer cannot retaliate in any way, such as discharging, demoting, suspending or harassing the whistle blower. If an employer retaliates in anyway, whistle-blower protection might entitle the employee to file a charge with a government agency, sue the employer or both.

To report information about fraud, waste or abuse involving Medicare or any other healthcare program involving only federal funds, call the toll-free hotline established by the federal Office of Inspector General in the U.S. Department of Health and Human Services. The hotline number is **1.800.HHS.TIPS (1.800.447.8477)**. For more information about this hotline and about other ways to contact the Office of Inspector General, you can go to *https://oig.hhs.gov/fraud/report-fraud/index.asp*.

Plan Name: MetroPlus Health Plan | Plan Phone No. 1.800.475.6387 | Plan Fax No. 1.866.255.7569

MetroPlusHealth
METROPLUS.ORG 1.855.809.4073 • TTY: 711

NYS Medicaid Prior Authorization Request Form For Prescriptions

Rationale for Exception Request or Prior Authorization - *All information must be complete and legible*

Patient Information

First Name:	Last Name:	MI:	☐ Male ☐ Female
Date of Birth: ____/____/_____	Member ID:	Is patient transitioning from a facility? ☐ Yes ☐ No If yes, provide name of facility: _____	

Provider Information

First Name:	Last Name:		Address:	
NPI No:[1]	Phone No:	Fax No:	Office Contact:	Specialty:

Medication/Medical and Dispensing Information

Medication:	Strength:	Frequency:	Qty:	Refill(s):
Case Specific Diagnosis/ICD10:[2]	Route of Administration: ☐ Oral ☐ IM ☐ SC ☐ Transdermal ☐ IV ☐ Other For physician administered, will this provider be ordering & administering? ☐ Yes ☐ No If no, supply administering provider:			

Please check one of the following:

This is a new medication and/or new health plan for the patient. ☐ **If checked, *go to question 1***	This is continued therapy previously covered by the patient's current health plan. ☐ **If checked, approx. date initiated ____/____. *Go to question 5***

1. Does the drug require a dose titration of either multiple strengths and/or multiple doses per day? ☐ Yes ☐ No
   If yes, provide titration schedule: _____
2. Is the drug being used for an FDA approved indication? ☐ Yes ☐ No
   2.(a) If the answer to 2 is **No**, is its use supported by Official Compendia (AHFS DI®, DRUGDEX ®)[3] ☐ Yes ☐ No
3. Has the patient experienced treatment failure with a preferred/formulary drug(s) or has the patient experienced an adverse reaction with a preferred/formulary drug(s) in the therapeutic class? If yes, complete the following: ☐ Yes ☐ No

Drug and Dose	Route	Frequency	Approx. date range therapy began & stopped	Outcome
			____/____ ____/____	
			____/____ ____/____	

4. Is there documented history of successful therapeutic control with a non-preferred/non-formulary drug and transition to a preferred/formulary drug is medically contraindicated? If yes, explain: ☐ Yes ☐ No

5. Is this a change in dosage/day for the above medication? ☐ Yes ☐ No
6. Does the request require an expedited review? ☐ Yes ☐ No
7. Attach relevant lab results, tests and diagnostic studies performed that support use of therapy. **Check if attached** ☐

Required clinical information: Please provide all relevant clinical information in the box below to support a medical necessity to determine coverage. Refer to health plan coverage requirements for the requested medication (see link above).
☐ Please check here if documentation is attached.

I attest that this information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a Medicaid MC claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Prescriber's Signature _____ Date ____/____/_____

Instructional Information for Prior Authorization

Upon our review of all required information, you will be contacted by the health plan.

When providing required clinical information, the following elements should be considered within the rationale to support your medical necessity request:

- *Height/Weight*
- *Compound ingredients*
- *Specific dosage form consideration*
- *Drug or Other Related Allergies*

Please consider providing the following information as applicable & when available:

- *Healthcare Common Procedure Coding System (HCPCS)* [4]
- *Transition of Care Hospital and/or Residential Treatment Facilities Information (contact, phone number, length of stay)*
- *Life Situations Information such as foster care transition, homelessness, poly-substance abuse and history of poor medication adherence*
- *Patient information (address, phone number)*
- *Provider information (direct electronic contact information: e-mail, etc.)*

This form must be signed by the prescriber but can also be completed by the prescriber or his/her authorized agent. *An authorized agent is an employee of the prescribing practitioner and has access to the patient's medical records (i.e. nurse, medical assistant*). The completed fax form and any supporting documents must be faxed to the proper health plan.

Helpful Definitions

[1] **NPI:** A national provider identifier (NPI) is a unique ten-digit identification number required by HIPAA for all health care providers in the United States. http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html?redirect=/nationalprovidentstand/

[2] **ICD-10:** The International Classification of Diseases (ICD) is designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics http://www.cdc.gov/nchs/icd.htm

[3] **AHFS Drug Information® (AHFS DI®)** provides evidence-based evaluation of pertinent clinical data concerning drugs, with a focus on assessing the advantages and disadvantages of various therapies, including interpretation of various claims of drug efficacy. http://www.ahfsdruginformation.com/ **DRUGDEX ®** System within the Micomedex product which provides peer-reviewed, evidence-based drug information including investigational & non prescription drugs. http://www.micromedex.com/

[4] **The HCPCS** is divided into two principal subsystems, referred to as level I and level II of the HCPCS:

- Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.

- Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items. http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html

Disenrollment Forms for Excluded Populations

The following populations are ineligible for enrollment in any Medicaid Managed Care plan. Please complete and fax this form to Customer Services at 1.212.908.8701 if you believe any of these circumstances apply to a MetroPlus member in your care.

Member Name: _____ Medicaid ID #: _____

Provider Name: _____ Phone #: _____

Please check the applicable box(es) below:

☐ Medicare/Medicaid dual eligible
☐ Individuals who become eligible for Medicaid only after spending down a portion of their income
☐ Residents of state psychiatric facilities and residential treatment facilities for children and youth
☐ Patients of residential health care facilities at the time of enrollment or patients who enter a residential health care facility subsequent to enrollment (except for short-term rehabilitative stays anticipated to be less than 30 days)
☐ Infants weighing less than 1200 grams at birth or infants younger than 6 months who meet the criteria for SSI
☐ Children in foster care
☐ Certified blind or disabled children living (or expected to live) separate and apart from their parents for 30 or more days
☐ Individuals expected to be Medicaid eligible for less than six months (except for pregnant women)
☐ Homeless persons residing in Department of Homeless Services (DHS) shelters and not yet enrolled in a plan at the time they enter the shelter
☐ Individuals receiving (at time of enrollment) institutional long-term care services through long-term home health care programs or child care facilities (except ICF services for the developmentally disabled)
☐ Individuals eligible for medical assistance benefits for tuberculosis-related services only
☐ Individuals placed in Office of Mental Health (OMH) licensed family care homes
☐ Individuals enrolled in the Restricted Recipient Program
☐ Individuals receiving hospice care services at the time of enrollment

Health Care Proxy

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About the Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. “Health care” means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?
If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?
Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?
All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?
Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?
Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?
Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?
Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

Frequently Asked Questions, *continued*

How will my health care agent know my wishes?
Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?
No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?
All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?
You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?
It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?
No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Frequently Asked Questions, *continued*

Is a Health Care Proxy the same as a living will?
No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you decide in advance decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?
Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?
Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. **Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.**

Can my health care agent make decisions for me about organ and/or tissue donation?
Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?
It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your health care agent; your decedent's agent; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; a guardian appointed by a court prior to the donor's death; or another person authorized to dispose of the body.

Health Care Proxy Form Instructions

Item (1)
Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments...

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments...

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments...

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)
You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse, if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

HEALTH CARE PROXY

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

NEW YORK STATE | Department of Health

1430 11/17

NEW YORK STATE EXTERNAL APPEAL APPLICATION

Complete and send this application within 4 months of the plan's final adverse determination for health services if you are the patient or the patient's designee, or within 60 days if you are a provider appealing on your own behalf to DFS.

Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany, NY 12210
or Fax to: (800) 332–2729. For help, call (800) 400–8882 or email externalappealquestions@dfs.ny.gov.

1. Applicant Name:			
2. Patient Name:			
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Non-Specified		
3. Patient Address:	Street:		
	City:	State:	Zip Code:
4. Patient Phone Number:	Primary: ( )	Secondary: ( )	
5. Patient Email Address:			
6. Patient Health Plan:		ID #:	
7. Patient's Physician/Prescriber:			
8. Physician/Prescriber Address:	Street:		
	City:	State:	Zip Code:
9. Physician/Prescriber Phone #:	( )	Fax:	( )
10. If the patient has a Medicaid Managed Care Plan, has patient requested a fair hearing through Medicaid or received a fair hearing determination?	☐ Yes	☐ No	☐ Don't know
11. To be completed if the applicant is the patient's designee			
Complete this section only if a designee is submitting this appeal on a patient's behalf. If the patient's provider is the designee complete section 14 instead of this section.			
Name of Designee:			
Relationship to Patient:			
Address:	Street:		
	City:	State:	Zip Code:
Phone Number:	( )	Fax:	( )
Designee Email Address:			

12. **Reason for Health Plan Denial** - check only one and **attach** a completed physician's attestation for all expedited appeals and all denial reasons except for Not Medically Necessary:

☐ Not medically necessary	☐ Experimental/investigational for a clinical trial
☐ Experimental/ investigational	☐ Experimental/investigational for a rare disease
☐ Out-of-network and the health plan proposed an alternate in-network service	☐ Out-of-network referral
☐ Formulary Exception (for individual and small group coverage, other than Medicaid or Child Health Plus)	

13. This appeal may be expedited. Expedited decisions are made within the timeframes described below, even if the patient, physician or prescriber does not provide needed medical information to the external appeal agent.		
If Expedited check one:	☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.	
	☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health, and patient's physician will complete the Physician Attestation and send it to the Department of Financial Services.	
	☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug, and patient's prescribing physician or other prescriber will complete the Physician Attestation and send it to the Department of Financial Services.	
If Standard check one:	☐ Standard Formulary Exception (72 hours)	☐ Standard Appeal for all other appeals (30 days)
***** If expedited you must call 888-990-3991 when the application is faxed*****		
14. To be completed if applicant is patient's provider		
Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. This section should be completed by providers appealing on their own behalf or appealing as a patient's designee. The initial denial and final adverse determination from the first level of appeal must be attached.		
☐ Provider filing own behalf	☐ Provider filing as designee on behalf of patient	
Provider Name:		
Person or Firm Representing Provider (if applicable):		
Contact Person for Correspondence:		
Address for Correspondence:	Street:	
	City:	State: Zip Code:
Phone Number:	( )	Fax: ( )
Email Address:		
I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.		
Provider Signature:		

15. Description and date(s) of Service: (Attach any additional information you want considered):	
16. External Appeal Eligibility (Check one):	
	☐ Attached is final adverse determination from the health plan.
	☐ Attached is the health plan's letter waiving an internal appeal.
	☐ Patient requests expedited internal appeal at same time as the external appeal.
	☐ Health plan did not comply with internal appeal requirements for patient appeal.
17. External Appeal Fee	
You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you.	
Please check one:	☐ Enclosed is a check or money order made out to the health plan.
	☐ Application was faxed and fee will be mailed to the Department within 3 days.
	☐ Patient is covered under Medicaid or Child Health Plus.
	☐ Patient requests fee waiver for hardship and will provide documentation to the health plan.
	☐ Health plan does not charge a fee for an external appeal or fee is not required.

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans.

When an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance use treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, power of attorney, healthcare proxy or executor, a copy of the legal supporting document should be included.

Signature:			
Print Name:			
Relationship to patient, if applicable:			
Patient Name:		Age:	
Patient's Health Plan ID#:			
Date: (required)			

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental/investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal. The patient's prescriber may also request an expedited formulary exception appeal. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately.

Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany NY, 12210
or Fax to: (800) 332-2729.

Type of Review Requested:	☐ Standard Appeal (30 days), or for a non-formulary drug (72 hours)	☐ Expedited Appeal (72 hours), or for a non-formulary drug (24 hours)
If Expedited check one:	☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized. ☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health. ☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug.	
If Expedited complete both:	☐ I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours (or 24 hours for a non-formulary drug) of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.	
	During non-business days, I can be reached at: ( )	

- For an **expedited appeal**, the patient's physician, or for a non-formulary drug, the patient's prescribing physician or other prescriber, must complete the box below and item **14**. **You must send information to the agent immediately in order for it to be considered.**
- For an **experimental/investigational** denial (other than a clinical trial or rare disease treatment) the patient's physician must complete items **1-10 and 14**.
- For a **clinical trial** denial, the patient's physician must complete items **1-9, 11 and 14**.
- For an **out-of-network service** denial (the health plan offers an alternate in-network service that is not materially different from the out-of-network service), the patient's physician must complete items **1-10 and 14**.
- For an **out-of-network referral** denial (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient), the patient's physician must complete items **1 - 9, 13 and 14**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 12 and 14**.

