MEMBER HANDBOOK

2020

plan ahead.

MetroPlus

Managed Long Term Care

MORE THAN JUST A HEALTHPLAN

MEMBER HANDBOOK

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I. Welcome to MetroPlus Managed Long Term Care

Dear MetroPlus MLTC Member,

Thank you for choosing MetroPlus Health Plan, Managed Long Term Care (MLTC), a program especially designed to provide people 21 years old and older who need Long Term Care Services and live in Brooklyn, Manhattan, the Bronx, Queens, or Staten Island with the opportunity to live independently at home.

MetroPlus MLTC offers coordinated services, providing health care assistance and facilitating access to the special services and programs you need. Our plan covers a wide range of services and benefits. This handbook will help you understand your coverage, benefits, and how to access the services you need.

We want you to be satisfied with the services we provide you under our MLTC plan. If you have any questions or concerns, please reach out to our dedicated Member Services Department Monday through Saturday, 8 am - 8 pm, by calling 1-855-355-MLTC (6582). After hours and on holidays please call our 24/7 Health Hotline at 1-800-442-2560, a representative will connect you to the MLTC staff member on call. TTY users can call 711. We will be glad to help you with all your needs. You can also visit our website www.metroplus.org.

Thank you for becoming a MetroPlus member.

Wishing you good health,

Talya Schwartz, MD
MetroPlus Health Plan President & Chief Executive Officer

MetroPlus Health Plan
160 Water Street
New York, NY 10038

MetroPlus Managed Long Term Care Plan is approved by the New York State Department of Health as a managed long-term care program for individuals who need long term care services and other health-related services. By enrolling in our plan, you will receive a coordinated plan of care and will have a Care Manager to help manage your care and services.

II. Enrollment

Enrolling in MetroPlus Managed Long Term Care is voluntary. MetroPlus will comply with the Conflict Free Evaluation and Enrollment Center enrollment protocols and implementation plan as further defined in guidance issued by the Department. As part of the MetroPlus Managed Long Term Care Enrollment Process, a nurse will call and arrange a home visit to discuss MetroPlus Managed Long Term Care face to face with you and your family. The nurse will review the eligibility criteria with you, and help determine if you qualify to be in the program. The nurse will also complete an assessment to evaluate your health and safety.

After the initial home visit assessment, your nurse care manager will begin to develop your individual care plan. Your care manager will contact you and your doctor to discuss your individual needs and coordinate services on your behalf.

If your doctor does not want to work with MetroPlus, we will discuss options with you. If you decide that you would like to change doctors, we can help you choose another doctor in your neighborhood.

When you choose to enroll in MetroPlus Managed Long Term Care, you may withdraw your application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment by indicating his/her wishes orally or in writing; we will confirm your withdrawal in writing.

MetroPlus's initial assessment for MLTC eligibility will be conducted within thirty (30) days of first contact by an individual requesting enrollment or of receiving a referral from the Enrollment Broker or other source.

To join MetroPlus Managed Long Term Care (MLTC) you must meet the following MLTC enrollment criteria:

- Be at least 21 years of age.
- Be a resident of the Bronx, Brooklyn, Manhattan, Queens, or Staten Island.
- Be eligible for Medicaid.
- Be able to stay at home safely without risk or harm to your health and safety.
- Be eligible for nursing home level of care at the time of enrollment, Medicaid only
- Be eligible for Managed Long-Term Care using an eligibility assessment tool (UAS)
- Require at least one of the following Community Based Long-Term care services for more than 120 days from the effective date of enrollment:
    - Nursing services in the home
    - Private Duty Nursing
    - Therapies in the home
    - Home Health Care Services
    - Personal Care Services in the home
    - Adult Day Health care
    - Consumer Directed Personal Assistance Services (CDPAS)

Conflict Free Evaluation and Enrollment Center

All initial eligibility determinations for potential enrollees new to community based long term care services are made by a Conflict-Free Evaluator. New York State's Conflict Free Evaluation and Enrollment Center is run by New York Medicaid CHOICE or Maximus, a state contractor. All persons seeking information about the MetroPlus MLTC plan, or seeking enrollment into such products will be forwarded to Maximus in accordance with Departmental rules and guidance. If Maximus determines persons to be eligible for MLTC, they will be forwarded to the MLTC plan of their choice.