1. Name of Physician (or Prescriber) completing this form:	
To appeal an experimental/investigational, clinical trial, out-of-network service, or out-of-network referral denial, the physician must be licensed and board-certified or board-eligible and qualified to practice in the area of practice appropriate to treat the patient. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.	

2. Physician (or Prescriber) Address:	Street:		
	City:	State:	Zip Code:
3. Contact Person:			
4. Phone Number:	( )	Fax:	( )
5. Physician (or Prescriber) Email:			
6. Name of Patient:			
7. Patient Address:			
8. Patient Phone Number:			
9. Patient Health Plan Name and ID Number:			

10. Experimental/Investigational Denial or Out-of-Network Service Denial
(Complete this section for an experimental/investigational denial or an out-of-network service denial only. DO NOT complete this item for appeal of clinical trial participation, rare disease, or an out-of-network referral denial.)

a. For an Experimental/Investigational Denial:

As the patient's physician I attest that (select one without altering):

OR	☐ Standard health services or procedures have been ineffective or would be medically inappropriate.
	☐ There does not exist a more beneficial standard health service or procedure covered by the health plan.
AND	☐ I recommended a health service or pharmaceutical product that, based on the following **two** documents of medical and scientific evidence **outlined in c and d below**, is likely to be more beneficial to the patient than any covered standard health service.

b. For an Out-of-Network Service Denial

☐ As the patient's physician I attest that the following out-of-network health service (identify service):

is materially different from the alternate in-network health service recommended by the health plan and (based on the following **two** documents of medical and scientific evidence) is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

c. List the documents relied upon and attach a copy of the documents:

Document #1 Title:					
Publication Name:		Issue Number:		Date:	
Document #2 Title:					
Publication Name		Issue Number:		Date:	

d. Supporting Documents		
The medical and scientific evidence listed above meets one of the following criteria (Note: peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.)		Check the applicable documents:
☐	Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;	☐ Document #1 ☐ Document #2
☐	Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;	☐ Document #1 ☐ Document #2
☐	Peer-reviewed abstracts accepted for presentation at major medical association meetings;	☐ Document #1 ☐ Document #2
☐	Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;	☐ Document #1 ☐ Document #2
☐	The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the National Comprehensive Cancer Network's Drugs and Biological Compendium; (iii) the American Dental Association Accepted Dental Therapeutics; (iv) Thomson Micromedex DrugDex; or (v) Elsevier Gold Standard's Clinical Pharmacology; or other compendia as identified by the Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal;	☐ Document #1 ☐ Document #2
☐	Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.	☐ Document #1 ☐ Document #2

11. Clinical Trial Denial	
☐	There exists a clinical trial which is open and for which the patient is eligible and has been or will likely be accepted.
Although not required, it is recommended you enclose clinical trial protocols and related information. The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified non-governmental research entity as identified in guidelines issued by individual NIH Institutes for Center Support Grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.	

12. Rare Disease Treatment Denial If provision of the service requires approval of an Institutional Review Board, include or attach the approval.	
☐	As a physician, other than the patient's treating physician, I attest the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service. The requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service.
☐ I do ☐ I do not have a material financial or professional relationship with the provider of the service (check one).	
Check one:	☐ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.
	☐ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

13. Out-of-Network Referral Denial	
As the patient's attending physician, I certify that the in-network health care provider(s) recommended by the health plan do not have the appropriate training and experience to meet the particular health care needs of the patient. I recommend the out-of-network provider indicated below, who has the appropriate training and experience to meet the particular health care needs of the patient and is able to provide the requested health service.	
Name of out-of-network provider:	
Address of out-of-network provider:	
Training and experience of out-of-network provider: (e.g., board certification, years treating the condition, # of procedures performed and outcome, any other pertinent information).	

14. Physician (or Prescriber) Signature			
I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.			
Signature of Physician (or Prescriber):		Date:	
Physician (or Prescriber) Name: (Print Clearly):			

HELPFUL HINTS FOR COMPLETING THE EXTERNAL APPEAL APPLICATION

Some sections of the application can be confusing. This will help explain what is expected for those sections.

Application

- **Number 11** is only required if the patient has designated someone other than the provider to act on their behalf.
- **Number 12** indicates the reason the health plan denied the service. This information is found on the Final Adverse Determination (denial letter) from the health plan.
- The Type of Review must be completed in **Number 13** if an expedited appeal is being requested. External appeals can only be expedited if the denial falls into one of these categories. If you already received the services, your appeal cannot be expedited. You must also indicate if this is for a Standard Formulary Exception or a Standard External Appeal.
- **Number 14** is required if the provider is submitting the application on their own behalf or behalf of the patient.
- **Number 15** is to be used to describe the services requested. You can attach a separate document with this information.
- **Number 17** relates to the fee that a health plan may charge for the external appeal. The Final Adverse Determination will indicate if the health plan charges a fee.

Patient Consent to the Release of Records for NYS External Appeal

- This document must be signed by the patient or their authorized representative. If the patient is a minor, the document must be signed their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Physician's Attestation for an External Appeal

- •For medical necessity, experimental/investigational, and out-of-network appeals, the first section is required if the attending physician is requesting an expedited appeal because the standard 30-day timeframe would jeopardize the patient's life, health or agility to regain maximum function, or the delay would pose an imminent or serious threat to the patient's health. The attending physician must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination within 72 hours of receipt. The decision must be issued even in the event of incomplete medical information or unanswered questions due to the inability to reach the attending physician.
- For formulary exception appeals, the first section is required if the attending physician or prescriber is requesting an expedited appeal because the patient is suffering from a health condition that may seriously jeopardize his or her life, health or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug. The attending physician or prescriber must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination within 24 hours of receipt. The decision must be issued even in the event of incomplete medical information or unanswered questions due to the inability to reach the attending physician/prescriber.

- **Number 10** is required for experimental/investigational and out-of-network service denials (where the health plan offers an alternate in-network service that is not materially different from the out-of-network service). Subsections a, c and d are required when appealing an experimental/investigational denial.
  - Subsection b, c and d are required for out-of-network service denials.
  - Subsection c must include information on the medical and scientific evidence (clinical peer reviewed literature) that supports the service requested for the patient's condition. Two articles are required. This section MUST be completed in full; "see attached" will not suffice. The documents that are acceptable for submission are described in Subsection d. There is no requirement that the two documents be from different categories.
- **Number 11** is required for coverage in a clinical trial. Please note, the Affordable Care Act requires coverage of routine patient costs associated with approved clinical trials. This requirement does NOT apply to grandfathered health plans.
- **Number 12** is required for the experimental/investigational denials for treatment of rare disease. The physician signing the attestation for treatment of a rare disease cannot be the patient's attending physician. They must disclose any relationship with the patient's attending physician and indicate which definition of "rare disease" applies to the patient's condition.
- **Number 13** must be completed for out-of-network referral denials (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient). The name and address of the out-of-network provider must be included as well as their training and experience. The information provided will be used by the clinical peer reviewer when comparing the qualifications of the in-network provider(s) to the out-of-network provider. Information such as the out-of-network provider's curriculum vitae, Board Certification, number of years of experience treating the condition, the number of times the out-of-network provider has performed the requested procedure and the outcomes of those procedures, and any other relevant information should be provided. This information may be provided in an attachment to the application.
- **Number 14** must be signed by a physician. Physician is defined in NYS Education Law as an MD or DO. Attestations signed by any other provider will not be accepted. For formulary exception appeals, Number 14 may be signed by a physician or prescriber.

XVI DEPRESSION & DRUG USE SCREENING TOOLS

Depression Screening

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL:				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Depression Screening

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.

2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

3. ***Consider Major Depressive Disorder***
—if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
—if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.

2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3

3. Add together column scores to get a TOTAL score.

4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.

5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Drug Screening

Step 1: ASK about drug use.

This screening instrument is appropriate for patients age 18 or older. You may deliver it as an interview and record patient responses, or read the Prescreen question aloud and have the patient complete the remaining questions (if applicable) as a written questionnaire. It is recommended that the person administering the screening review the sample script to introduce the screening process. The script offers helpful language for introducing what can be a sensitive topic for patients.

Step 1: ASK about drug use.
A. Introduce yourself and establish rapport.
B. Ask about lifetime drug use.
C. Begin the NIDA-Modified WHO ASSIST.
D. Score the ASSIST and identify patient's risk level.

A. Introduce yourself and establish rapport.

Before you begin the interview, please read the following to the patient:

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I am interested in those only if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

- If the patient declines screening, advise the patient that you respect that decision but would like to inform him/her about the potential harms of drug use.

B. Ask patients about lifetime drug use using the Prescreen Question of the NIDA-Modified ASSIST.

Reminder:

Patients should be advised of the limits of confidentiality and insurance coverage for conditions occurring under the influence of alcohol or illicit drugs (these vary by State and provider).

- Without being judgmental or confrontational, ask the patient if he or she has "ever used" any of the substances listed—see the Prescreen question on the NIDA-Modified ASSIST (http://www.drugabuse.gov/nidamed/screening/nmassist.pdf) for a list. **Note:** If the patient mentions a drug not on the list (e.g., steroids), please enter it in the "other" category.

- Be prepared to gently probe certain questions. For example, if the patient answers "No" to every substance, ask a probing question such as "Not even when you were younger, perhaps in high school or college?"

- If the patient says "No" for all drugs in Prescreen, reinforce abstinence. For example, you may say "It is really good to hear you aren't using drugs. That is a very smart health choice." **Screening is complete.**

- If the patient says "Yes" to any of the drugs, **go to C.**

Begin the NIDA-Modified ASSIST (Link to PDF of tool).

- For patients who answer **"never"** to Question 1 (In the past three months, how often have you used the substances you mentioned?)**:** Skip to Questions 5–7 to determine if they have symptoms of a prior substance use problem. Provide feedback (see Step 2) and reinforce abstinence.

- For patients who report use of **tobacco:** *Any* tobacco use in the past three months places a patient at risk.
  - **Advise** all tobacco users to quit. For more information on smoking cessation, please see *Helping Smokers Quit: A Guide for Clinicians* at http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm.

- For patients who report use of **alcohol:** Question the patient in more detail about frequency and quantity of use:

How many times in the past year have you had:

For men: 5 or more drinks in a day?

For women: 4 or more drinks in a day?

If the answer is:

☐ None: **Advise** patient to stay within these limits.
For healthy men under the age of 65: No more than 4 drinks per day AND no more than 14 drinks per week.
For healthy women under the age of 65 and not pregnant (and healthy men over the age of 65): No more than 3 drinks per day AND no more than 7 drinks per week.
Recommend lower limits or abstinence as medically indicated for patients who:

- Take medications that interact with alcohol
- Have a health condition exacerbated by alcohol
- Are pregnant (advise abstinence).

Encourage patients to talk openly about alcohol and any concerns that may arise, rescreen annually.

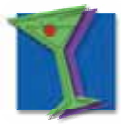
Reminder:

Many people don't know what counts as a standard drink (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor).

For information, please see http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide13_p_mats.htm

☐ One or more times of heavy drinking (≥ 5 for men; ≥ 4 for women): Patient is an at-risk drinker.

Please see the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Web site "Helping patients who drink too much: A clinician's guide" at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm for additional information to **Ask**, **Assess, Advise, Assist, and Arrange** help for at-risk drinkers or patients with alcohol use disorders.



- For patients who report **any illicit or nonmedical prescription drug use,** go to Questions 2 through 7. **Note:** Ask Question 7 if the patient reports the use of any drug that might be injected, including those that might be listed in the "other" category (e.g., steroids).

- For patients who report **alcohol *as well as* any illicit or nonmedical prescription drug use**, ask alcohol follow-up questions and then go to Questions 2–7.

D. Score the full NIDA-Modified ASSIST for illicit and nonmedical prescription drug use.

- For each substance, add up the scores received for Questions 1–6. This is the Substance Involvement (SI) score. Do not include the results from either Step 1 (Prescreen) or Question 7 in your SI score. The patient will receive an SI score for ***each*** substance endorsed, not a cumulative score. Therefore, the patient's risk level may differ from drug to drug.

Use the resultant SI score to identify patient's risk level. If more than one substance is reported, focus intervention on the substance with the highest score.

High Risk
Score ≥ 27

- ✓ Provide feedback on the screening results
- ✓ **Advise, Assess,** and **Assist**
- ✓ **Arrange** referral
- ✓ Offer continuing support

Moderate Risk
Score 4–26

- ✓ Provide feedback
- ✓ **Advise, Assess,** and **Assist**
- ✓ Consider referral based on clinical judgment
- ✓ Offer continuing support

Lower Risk
Score 0–3

- ✓ Provide feedback
- ✓ Reinforce abstinence
- ✓ Offer continuing support

Reminder:

Use clinical judgment if the patient reports use of multiple drugs but does not score highly on any of them (i.e., consider an intervention).

XVII METROPLUSHEALTH APPROVED IN-OFFICE LAB TESTS

Effective January 1, 2011

CPT Code	Test Description
81000	Routine urinalysis
81001	Urinalysis, automated, w/microscopy
81002	Urinalysis, non-automated w/o microscopy
81003	Urinalysis, automated, w/o microscopy
81005	Urinalysis
81007	Urine screen for bacteria
81025	Urine Pregnancy test
82042	Urine
82043	Urine, microalbumin, quantitative
82044	Urine, microalbumin, semiquantitative
82247	Bilirubin, total
82248	Bilirubin, direct
82270 - 82272	Fecal occult blood testing
82947	Glucose; quantitative
82948	Glucose, blood, reagent strip
82962	Blood glucose by FDA approved glucose monitoring devices
82951	Glucose tolerance test (OB office only)
83036 & 83037	Hemoglobin A1C
83655	Lead (finger stick lead testing only)
84702	hCG, quantitative
84703	hCG, qualitative

CPT Code	Test Description
85007	Blood count; blood smear, microscopic exam with manual diff WBC count
85013	Blood count, spun microhematocrit
85014	Blood count, other than spun hematocrit
85018	Hemoglobin
85025	CBC with differential
85027	CBC without differential
85610	Prothrombin time
86308	Mono
86403	Rapid Strep Test
86580	Tuberculosis, intradermal
87070	Culture, nose or throat
87081	Culture, bacterial
87210	Wet mount w/simple stain
87220	KOH prep
87430	Streptococcus, group A
87480	Candida, direct probe
87510	Gardnerella vaginalis, direct probe
86701	Antibody HIV-1 test (with modifier 92)
86703	Antibody HIV-1 and HIV-2 single assay (with modifier 92)
87797	Direct probe, NOS
87804	Influenza

XVIII CORRECT CODING EQUALS ACCURATE RISK SCORES AND MEDICAID/MEDICARE COMPLIANCE

The Risk Adjustment Payment System (RAPS), a diagnostic coding system that enables the Centers for Medicare and Medicaid Services to predict the cost of a member's care and calculate the appropriate reimbursement to health plans, requires accuracy and specificity in diagnostic coding. Clinical specificity of a disease/condition can be expressed through the fourth (4th), fifth (5th), sixth (6th), and/or seventh (7th) digit of some ICD-10-CM diagnostic codes. Documentation in the medical record of a face-to-face encounter with a Medicare or Medicaid member must include all conditions and comorbidities being treated and managed. Specificity of coding is based on the accuracy of information written in the medical records.

What you need to do to ensure compliance with these requirements:

- ✓ Code all claims for Medicare and Medicaid members to the highest level of specificity using the fourth (4th), fifth (5th), sixth (6th), and/or seventh (7th) digit of codes when applicable.
- ✓ Ensure medical record documentation is clear, concise, consistent, complete, and legible.
- ✓ Include the member's identification on each page of the medical record, the date of service, the signature(s) of the person(s) doing the treatment, reason for the visit, care rendered, conclusion and diagnosis, and follow-up care plan in all medical records.
- ✓ Include the provider's credentials on the medical record, either written next to his/her signature or using a pre-printed stamp with the provider's name on the practice's stationery.
- ✓ Report and submit all diagnoses that impact the patient's evaluation, care, and treatment; reason for the visit; coexisting acute conditions; chronic conditions; or relevant past conditions.
- ✓ Respond to request for an onsite appointment by MetroPlusHealth within seven (7) business days.

HIV Specific Model Consent Form

Chapter 308 of the Laws of 2010 instructs the New York State Department of Health (DOH) to create standard model forms for obtaining consent for HIV testing. The model below is for those providers who use the Department's current "Informed Consent to Perform HIV Testing" form, DOH-2556 Parts A and B. This form may be modified, or the provider may modify its own consent form, without Department approval but the form must contain information consistent with the model form and must be written in a clear and coherent manner using words with everyday common meanings. Note that Part A remains unchanged and is available on the Department's website in dozens of languages.

Informed Consent to Perform HIV Testing Part B

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name: _____ Date: _____

Signature: _____

(patient or person authorized to consent)

Medical Record #:_____ (8/25/10)

XIX MODEL FORM FOR DOCUMENTING OFFER OF HIV TESTING

(Optional Form; Compliance with the required offer of an HIV test may be documented through proper annotation of the patient medical record)

Chapter 308 of the Laws of 2010 instructs the New York State Department of Health (DOH) to create standard model forms for obtaining consent for HIV testing. The model below is for documenting the offer of HIV testing. It may be modified without Department approval but must contain information consistent with the model form and must be written in a clear and coherent manner using words with everyday common meanings. Providers may also comply with the requirement for documenting the offer by proper notation in the patient's medical record.

Offer of HIV Testing

New York State Public Health Law requires that an offer of HIV related testing be made to all persons ages of 13 and over receiving hospital or primary care services except under specific circumstances. This includes inpatients, persons seeking services in emergency departments those receiving primary care on an outpatient basis at a clinic or from a physician, physician assistant, nurse practitioner or midwife.

HIV is the virus that causes AIDS and is passed from one person to another during unprotected sex (oral, anal or vaginal sex without a condom) with someone who has HIV. HIV is also passed through contact with blood as in sharing needles (piercing, tattooing or injecting drugs of any kind) or sharing "works" with a person who has HIV.

If your test result is negative, you can learn how to protect yourself from being infected in the future. If you are positive, you can take steps to prevent passing the virus to others, and you can receive treatment for HIV and learn about other ways to stay healthy.

_____ Yes, I would like to speak to someone about HIV testing.

_____ No, I do not wish to have an HIV test today.

Patient Name: _____ Date: _____

Signature: _____

(patient or person authorized to consent)

Medical Record #:_____ (8/25/10)

XX CULTURAL COMPETENCY

As part of MetroPlusHealth's continuing mission to provide quality care to all of our members, we encourage our network providers to take advantage of the many resources available on Cultural Competency. Cultural Competency is the ability to work effectively with your patients, regardless of their culture, religion, ethnicity, or socio-economic status. Gaining Cultural Competency Skills will benefit your patients and your practice.

Continuing Education Programs:

- **Think Cultural Health** (*https://www.thinkculturalhealth.hhs.gov/*) – provided by the US Department of Health and Human Services. The website features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS. It offers the opportunity to earn free CME credits.
- **A Physician's Practical Guide to Culturally Competent Care** (*https://cccm.thinkculturalhealth.hhs.gov/*) – This e-learning program will equip health care providers with competencies that will enable them to better treat the increasingly diverse U.S. population. This is a self-directed training course designed for physicians, physician assistants, and nurse practitioners. Up to 9 CME credits for physicians, physician assistants and nurse practitioners.
- **Cross Cultural Health Care – Case Studies** (*http://support.mchtraining.net/national_ccce/index.html*) – This interactive, engaging learning module includes core concepts of, and four cross cultural health care case studies, each accompanied by a lecture and learning activities. The purpose of these case studies is to familiarize the learner with the many issues that may arise while working in a pediatric setting with people from different cultures.

For Additional Information About Cultural Competency:

- **American Academy of Family Physicians** gives links to other resources with guidelines on cultural competency. Assessment tools, brochures/manuals and videos are included on these sites, as well access to CME courses provided by AAFP.
- The **American Medical Association** (AMA) offers information in regard to the health problems that arise because of cultural incompetence. AMA also offers a program to increase the awareness of the imbalance of care that patients from different backgrounds receive. For AMA members the kit costs $10 and $15 for non-members.
- **Diversity and Cultural Competency** is American Health Insurance Plan's (AHIP) web portal that has activities, research findings, and training courses as well as published communicative information that is catered to teaching and reducing health care inequality due to diverse cultures.
- **Critical Measures** is a training and management consulting company. Their website provides a guide that defines cultural competence, explains its importance, and describes how health care professionals can gain training in the cultural competency field. Critical Measures also provides access to CME courses from their site.
- **Ask Me 3** is a tool catered to health care practitioners and patients that improves the communication between doctors and patients.
- The **Substance Abuse and Mental Health Services Administration** (SAMSHSA) has many publications that aid practitioners and clinicians with giving efficient health services to people of different cultural backgrounds. To find more information, visit SAMHSA's site and enter "cultural competence" in the search box.

XXI SOCIAL SERVICES FOR SENIORS – QUICK REFERENCE GUIDE

Social Security

Monthly payments to insured workers and their dependents or survivors.

Apply to: Social Security Administration (800) 772-1213.

Retirement Benefits

- You may start receiving benefits as early as age 62. You do not need to be retired.
- Other family members of retiree may be eligible:
- Spouse, if age 62 or older
- Spouse at any age if caring for a child under 16
- Unmarried children under 18
- Divorced spouses if currently unmarried; were married at least 10 years to retiree; age 62 or older
- Survivor Beneficiaries:
- Widowed spouse 60 or older
- Widowed spouse 50 or older and disabled
- Widowed at any age if caring for a child under 16 or disabled
- Unmarried children under 18
- Dependent parents
- Ask about children and grandchildren.

Note: However, if you are under full retirement age when you start getting your Social Security payments, $1.00 in benefits will be deducted for each $2.00 you earn above the limit. For 2009 that limit is $14,160. When you reach full retirement age, you will get your Social Security payments with no deduction on your earnings.

Direct Deposit Available

Supplemental Security Income (SSI)

A monthly payment to people with low-income who are 65 or older or blind or disabled. Payments supplement Social Security and/or other income. With some exceptions, citizenship is required.

Apply to: Social Security Administration (800) 772-1213.

Note: Applicants eligible for SSI may also qualify for Medicaid and Food Stamps.

Eligibility Requirements: 65 years of age or older or a disability, income, and assets.

Income: The more income you have, the lower your SSI benefit. Payments not counted by SSI as income include the first $20.00 of unearned income received in a month; the first $65.00 of earned income and half the amount over $65.00.

Allowable Assets: $2,000 (one person), $3,000 (couple) plus burial fund, $1,500 per person.

Maximum Monthly Benefits: For an individual living alone: $761. A couple: $1,115. The amount may differ if the recipient is living with others: for one person $697, for a couple $1,057. Inquire about benefits levels for family care and residential care.

Food Stamps

Allowances issued on a monthly basis that are used in place of cash to purchase food items at participating stores and supermarkets. With some exceptions, citizenship is required.

Call 311 for more information.

You may qualify if you:

- work for low wages
- work part-time
- are unemployed
- receive Public Assistance, SSI or other assistance payments
- are elderly or disabled and live on low income.

Eligibility Requirements: *Assets and Income*

Assets: Although there is an assets limit for persons under age 60, applicants who are 60 or older or disabled and meet Food Stamps income guidelines might be considered "categorically eligible" and exempt from the assets limit.

Income: Monthly limit for one person $1,127.00; couples $1,517.00. If a household member is 60 or older or disabled, net income must be 100% of current poverty level. *Seniors are encouraged to apply because allowable income is calculated individually based on living arrangements and out of pocket, medically related expenses.*

Note: Eligibility is determined only after completing a full Food Stamp budget form, using all applicable income deductions. Different income deductions apply in specific situations such as having no cooking facility, living in a shelter, or only one spouse applying.

Commodity Supplemental Food Program (CSFP)

The New York State Department of Health's Commodity Supplemental Food Program (CSFP) offers free, nutritious foods to seniors aged 60 years of age and older, and to some women and children that are not eligible for the Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program.