Potential members transferring from another MLTC plan do not need a Conflict Free Evaluation.

Maximus can be reached by telephone:

Phone: 1-855-222-8350

Hours of Operation:

Monday – Friday: 8:30AM to 8:00PM

Saturday: 10AM – 6PM

Transfer from Mainstream Managed Care to Managed Long Term Care

Medicaid applicants can enroll when there is a need of a service that cannot be provided in the MMCP or if the member has become eligible for Medicare and meets MLTC enrollment criteria.

Medicaid only enrollees in a Mainstream Managed Care Plan who wish to enroll in MetroPlus MLTC must meet the need of at least one of the following services:

- Home Delivered or Congregate Meals
- Social Day Care Services (SDCS)
- Environmental Modification and Support
- ***In addition, the applicant must meet the MLTC enrollment criteria mentioned above.***

During the transfer process, MetroPlus staff is available to assist applicants if needed and help complete required forms; supporting applicants in the transfer process.

Transitional Care

New members may continue an ongoing course of treatment for a transitional period of up to 60 days from the effective enrollment date with a non-network health care provider. The provider must accept payment at the plan rate, follow MetroPlus Managed Long Term Care's quality assurance and other policies, and tell us about your medical care. This period will apply even if the provider fails to notify the plan and request authorization during the 60-day transitional period.

If your health care provider leaves the network, your treatment may be continued for a transitional period of up to 90 days; if the provider accepts payment at the plan rate, follows MetroPlus Managed Long Term Care's quality assurance and other policies, and tells us about your medical care. Continuity of care applies to all covered services including home health care and private duty nursing services.

Authorization for this transitional period does not apply for non-covered benefits. Coverage during the transitional period will continue at no additional cost.

If you are transitioning from a Medicaid community based long term care program, we will continue to provide services authorized under your preexisting plan for a minimum of ninety (90) days. The plan will also issue a notice of action for any restriction, reduction, suspension or termination of authorized services, for those transitioning from a Medicaid community-based managed long-term care program.

The plan will authorize and cover Community Based Long Term Care Services (CBLTCS) and Institutional Long-Term Services and Supports (ILTSS) at the same level, scope and amount as you received under a Medicaid fee-for service program for 90 days following enrollment or until MetroPlus' PCSP is in place, whichever is later. MetroPlus will not deny payment to providers of transitional care CBLTCS and ILTSS solely on the basis that the provider failed to request prior authorization except where a Participating Provider Agreement describes an alternate arrangement for authorization of transitional care. Finally, MetroPlus shall work a CBLTCS and ILTSS provider to arrange a safe transition for the Enrollee, which may be to a higher level of care, where an existing medical order has or is about to expire, and a new medical order is required for the continued provision of CBLTCS and ILTSS during the transitional period but cannot be obtained after reasonable effort.

How to Contact MetroPlus Managed Long Term Care

For help with questions or concerns about your claims, billing, ID card or your Care Manager, please call or write to MetroPlus Managed Long Term Care Member Services. We are happy to help you.

Call:	**1-855-355-MLTC (6582)** Monday through Saturday 8 am - 8 pm After hours and during holidays please call **1-800-442-2560** and you will be connected to an MLTC staff member. Calls to this number are free. Member Services also has free language interpreter services available for non-English speakers.
TTY Users:	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Fax:	1-212-908-5282
Write:	MetroPlus Health Plan MLTC 160 Water Street, 3rd Floor New York, NY 10038
Website:	**www.metroplus.org**

III. Special Features of MetroPlus Managed Long Term Care

Care Management

As a member of MetroPlus Managed Long Term Care, you have a single number to access all medically necessary services. This number is **1-855-355-MLTC (6582)**. TTY User number is 711.