Call the center nearest you for application information:

Catholic Charities Neighborhood Services
89-56 162nd Street
Jamaica, NY 11432
(718) 523-2220

Kings County Hospital Center
840 Alabama Avenue
Brooklyn, NY 11207
(718) 498-9208

Other Food-related websites for Seniors are:

- Meals-On-Wheels – getmeals@citymeals.org
- Diabetic Meals – www.magickitchen.com

Free Meal Locations – www.hitesite.org

Transportation Services

MTA Reduced Fare

Individuals 65 and older or have a disability may apply for a Reduced Fare card:

MTA Customer Service Center
3 Stone Street,
New York, NY 10004
Or call 212-METROCARD

Documentation is needed when applying for Reduced Fare Metrocard or Photo Identification Metrocard.

Eligibility Requirements: *65 years of age or older or a disability.*

AMTRAK Passenger Discount for Seniors

Seniors Save 15%

Amtrak travelers 62 years of age and over are eligible to receive a 15% discount on the lowest available rail fare on most Amtrak trains. On cross-border services operated jointly by Amtrak and VIA Rail Canada, a 10% Senior discount is applicable to travelers aged 60 and over.

Eligibility Requirements: *62 years of age or older.*

Accessible Dispatch Program

Call 311 for more information.

This system links passengers that use wheelchairs with accessible vehicles through a central dispatcher. 311 connects the passenger to the dispatcher. The dispatcher collects the passenger's pick-up location and communicates electronically with participating drivers. The closest available driver accepts the dispatch and picks up the passenger. Fares charged for Accessible Service are the same as the metered rate of all NYC yellow cabs.

Eligibility Requirements: *Passengers that use Wheelchairs.*

Access-A-Ride

Call 311 for more information.

MTA New York City Transit operates Access-A-Ride (AAA), the City's paratransit system. AAR provides transportation for people with disabilities who are unable to use public bus or subway service for some or all of their trips. Service is available 24 hours a day, seven days a week, including holidays.

Eligibility Requirements: *Passengers with Disability who are unable to use Public Bus or Subway Service.*

Social Services for Seniors – Quick Reference Guide (QRG)

Home/Apartment Related Services

Senior Citizen Rent Increase Exemption (SCRIE)

Call 311 for more information.

SCRIE provides elderly renters with exemptions from most future rent increases. SCRIE covers increases for renewal leases, Maximum Base Rent (MBR) increases, fuel, landlord hardship, and major capital improvements. SCRIE does not cover increases for direct services or new equipment. Rent must be at least 1/3 of net monthly income. For rent-stabilized apartments, tenants must have a valid one or two-year lease.

Eligibility Requirements: Head of household 62 years of age or older; $29,000 annual household income limit.

Senior Citizen Homeowners Exemption (SCHE)

Call 311 for more information.

Savings of up to 50% to qualified property owners of 1 to 3 units dwelling, condominiums or cooperative apartments. Applicants must be age 65 or older, have held title to the property for at least 12 consecutive months and the property must be applicant's legal residence, used exclusively for residential purposes.

Eligibility Requirements: 65 years of age or older; $36,400 income limit for the last calendar year.

Real Property Tax Credit (IT-214) and/or City of New York School Tax Credit (NYC-210)

Call for more information or apply to:

Taxpayers Assistance Bureau
New York State Department
for Taxation and Finance
1-800-225-5829

Provides tax credit or cash payment of up to $375 to homeowners or renters for part of previous year's rent or real property taxes. To qualify, current market value (home, garage, land, etc.) must be $85,000 or less; or average monthly rent must be $450 or less, not including heat, gas or electricity.
Eligibility Requirements: $18,000 income limit.

Weatherization Referral and Packaging Program (WRAP)

Call 311 for more information.

Provides low-income elderly with free weatherization services to lower their energy bills and increase the comfort of their homes. Services include insulation, replacement of doors and windows and repairs furnaces and roofs.
Eligibility Requirements: 60 years of age or older; Monthly Income Limit $1,963.00 (one person); $2,567.00 (couple)

Repair and Safety Services

Call 212-962-7559 or e-mail: nyfscinc@aol.com

New York Foundation for Senior Citizens, Inc.
11 Park Place, 14th Floor
New York, NY 10007-2801

Through this Program, senior homeowners and renters with limited finances benefit from free home maintenance and repair services. Services include minor plumbing, gutter- cleaning, masonry, electrical, carpentry, caulking, weather- stripping, and the installation of crime prevention devices, as well as some emergency services.

Lifeline for Verizon Customers in New York

For more information call Verizon 800-483-2000 or visit: http://www22.verizon.com

Lifeline is a government program that offers qualified low income households a discount on their monthly local telephone bill. Each state has its own guidelines to qualify. The application and qualification process differs by state and sometimes by individual phone company.

Eligibility Requirements: Program Based (Food Stamps; Medicaid; Low Income Home Energy Assistance Program (LIHEAP); Supplemental Security Income (SSI); Temporary Assistance for Needy Families (TANF); Persons with a non-service related disability and receiving Veterans Disability Pension or Veterans Surviving Spouse Pension; Additional eligibility criteria may apply to residents of federally recognized tribal lands) and Income Based (Tax Return required to determine eligibility)

Home Energy Assistance Program (HEAP)

Call 311 for more information.

A one-time grant per year to help low-income homeowners and renters pay fuel and utility cost. Available to both households that pay directly for heat and households where heat is included in rent. Benefit amounts range from $40.00 - $585.00. Eligible households that pay directly for heat with their main source of heat being oil, kerosene or propane may receive a benefit up to $800.00.
Eligibility Requirements: Monthly Income Limit $1,963.00 (one person); $2,567.00 (couple).

Health Related Services

Medicare Savings Program

Call 311 for more information or write to:
Medicare Savings Program Applications
PO BOX 3011 Jamaica, NY 11431

1. ***Qualified Medicare Beneficiaries (QMB)***
   Those covered by Part A and Part B may be able to have Medicaid cover the monthly premium ($96.40) in addition to deductibles and co-insurance.
   Eligibility Requirements: 65 years of age or older or disabled receiving Medicare after being on Social Security Disability for two years; Monthly Income Limit $903.00 (one person); $1,215.00 (couple)
2. ***Specified Low-Income Medicare Beneficiaries (SLIMB)***
   Those covered by Part A and Part B may be able to have Medicaid pay the Medicare Part B medical premium ($96.40).
   Eligibility Requirements: 65 years of age or older or disabled receiving Medicare after being on Social Security Disability for two years; Monthly Income Limit $1,083.00 (one person); $1,457.00 (couple)
3. ***Qualified Individual 1 (QI-1)***
   Those covered by Part A and Part B may be able to have Medicaid pay the Medicare Part B medical premium ($96.40).
   Eligibility Requirements: 65 years of age or older or disabled receiving Medicare after being on Social Security Disability for two years; Monthly Income Limit $1,219.00 (one person); $1,640.00 (couple)

New York Prescription Saver Card

A free pharmacy discount card for New York State residents; use this card at participating pharmacies to save as much as 60% on generics and 30% on brand name drugs.

Call New York Prescription Saver at 1-800-788-6917 or visit https://nyprescriptionsaver.fhsc.com/

Eligibility Requirements: Age 50 to 65 not receiving Medicaid; Income $35,000.00 (single); $50,000.00 (Married)

Elder Pharmaceutical Insurance Coverage (EPIC)

For information call EPIC 1-800-332-3742

Two coverage plans to choose from: Annual Fee Plan and Deductible Plan; saves more than half the cost of most prescription drugs.
Eligibility Requirements: 65 years of age or older; Annual Income Limit $35,000.00 (one person); $50,000.00 (couple); Pharmacy must be EPIC participants.

Miscellaneous

America The Beautiful - The National Parks and Federal Recreational Lands Annual Pass

The pass is a lifetime entrance pass to national parks, monuments, historic sites, recreation areas, and national wildlife refuges that charge an entrance fee.

A Golden Age Passport must be obtained in person at a federal area where an entrance fee is charged. There is a one-time $10 processing charge to obtain the Golden Age Passport.

Eligibility Requirements: 62 years of age or older OR medically determined to be blind or permanently disabled; Citizens or Permanent Residents of the US.

Big Apple Senior Strollers

For more information call 311 or visit: www.nyc.gov

Other Websites for Seniors

- ***www.BenefitsCheckUp.org***
- ***www.onestopseniorservices.org***
- ***http://cscs-ny.org***
- ***www.nyfsc.org***

XXII METROPLUSHEALTH: NOTICE TO PROVIDERS REGARDING PROTECTED HEALTH INFORMATION AND PRIVACY PRACTICES

Effective June 1, 2017

By law, MetroPlusHealth must protect the privacy of our member's health information, and you as a MetroPlusHealth provider must also protect the privacy of your patient's information. MetroPlusHealth is providing this notice detailing our legal duties and privacy practices so that you are aware of them and ensure your practice adheres to these same rules. This notice describes how MetroPlusHealth may use and give out ("disclose") protected health information ("PHI") and provides you with knowledge of how MetroPlusHealth expects you in turn should handle member PHI. MetroPlusHealth follows the practices described in our current Privacy Notice & Notice of Health Information Privacy Practices and you as a provider are required to have your own privacy notices and practices.

Additional resources and guidance regarding what information has to be included in your notice of privacy practices is available at the U.S. Department of Health & Human Services website here: *http://www.hhs.gov/hipaa*.

To see how MetroPlusHealth complies with Privacy Notice requirements, you can find the following notices on the MetroPlusHealth website at *https://www.metroplus.org/privacy-policies*.

- MetroPlusHealth Privacy Notice (As required by NYS Insurance Law Reg. 169)
- MetroPlusHealth Notice of Health Information Privacy Practices (As required by HIPAA)
- MetroPlusHealth Privacy Policies from our website, *www.metroplus.org*
- In addition, each of the above privacy notices contains a Multi-Language Interpreter Services and Non-Discrimination notice as required by Section 1557 of the Affordable Care Act

HIPAA Privacy Rule Summary

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The Privacy Rule standards address the use and disclosure of individuals' health information – called "protected health information" by organizations subject to the Privacy Rule – called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used.

Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

This is a summary of key elements of the Privacy Rule and not a complete or comprehensive guide to compliance. Entities regulated by the Rule are obligated to comply with all of its applicable requirements and should not rely on this summary as a source of legal information or advice. To make it easier for entities to review the complete requirements of the Rule, provisions of the Rule referenced in this summary are cited in notes at the end of this document.

To view the entire Rule, and for other additional helpful information about how it applies, see the OCR website: *http://www.hhs.gov/hipaa*. In the event of a conflict between this summary and the Rule, the Rule governs. To review the entire Rule itself, and for other additional helpful information about how it applies, see the OCR website: *http://www.hhs.gov/hipaa*.

XXIII PROVIDER GUIDE TO HIV TESTING

as Recommended by New York State Department of Health AIDS Institute

Who Should be Tested for HIV?

What does the NYSDOH AIDS Institute guideline recommend for HIV screening in the general population? Healthcare providers should offer *HIV testing* to all individuals aged >13 years as part of routine healthcare.

What does NYS public health law require with regard to HIV testing? *New York State public health law* requires that all individuals aged >13 years receiving care in a primary care setting, an emergency room, or a hospital are offered an HIV test at least once and mandates that care providers offer an HIV test to any person, regardless of age, if there is evidence of activity that puts an individual at risk of HIV acquisition.

Who should be offered *ongoing* testing for HIV? Healthcare providers should offer an HIV test at least annually to all individuals whose behavior increases their risk for exposure to HIV (such behavior includes condomless anal sex, sex with multiple or anonymous partners, needle-sharing, or sex with partners who share needles). Since many people choose not to disclose risk behaviors, care providers should consider adopting a low threshold for recommending HIV testing.

Also, any individual who has been diagnosed with a sexually transmitted infection (STI) should be offered HIV testing.

How often should HIV screening be performed in individuals who engage in high-risk behavior? Healthcare providers should screen patients who engage in high-risk behavior every 3 months and should provide or refer these individuals for ongoing medical care, risk-reduction counseling and services, and HIV prevention, such as pre-exposure prophylaxis (PrEP). Access to care and prevention are important to maintain the health of individuals at risk and to prevent transmission by those who acquire HIV.

How often should HIV screening be performed in individuals who would not fall into a high-risk behavior category? According to data from the CDC [Dailey, et al. 2017], 1 in 2 individuals with HIV have had the virus at least 3 years before diagnosis. Many of these individuals did not acknowledge themselves to be at high risk. The U.S. Preventative Health Task Force notes that for individuals not engaged in the high-risk behavior outlined above, but are still at increased risk, a somewhat longer interval (for example, 3 to 5 years) may be adopted [U.S. Preventive Services Task Force 2016]. A change in sexual partner or marital status merits repeat HIV screening. Routine rescreening may not be necessary for individuals who have not been at increased risk since they were found to be HIV-negative. Women screened during a previous pregnancy should be rescreened in subsequent pregnancies.

Consent

Is written consent required before an HIV test is ordered? As of May 17, 2017, neither written nor oral consent is needed before ordering an HIV test; however, patients must be informed that an HIV test will be performed and they may opt out.

Recommended HIV Test

What is the best test to use for HIV screening? The optimal test for screening is a 4th-generation HIV 1/2 antigen/antibody (Ag/Ab) immunoassay, which is a laboratory-based test that uses serum or plasma.

Can a rapid point-of-care test be used for HIV screening? Yes, although it will detect antibodies later in the course of HIV infection and may miss early infection in many cases. There are also newer point-of-care tests that detect antigen and, therefore, earlier infection. It is worth clarifying with your facility which rapid test is used.

Which HIV test should be performed in an individual who has been diagnosed with an STI? The optimal HIV test is always a 4th-generation HIV Ag/Ab blood test.

Should a 4th-generation Ag/Ab HIV test be used to screen for HIV in individuals who are taking PrEP? Yes, that is the optimal test. A rapid point-of-care test can be performed at the same time so patients have an immediate answer, but the rapid test should not replace the 4th-generation Ag/Ab test. If exposure is recent (within past 10 days) or patient has signs or symptoms of acute HIV, an HIV RNA test should be ordered.

HIV Testing Follow-Up

What follow-up is recommended if the 4th-generation HIV Ag/Ab test is reactive but the confirmatory HIV-1/2 differentiation assay is indeterminate or negative? An HIV-1 viral load test will differentiate acute HIV infection from a false positive screening result.

What follow-up is recommended if an individual has a reactive point-of-care rapid test (such as OraQuick)? As follow-up, the healthcare provider should:

- Perform a 4th-generation HIV Ag/Ab test and counsel the patient that the result of the rapid test is preliminary pending the result of the confirmatory HIV test and follow-up differentiation assay.
- Discuss the patient's option of starting antiretroviral therapy (ART) while awaiting confirmatory test results.
- Screen for suicidality and domestic violence and make sure the patient is safe.
- Make sure a return appointment is scheduled so test results can be delivered in person.

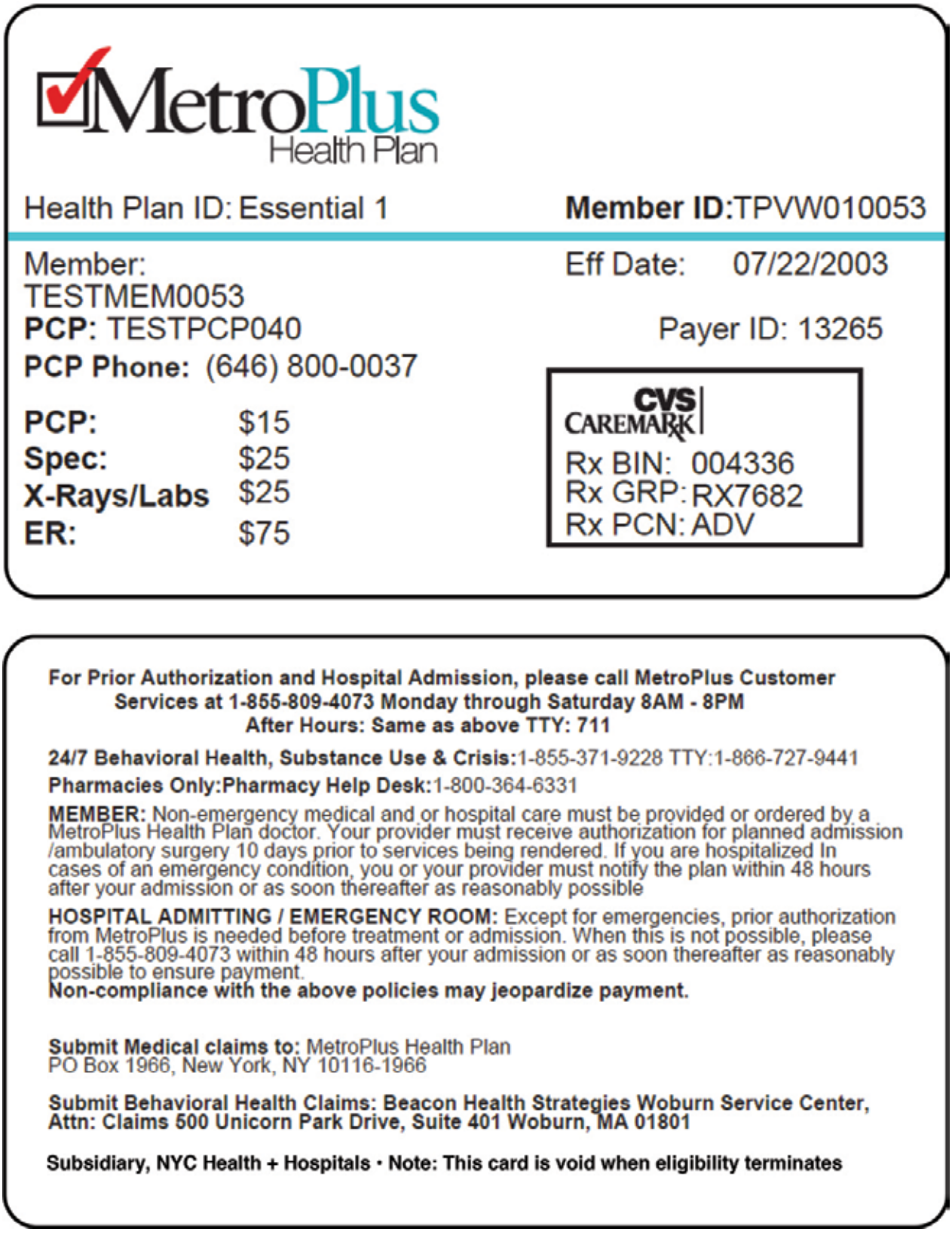
What follow-up is recommended when a patient's 4th-generation HIV Ag/Ab test is reactive? In this scenario, the healthcare provider should:

- Have the patient's specimens tested for HIV-1 and HIV-2 antibodies. Order HIV 1/ 2 Ag/Ab assay with reflex. Always include "with reflex" so if indicated, additional recommended tests are conducted on the same specimen.
- If the results are negative or indeterminate, then perform an HIV-1 RNA test.
- Interpret the final result based on a combination of test results. The *NYSDOH Testing Toolkit* provides more information about HIV diagnostic tests and the CDC's *Recommended Laboratory*

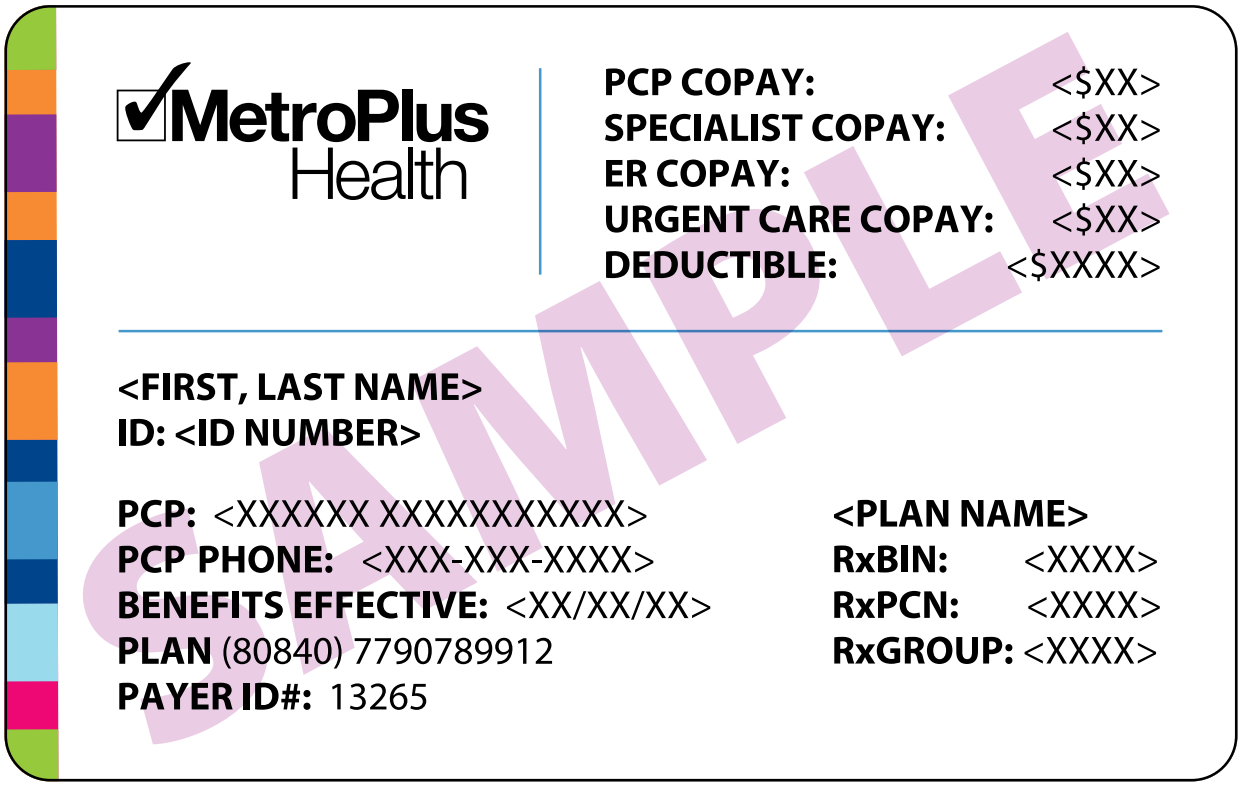
HIV Testing Algorithm for Serum or Plasma Specimens. The NYSDOH AIDS Institute guideline *HIV Testing* may be consulted as well.

- Discuss *ART initiation* at the time of a positive result with the first rapid test. Initiation of ART during acute infection may have a number of beneficial clinical outcomes.
- When a diagnosis of *acute HIV infection* is made, discuss the importance of notifying all recent contacts and refer patients to partner notification services, as mandated by *New York State Law*. The Department of Health can provide assistance if necessary.

What follow-up is recommended if an individual's HIV test is negative but they remain at high risk of acquiring HIV? In this scenario, the healthcare provider should discuss and/or recommend PrEP and ensure that the patient has access to PrEP services. The healthcare provider should also provide risk-reduction counseling (e.g., safer sex practices, needle exchange, post-exposure prophylaxis [PEP]) and advise retesting for HIV every 3 months for as long as the individual is at risk.



Sample Member ID Card: Essential Plan



Sample Member ID Card: Marketplace/Commercial

CVS CAREMARK

MetroPlus Health Plan

MEMBER IDENTIFICATION CARD

Subscriber Name: **<Member Name>**
Member No: **<Members' Number>**
RX BIN #004336 PCN ADV GRP RXMPHP
Health Center: **<Hospital Name>**
Primary Care Physician: **<Doctors' Name>**
Telephone Number: **<Dr.s' Telephone Number>**
Subscriber Effective Date: **<Effective Date>**

CALL 1-800-442-2560 FOR EMERGENCY MEDICAL CARE WHEN YOUR HEALTH CENTER IS CLOSED

MEMBER: Non-emergency medical and / or hospital care must be provided or ordered by a MetroPlus Health Plan doctor. Your provider must receive authorization for elective admission/ambulatory surgery ten (10) days prior to services being rendered.

HOSPITAL ADMISSIONS: Except for emergencies, prior authorization from MetroPlus is needed before treatment or admission. When this is not possible, call the **UM Department: 1-800-303-9629, or fax 1-212-908-8901** within one (1) business day of rendered services to ensure payment.