When you join MetroPlus Managed Long Term Care, you will be assigned a Care Manager and others to help support and manage your care needs. The team consists of your Care Manager, a Care Management Associate, and a Social Worker. Your Care Manager with the rest of your care team, will work with you, your family, your primary care physician (PCP) or others that you choose to work on your behalf.

Your Care team members are available to assist you with any issues. They are there to help you decide what services are most important to help you remain at home. The Care Management Team will develop a Person-Centered Service Plan (PCSP), in collaboration with you or anyone that you assigned to speak on your behalf and your doctor, designed to meet your health care needs. The PCSP will include your goals, objectives and special needs. This plan will change as your needs and condition change and will be re-evaluated at least every six (6) months. The Care Management team will monitor this plan to ensure that it continually meets your needs.

To monitor your needs, it is important for your Care Management Team to talk to you and for you to communicate with the team. They need to know what you need. Be sure to have a list of things prepared to discuss whenever you talk to members of your Care Management Team.

Your Care Management Team (Care manager and Care Management Associate) will work to coordinate services that you need to meet your care needs. The team will also communicate with your doctor on an ongoing basis and as needed. The Care Management Team will arrange appointments for you, assist with accessing transportation to and from appointments, and communicate with other care providers, for services covered by MetroPlus Health Plan, as well as for those services not covered by MetroPlus.

The goal of the Care Management Team working so closely with you, your family or friends and your doctors is to ensure that your needs are met, problem are identified and addressed early, you are safe in your home and we avoid unnecessary hospitalizations.

IV. Benefits

Covered Services

MetroPlus is responsible for coordinating, arranging, and authorizing payment to providers for these services. Covered services are provided to you through our network of participating providers.

Covered Services Include:

Covered Services	Definition
Care Management	Care Management is a process that ensures consistent oversight, coordination and support to you and your family in accessing MLTCP- covered services as well as non-covered services. To meet the needs that are outlined in your PCSP, care management teams refer and coordinate medical, social, educational, psychosocial, financial and other services.
Nursing Home Care (Residential Health Care Facility also known as Institutional Long-Term Services and Supports (ITLSS))	Short or long-term care provided in a NYS licensed skilled care residential facility. Care is provided to you through MetroPlus network facilities.
Home Care - Nursing	Intermittent, part-time nursing services. Nursing services must be provided by RNs and LPNs. Nursing services include care rendered directly to the individual and instructions to caregiver in the procedures necessary for your treatment or maintenance.
Home Health Aide	Home Health Aide services in addition to Vital Signs, administrating pre-drawn insulin, passive range of motion exercises, and housekeeping services.

Private Duty Nursing	Private duty nursing services are medically necessary services provided to you at your permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies (CHHAs).
Physical Therapy (PT)	Exercise and physical activities used to condition muscles and improve levels of activity. PT must be provided by a licensed physical therapist in accordance with your plan of care. Coverage of physical therapy provided in a setting other than a home is limited to 40 visits per calendar year. However, a member will be approved based on need and as required by the plan of care.
Occupational Therapy (OT)	Therapy using meaningful activities of daily living to assist people who have difficulty acquiring or performing meaningful work due to impairment or limitation of physical or mental function. OT must be performed by a licensed occupational therapist in accordance with your plan of care. Coverage of occupational therapy provided in a setting other than a home is limited to 20 visits per calendar year. However, a member will be approved based on need and as required by the plan of care.
Speech Therapy (ST)/ Speech Language Pathology	A licensed and registered speech-language pathologist provides rehabilitation services for maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Coverage of speech therapy provided in a setting other than a home is limited to 20 visits per calendar year. However, a member will be approved based on need and as required by the plan of care.
Adult Day Health Care (ADHC)	Care and services provided in a health care facility which includes: medical, nursing, nutrition, social services, rehabilitation therapy, leisure time activities, dental, or other services.