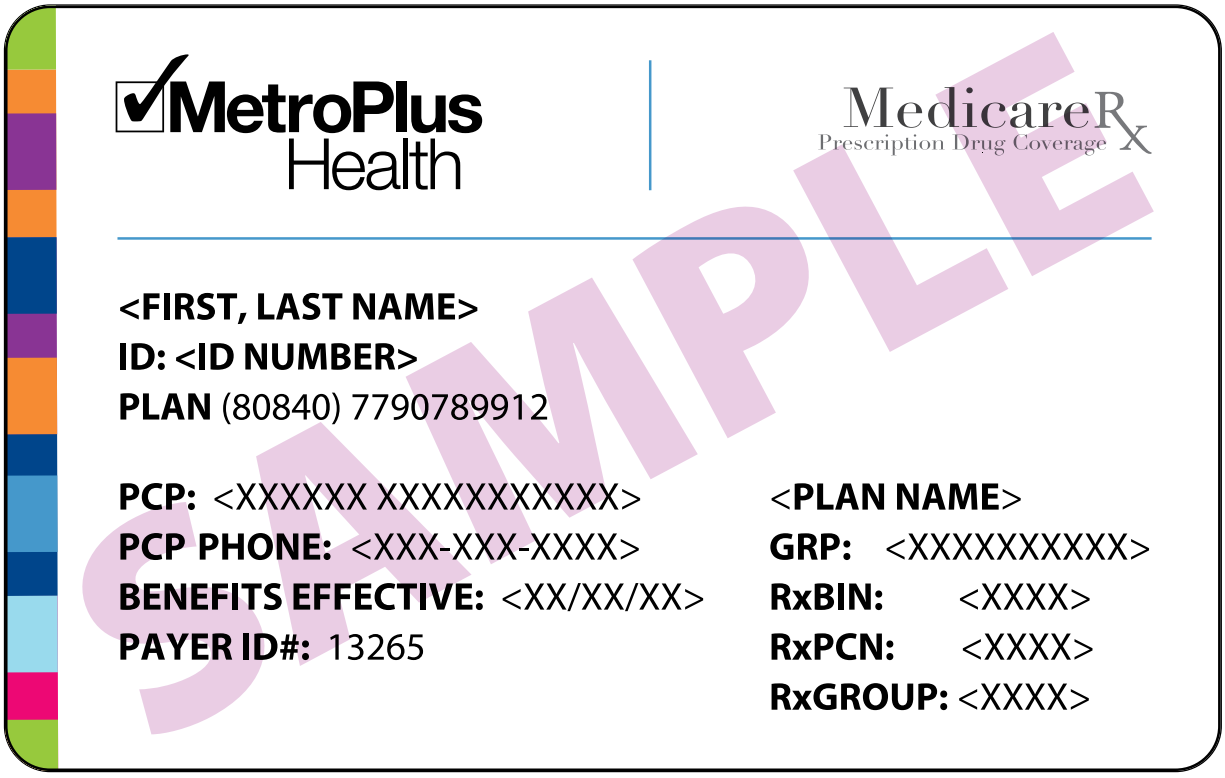
For questions, please contact the MetroPlus Customer Services Department at:
160 Water Street, 3rd Floor • New York, NY 10038
1-800-303-9626 • TTY: 711

For Questions about Dental Coverage, please call Healthplex Member Services at: 1-888-468-2189.

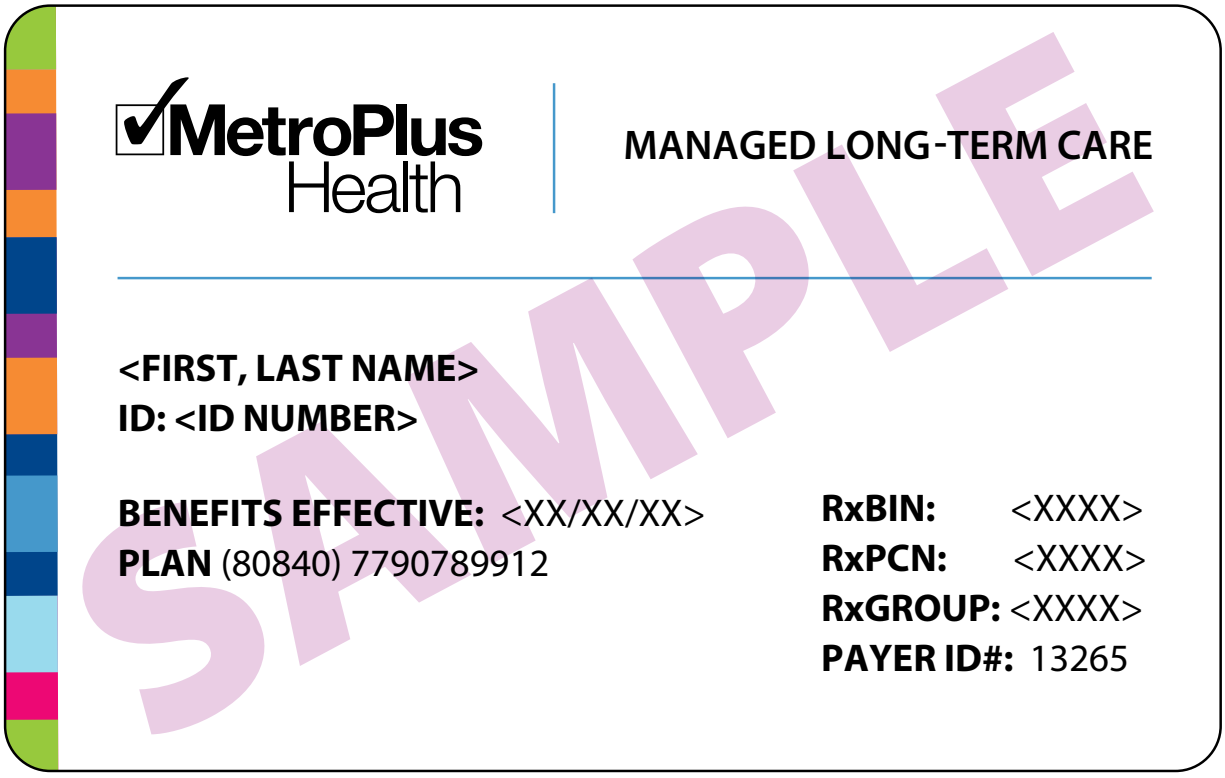
24/7 Behavioral Health, Substance Use & Crisis: 1-855-371-9228 • TTY: 1-866-727-9441
Behavioral Health Claims: Beacon Health Strategies • Woburn Service Center, Attn: Claims
500 Unicorn Park Drive, Suite 401 • Woburn, MA 01801

Subsidiary, NYC Health + Hospitals
Note: This card is void when eligibility terminates.

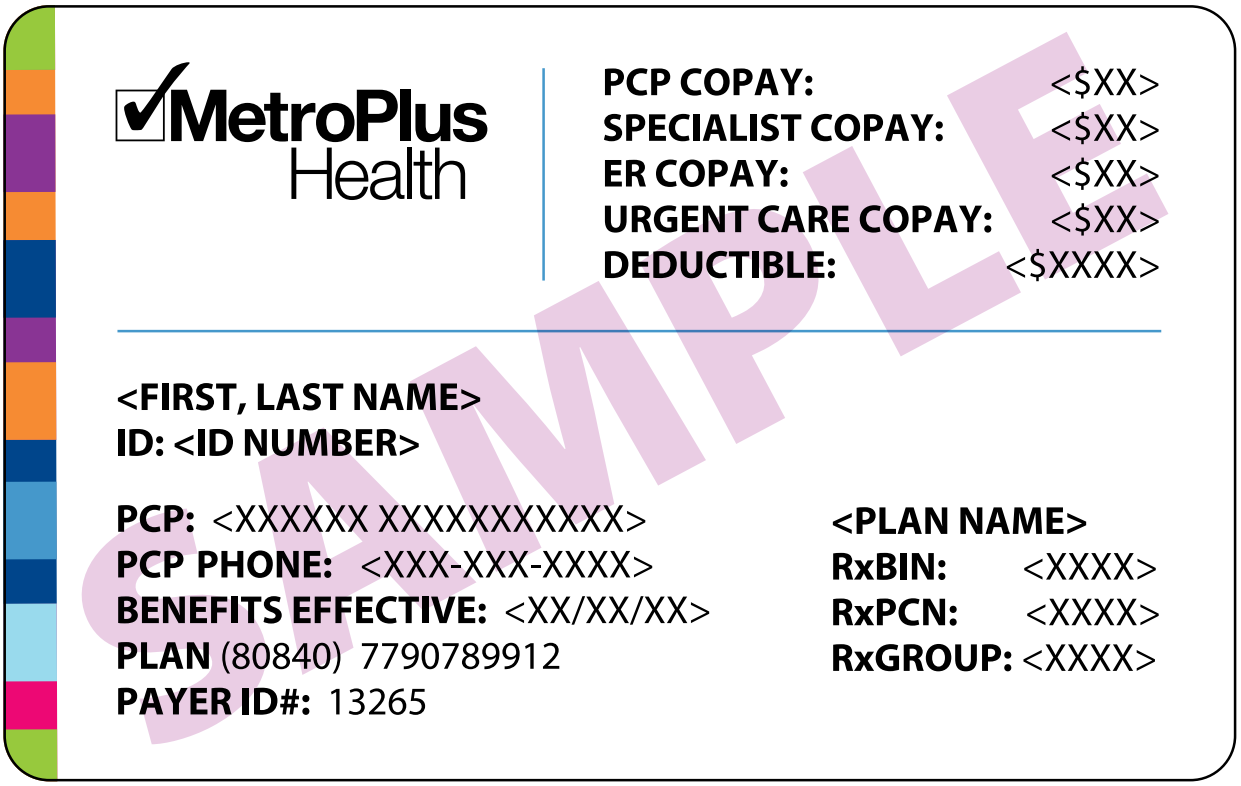
Sample Member ID Card: Medicaid

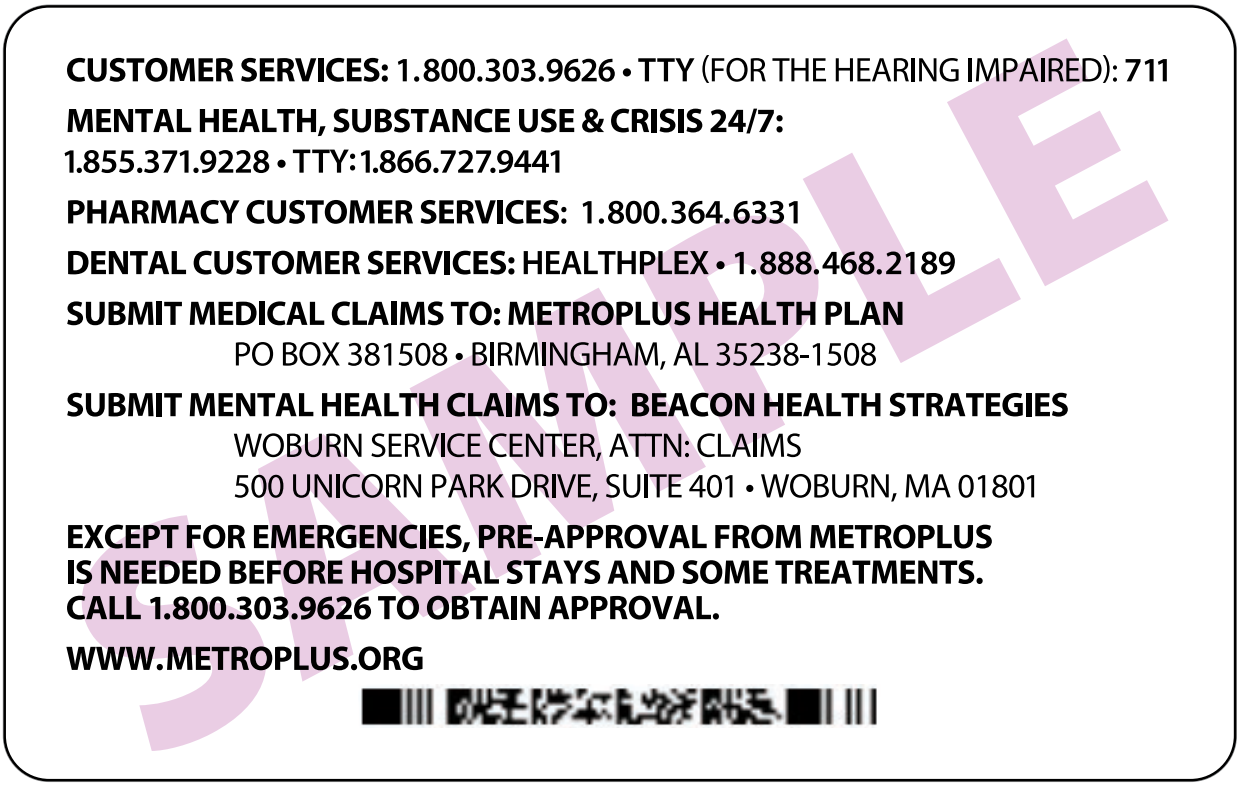


Sample Member ID Card: Medicare

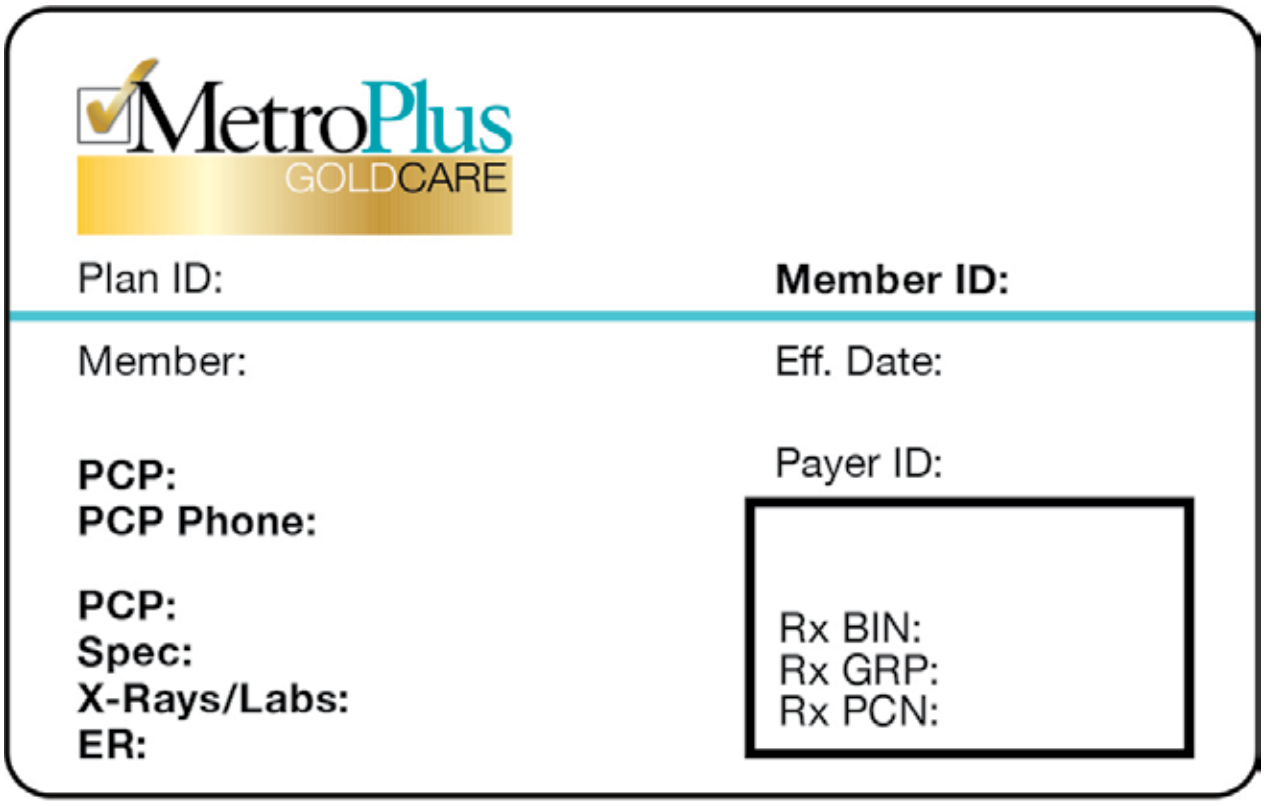


Sample Member ID Card: Managed Long-Term Care





Sample Member ID Card: Gold


MetroPlus
GOLDCARE

Plan ID:

Member ID:

Member:

Eff. Date:

PCP:
PCP Phone:

Payer ID:

PCP:
Spec:
X-Rays/Labs:
ER:

Rx BIN:
Rx GRP:
Rx PCN:

MEMBER: Non-emergency medical and/or hospital care must be provided for or be ordered by a MetroPlus Health Plan doctor.

HOSPITAL ADMITTING/EMERGENCY ROOM: Except for emergencies, prior authorization from MetroPlus Health Plan is needed before treatment or admission. When this is not possible, please call the Utilization Management (UM) Department within one (1) business day of rendered services to ensure payment. The UM Department can be contacted by calling (800) 303-9629, or by fax (212) 908-8901.

Any member questions should be directed to the MetroPlus GoldCare Member Services Department:

160 Water Street, 3rd Floor • New York, NY 10038
1-877-475-3795 • TTY: 711

24/7 BEHAVIORAL HEALTH, SUBSTANCE USE & CRISIS:
1-855-371-9228 • TTY: 1-866-727-9441
Behavioral Health Claims: Beacon Health Strategies • Woburn Service Center, Attn: Claims
500 Unicorn Park Drive, Suite 401 • Woburn, MA 01801

FOR PHARMACIES ONLY: Pharmacy Help Desk: 1.800.364.6331
Note: This card is void when eligibility terminates.
Subsidiary, NYC Health + Hospitals

Sample Member ID Card: GoldCare

LDSS-3134 (2/01)

STERILIZATION CONSENT FORM

PATIENT NAME	CHART NO.	RECIPIENT ID NO.
HOSPITAL/CLINIC		

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____. When I asked for the
(doctor or clinic)
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation know as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year

I, _____, hereby consent of my own free will to be sterilized by _____
(Doctor)
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date: _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

☐ 1 American Indian or Alaska Native
☐ 2 Asian or Pacific Islander
☐ 3 Black (not of Hispanic origin)
☐ 4 Hispanic
☐ 5 White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
Name of Individual
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowlingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon
_____ on _____
Name of individual to be sterilized *Date of sterilization*
_____, I explained to him/her the
Operation
nature of the sterilization operation _____, the
Specify type of operation
fact that it is intended to be a final irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is a least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. (Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date sterilization was performed.

(2) This sterilization was preformed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable and fill in information requested):

☐ 1. Premature delivery
Individual's expected date of delivery: _____

☐ 2. Emergency abdominal surgery: _____
(describe circumstances): _____

_____ _____
Physician *Date*

THE FOLLOWING MUST BE COMPLETED FOR STERILIZATIONS PERFORMED IN NEW YORK CITY -- WITNESS CERTIFICATION

I, _____ do certify that on _____ I was present while the counselor read and explained the consent form to _____ and saw the patient sign the consent form in his/her handwriting.
(patient's name)

SIGNATURE OF WITNESS	TITLE	DATE
X		

REAFFIRMATION (to be signed by the patient on admission for Sterilization)

I certify that I have carefully considered all the information, advice and explanations given to me at the time I originally signed the consent form. I have decided that I still want to be sterilized by the procedure noted in the original consent form, and I hereby affirm that decision.

SIGNATURE OF PATIENT	DATE	SIGNATURE OF WITNESS	DATE
X		X	

DISTRIBUTION: 1 – Medical Record File 2 – Hospital Claim 3- Surgeon Claim 4 – Anesthesiologist Claim 5 – Patient

LDSS-3113 (4/84)

ACKNOWLEDGEMENT OF HYSTERECTOMY INFORMATION

(NYS MEDICAID PROGRAM)

EITHER PART I OR PART II MUST BE COMPLETED

RECIPIENT ID NO.	SURGEON'S NAME

PART I: RECIPIENT'S ACKNOWLEDGMENT STATEMENT AND SURGEON'S CERTIFICATION

RECIPIENT'S ACKNOWLEDGMENT STATEMENT

It has been explained to me, _____ (RECIPIENT NAME), that the hysterectomy to be performed on me will make it impossible for me to become pregnant or bear children. I understand that a hysterectomy is a permanent operation. The reason for performing the hysterectomy and the discomforts, risks and benefits associated with the hysterectomy have been explained to me and all my questions have been answered to my satisfaction prior to the surgery.

RECIPIENT OR REPRESENTATIVE SIGNATURE	DATE	INTERPRETER'S SIGNATURE (If required)	DATE
X		X	

SURGEON'S CERTIFICATION

The hysterectomy to be performed for the above mentioned recipient is solely for medical indications. The hysterectomy is not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing.

SURGEON'S SIGNATURE	DATE
X	

PART II: WAIVER OF ACKNOWLEDGMENT AND SURGEON'S CERTIFICATION

The hysterectomy performed on _____ (RECIPIENT NAME) was solely for medical indications. The hysterectomy was not primarily or secondarily for family planning reasons, that is, for rendering the recipient permanently incapable of reproducing. I did not obtain Acknowledgement of Receipt of Hysterectomy information from her and have her complete Part I of this form because (please check the appropriate statement and describe the circumstances where indicated):

☐ 1. She was sterile prior to the hysterectomy.
(briefly describe the cause of sterility) _____

_____

☐ 2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgment was not possible. (briefly describe the nature of the emergency)

_____

_____

☐ 3. She was not a Medicaid recipient at the time the hysterectomy was performed but I did inform her prior to surgery that the procedure would make her permanently incapable of reproducing.

SURGEON'S SIGNATURE	**DATE**
X	

DISTRIBUTION: File patient's medical record; hospital submit with claim for payment; surgeon and anesthesiologist submit with claims for payment; patient.

<DATE>
<PROVIDER NAME>
<PROVIDER ADDRESS>

Informed Consent Procedures for Hysterectomy and Sterilization

MetroPlusHealth providers are required to comply with New York City Department of Health and Mental Hygiene (NYCDOHMH) informed consent guidelines in 42 CFR, Part 441, Sub Part F and 18 NYCRR Section 505.13. A member undergoing a hysterectomy must be notified verbally and in writing that the procedure will render her permanently sterile. She or her authorized representative must sign the required consent form.

This requirement is only waived if the hysterectomy was performed in a life threatening (emergency) situation or when the evidence exists that the member was sterile prior to the procedure. If either situation occurs, then the surgeon's attestation must be completed stating that one of these circumstances existed.

Specific Disclosures:

The physician performing the sterilization procedure must be available to answer questions and provide all requested information and advice in addition to providing the form and informed consent. The following issues must be discussed with the member seeking sterilization at least thirty (30) days before the procedure is performed.

- Member's right to withdraw consent at any time prior to the procedure without jeopardizing any future treatment or federally subsidized benefit.
- Alternative methods of family planning and birth control.
- Irreversibility of the sterilization procedure.
- Detailed and thorough explanation of the procedure to be performed.
- Full description of the associated risks, side effects, and discomforts (including those associated with any anesthesia to be used).
- Full explanation of the benefits or advantages to be expected after undergoing the procedure.
- Explanation that the procedure will not be performed for at least thirty (30) days except in cases of premature delivery or emergency abdominal surgery.

MetroPlusHealth will monitor compliance with the informed consent procedures for hysterectomy and sterilization as specified in 42 CFR, Part 441, Sub Part F and 18 NYCRR Section 505.13. Our records indicate that our member <MEMBER'S NAME> had a sterilization procedure on <DATE OF SERVICE>. **Please FAX a copy of the member's signed consent form to MetroPlusHealth, Attention: Bethel Ndubueze, Quality Management Department at 212.908.5188.**

Note: If standards are not met Networks Relations will outreach to individual providers to discuss the importance of complying with the informed consent procedures for hysterectomy and sterilization. Providers who are found to be non-compliant with regulatory requirements will be re-evaluated after a period of 6 months and if still non-compliant will be presented to the Credentialing Committee for further action.

If you have any questions, please feel free to contact me at **212.908.8581**. Thank you.

Catherine Lopez
Senior Associate Director Quality Management

XXXIV CONTRACEPTIVE SERVICES

$0 Cost-Share Services, Products & Drugs covered by MetroPlusHealth

QHP/Essential Plan

Family Planning and Reproductive Health Services

MetroPlusHealth covers family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise covered under the Prescription Drug Coverage section of this Contract, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. MetroPlusHealth also covers vasectomies subject to Copayments, Deductibles or Coinsurance. MetroPlusHealth does not cover services related to the reversal of elective sterilizations.

Covered Prescription Drugs include but are not limited to contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

Interruption of Pregnancy

MetroPlusHealth covers therapeutic abortions including abortions in cases of rape, incest or fetal malformation (i.e., medically necessary abortions). We cover elective abortions for one (1) procedure per Member, per Plan Year.

Designated Pharmacies

If your patients require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, MetroPlusHealth may direct them to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports. If your patients are directed to a Designated Pharmacy and they choose not to obtain the Prescription Drug from a Designated Pharmacy, your patient will not have Coverage for that Prescription Drug. Contraceptives are included in the therapeutic class of Prescription Drugs or conditions.

See the full QHP and Essential formulary at *https://www.metroplus.org/member-services/formularies*.

XXXV CONTRACTED UTILIZATION REVIEW AGENTS' PHONE NUMBERS

Beacon Health Options is contracted with MetroPlusHealth to provide Behavioral Health and Substance Abuse Benefit Management Services. Contact Beacon for authorization at **1.855.371.9228**.

CVS Caremark is contracted with MetroPlusHealth to provide Pharmacy Benefit Management services, including utilization management for certain medications. Contact Caremark for prior authorization at **1.877.433.7643**.

SGM Specialty Pharmacy is part of Caremark, and they are contracted to review and issue prior authorization for certain specialty medications. Contact them at **1.866.814.5506**.

Integra Partners is contracted with MetroPlusHealth to provide Durable Medical Equipment (DME) benefit management services. Contact Integra Partners for prior authorizations at **1.866.679.1647** or via fax at **1.212.908.5185**.

Healthplex is contracted with MetroPlusHealth to provide Dental Benefit Management services, including utilization management for dental. Contact Healthplex at **1.888.468.2183**.

XXXVI MEDICAL MANAGEMENT: CARE MANAGEMENT TRAINING PROGRAM

Learning Objectives

- Model of Care
- Roles and Responsibilities of the Care Manager
- Roles and Responsibility of the Interdisciplinary Care Team (IDCT)
- Assessment & Care Planning
- Coordination of Services

Model of Care

The Model of Care (MOC)

- A care management plan that complies with CMS and NCQA model of care elements for a Special Needs (SNP) plan
- Provides the structure for care management processes and systems that enables plans to provide coordinated care for participants
- Has goals and objectives for the targeted population, an extensive provider network, uses nationally-recognized clinical practice guidelines; conducts health risk assessments to identify the special needs of beneficiaries, adds services for the most vulnerable participants including frail, disabled or near end-of-life

The Model of Care must include the following elements:

- Description of the target population
- Measurable goals
- Staff Structure and Care Management goals
- Interdisciplinary Care Team (IDCT)
- Provider Network having specialized expertise and use of Clinical Practice Guidelines and Protocols
- Model of Care training for Personnel and Provider Network
- Health Risk Assessment
- Individualized Care Plan
- Communication Network
- Care Management for the Most Vulnerable Subpopulations
- Performance and Health Outcome Measurements

Roles and Responsibilities of the Care Manager

The Care Manager is:

- The central point person who coordinates the care and services of participants across the continuum of illness
- Promotes effective utilization and monitoring of health care resources; and participates in the IDCT to achieve optimal clinical and resource outcomes
- Communicates with the participant, family, PCP, specialists and other members of the health care team to gather information pertinent to the identification of the participant's health care needs

- Develops a person-centered service plan (care plan) based upon participant-centered goals; updates the plan as needed to reflect the participant's current health status and needs by coordinating and communicating with the PCP and other providers of care

The Care Manager:

- Advocates, informs and educates participants
- Ensures participants obtain timely, cost-effective quality care in the appropriate setting; identifies and facilitates access to community resources
- Ensures the coordination of Medicare and Medicaid services, including mental health, substance abuse and rehabilitation services.
- Conducts inpatient admission review, coordination of continuing stay, discharge planning, care transitions and review of requests for pre-authorization of elective admissions and procedures
- Collaborates with the IDCT and the Primary Care Physician to ensure continuity and appropriateness of care

Roles and Responsibilities of the IDCT

The IDCT is:

- A licensed medical and/or clinical professional with a strong background in medical and behavioral components to support the clinically complex and social aspects of care
- Led by the Senior Director of Case Management, who is responsible with the IDCT for assuring clear and timely communications amongst the team, providers of care and community-based programs; ensuring the participant care plan is implemented

Additional participants of the IDCT are based on the participant's individualized needs, but at a minimum has expertise in medical, social, behavioral and community aspects of care needed to coordinate care management.

Core IDCT members must include:

- Participant and/or, in the case of incapacity, an authorized representative
- The SNP Plan Care Manager

Depending on the need, the IDCT may also include other health care professionals, but not limited to:

- Assessment Nurse
- The participant's Home Health Aide
- Home care provider
- Physical and/or occupational therapist
- Pastoral specialist/professional

Roles and Responsibilities of the IDCT:

- Participant-centered care coordination and management
- The participant is the core focus of the IDCT and their input comes through the care planning process.
- Assists the participant with coordination and transitions of care

- The IDCT functions as a multidisciplinary care team, supporting the participant to improve participant health outcomes

Assessment & Care Planning

- A collaborative process that includes continuous assessment, planning, implementation, coordination, monitoring, and evaluation of options and services to meet the participant's health care needs and goals of care
- Accomplished by using available resources to promote quality, cost-effective outcomes
- Participants have access to a wide range of services including primary, secondary and acute care
- Utilization of these services will be consistent with their goals of care and advance care directives
- The MOC integrates these services through an interdisciplinary care planning process, which manages transitions of care to ensure continuity across all settings
- SNP participants will have a Health Risk Assessment (HRA) within 30 days of enrollment and then every six months or whenever there is a significant change in condition
- Participants will be visited in their home or place of residence by an Assessment Nurse, who will conduct a comprehensive complex care assessment using these assessment tools
- SNP participants' needs are fully assessed, including but not limited to medical, social, financial and housing needs
- Within 60 days of enrollment, the participant's comprehensive care plan is developed by the Care Manager with input from the IDCT
- Reassessment, PCSP review and revision is required at least every six months and more frequently if there is a significant change in condition

Examples of data gathered by the HRA for risk stratification are detailed information within the following categories:

- Active diagnoses
- Health conditions
- Medications
- Special treatments and procedures
- Hearing/Speech/Vision
- Cognitive patterns
- Mood/Behaviors
- Functional Status
- Bowel and bladder function and continence
- Swallowing and nutritional status
- Skin conditions

- The Care Manager analyzes the medical records and the assessment information during the care plan development and at each six-month interval, or whenever there is a significant change in condition
- Evaluations may include: review of UM history, claims data, telephonic discussions with the participant/health care proxy, family or authorized representative (with participant consent, or for participant who lacks capacity to participate in interview/discussion) and include an assessment of cognitive function and mental status
- The overall assessment, as well as the risk stratification level (low, medium, high) is reflected in the care plan

- Providers receive their patients' completed PCSP by mail, which indicate the participants' risk score
- Active problems uncovered during the review of the assessment and care plan development are presented at the Interdisciplinary Care Team (IDCT) meetings for review
- A root cause analysis and new interventions are determined and updated in the plan of care.
- Problems that are no longer active will be noted and maintained as part of the participant's past history.
- The care plan is developed by the IDCT
- The IDCT contributes toward the development of a comprehensive care plan based upon the specialized needs of the participant
- The PCSP incorporates the participant's goals of care as well as his/her functional, medical and psychosocial needs
- The Care Manager discusses the PCSP with the participant or their authorized representative at the time of initial and semi-annual assessment or whenever the participant experiences a significant change in condition
- Care plan conversations are held with the participant or authorized representative; these conversations may be face-to-face or telephonic as it relates to the participant's care needs

PCSP Elements

The individual care plan may include, but not be limited to, the following:

- Participant's risk stratification/ acuity level
- Self-management goals
- Resources/specific services and benefits to be utilized
- Determining the appropriate level of care
- Coordination of the participant's Medicare and Medicaid benefits
- Planning for continuity of care, including care transitions
- Potential barriers to achieving their identified goals
- Collaborative approaches to be used, including family participation
- Providing educational materials and one-to-one education
- Short and long-term goals
- Participant self-reported information
- Information obtained from the PCP or specialist
- Pharmacy profile
- *Supplemental Benefits/Add-On Services include:*
  - Transportation
  - Vision
  - Dental
  - Telehealth house calls

Coordination of Services

- Care Manager coordinate and conduct out-reach calls to participants and/or providers in conjunction with their respective care plans.
- Communication is frequent to the PCP, treating provider or specialist, keeping them informed of the participant's condition and potential needs

- Care Managers maintain comprehensive case notes on all participants in the medical management system, as well as other applicable files. This includes, but is not limited to, the following:
  - Telephone contacts with provider
  - Telephone contacts with participant, and/or participant's legal guardian
  - Educational mailings sent to participants
  - Community resources shared or mailed to the participant
  - Assessment outcomes
  - Appointments and/or services

Coordination of services also includes, but is not limited to:

- Community-based and facility-based LTSS
- Self-direction of services
- Behavioral health
  - How to identify behavioral health and community-based and facility-based LTSS needs
  - How to obtain services to meet behavioral and community-based and facility-based LTSS needs
- Durable medical equipment (issues related to access and use)
- Care transitions
- Skilled nursing needs
- Pharmacy and Part D services (medications and their adverse effects)
- Depression, challenging behaviors, Alzheimer's disease and other disease-related dementias

Olmstead Act

In 2009, the Civil Rights Division launched an aggressive effort to enforce the Supreme Court's decision in *Olmstead v. L.C.*, a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. President Obama issued a proclamation launching the "Year of Community Living," and has directed the Administration to redouble enforcement efforts. The Division has responded by working with state and local governments officials, disability rights groups and attorneys around the country, and with representatives of the Department of Health and Human Services, to fashion an effective, nationwide program to enforce the integration mandate of the Department's regulation implementing Title II of the ADA.

Wellness Principles

- Wellness is an active process
- Wellness involves positive proactive choices that enhance physical, intellectual, emotional, social, spiritual, and environmental health.
- MetroPlusHealth seeks to increase access to primary care and preventive health services for participants by ensuring access to primary care providers (PCP) annually and following an admission to the hospital, mental health facility or nursing home which is a key factor in preventing readmissions.

- Each participant will have a comprehensive, customized care and service plan that addresses their needs for services, primary and preventive health care, behavioral health services, dental and vision care, and specialty medical services as needed. A participant-centered focus, coupled with the engagement of each participant's circle of support, is the primary objective of the SNP program to support personal outcomes.
- MetroPlusHealth seeks to increase the number of SNP participants that have the following preventive services:
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Colon Cancer Screening
  - Prostate Cancer Screening
  - Annual Physical Exam
  - Diabetic Screening and Management
  - Immunizations – influenza, pneumonia, hepatitis B
  - Glaucoma Screening
  - Smoking Cessation
  - Abdominal Aortic Aneurysm screening
  - Bone Mineral Density
  - HIV Testing

XXXVII NATIONAL DIABETES PREVENTION PROGRAM

Effective February 1, 2020, the National Diabetes Prevention Program (NDPP) is included in the Medicaid managed care (MMC) benefit package. This applies to mainstream MMC plans, HIV Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs).

Overview

The National Diabetes Prevention Program (NDPP) is an evidence-based educational and support program, taught by trained Lifestyle Coaches, that is designed to prevent or delay the onset of type 2 diabetes. This benefit will cover 22 NDPP group training sessions over the course of a calendar year and is taught using a trained lifestyle coach.

Eligibility

Members may be eligible for diabetes prevention services if they have a recommendation by a physician or other licensed practitioner and are:

- At least 18 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

Also, they must meet *one* of the following criteria:

- They have had a blood test result in the prediabetes range within the past year, or
- They have been previously diagnosed with gestational diabetes, or
- They score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test: http://www.diabetes.org/are-you-at-risk/diabetes-risk-test/

Program Structure

- Does not limit NDPP services to once per lifetime,
- Consists of only in-person group training sessions,
- Requires sessions be taught using a CDC-approved curriculum,
- Requires sessions be taught by trained Lifestyle Coaches, who can be health professionals or non-licensed personnel,
- Requires sessions be approximately one-hour in length,
- Requires sessions include recording of the member's body weight.
- Year-long program
  - At least 16 weekly sessions in months 1 – 6
  - At least 6 monthly sessions in months 7 – 12

NDPP Provider information

- Providers should bill on an 837P
- Provider enrollment and maintenance information can be found at the following link: https://www.emedny.org/info/ProviderEnrollment/ndpp/index.aspx
- •The Medicaid enrolled provider listing can be found here: https://health.data.ny.gov/Health/Medicaid-Enrolled-Provider-Listing/keti-qx5t

Service Description	Units	MEDS Category of Services (COS)	HCPCS Procedure Code	Provider Specialty Code
In-person NDPP group counseling sessions	Per member, per session	01	0403T	105
Incentive Payment	Once over the course of 22 sessions, when member first achieves the 5% weight-loss baseline	01	G9880	105

UPDATED
JUNE 2020

MetroPlusHealth

WE'RE METROPLUSHEALTH. WE'RE NEW YORK CITY.