Social Day Care (SADC)	Social day care is a structured program which provides functionally impaired individuals with socialization; supervision and monitoring; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include but are not limited to personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.
Social and Environmental Supports	Services and items include, but are not limited to, home maintenance tasks, homemaker/care services, housing improvement, and respite care.
Personal Care Services (PCS)	Assistance with one or more activities of daily living (ADLS), such as walking, cooking, cleaning, bathing, using the bathroom, personal hygiene, dressing, feeding, nutritional and environment support function tasks.
Consumer Directed Personal Assistance Service (CDPAS)	Allows you or the person acting on your behalf to assume full responsibility for hiring, training, supervising, arranging back-up coverage when necessary, keeping payroll records, and if necessary terminating the employment of person providing personal care services. This service allows you to have someone in your home that you are familiar with taking care of you.
Personal Emergency Response System	An electronic device which enables you to secure help in the event of a physical, emotional or environmental emergency.
Podiatry	Services by a podiatrist which may include routine foot care when they are performed as a necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections.
Non-Emergency Transportation	Transportation to and from your medical appointments via the necessary mode of transportation which could include Ambulance (must meet the necessary criteria), Ambulette/Van or car service.

Optometry/Eyeglasses	Includes the services of an optometrist and an ophthalmic dispenser, eyeglasses, medically necessary contact lenses and other low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by your condition.
Audiology	Audiology services include examination, testing, hearing aid evaluation, and prescription.
Hearing aids and batteries	Hearing aid services include selecting, fitting, repairs, replacement replacements, special fittings and batteries.
Dentistry	Includes but is not limited to routine exams, preventive and therapeutic dental care, dental implants, dentures and supplies.
Respiratory Therapy	The provision of preventive, maintenance and rehabilitative airway-related techniques and procedures including oxygen and other inhalation therapies prescribed by a physician and provided by a qualified respiratory therapist.
Nutrition	Nutritional services are available through a certified dietician or your care manager to assist you and make specific recommendations based on your needs.
Telehealth Services	Telehealth services use electronic information and communication technologies to deliver health care services like assessment, diagnosis, consultation, treatment, education, care management and/or self-management.
Home Delivered or Congregate Meals	Meals delivered to you if you lack cooking facilities or have other special circumstances.
Durable Medical Equipment (DME)	Includes medical/surgical supplies, prosthetics and orthotics, orthopedic footwear, enteral and parenteral formula, and hearing aid batteries. Durable medical equipment includes devices and equipment, other than prosthetic or orthotic appliances and devices, that must have been ordered by a practitioner for use in the home and are for in the treatment of a specific medical condition.

Medical/Surgical Supplies	Items for medical use other than drugs, which treat a specific medical condition such as diabetes, wound dressings and other prescribed therapeutic supplies.
Medical Equipment	Adaptive devices and equipment prescribed by a medical provider.
Orthotics	Appliances and devices used to support or correct the function of a movable part of the body.
Orthopedic Footwear	Shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.
Prosthetics	Artificial substitute or replacement of a limb.
Nutritional supplements - Enteral and parenteral	Liquid nutritional supplements that is prescribed by your physician based on medical necessity.

Non-Covered Services

You can still receive the following services listed below. Medicare and/or Medicaid may cover these services on a fee-for-service basis from a provider who accepts Medicare and/or Medicaid.

These Are Some Examples of Non-Covered Services:

Non-Covered Services	Definition
Chronic Renal Dialysis	Method used to treat advanced and permanent kidney failure, provided by a renal dialysis center.
Emergency transportation	Transportation by ambulance because of an emergency condition.
Inpatient hospital care services	A hospital or other institutional bed for receiving care, including room, board and general nursing.
Outpatient hospital care services	Care received in a clinic, medical office or other site affiliated with a hospital without staying in the hospital.

Laboratory and Radioisotope Services	Tests and procedures ordered by a qualified medical professional.
Rural Health Clinic Services	Federally Qualified Health Centers (FQHCs) providing affordable, quality primary care services.
Mental Health Services	Medical specialty concerned with the prevention, diagnosis, and treatment of mental illness.
Primary Care Physician and Specialty Doctor Services	Preventive care, primary medical care and specialty services that fall within a physician's scope of practice. This includes nurse practitioners and physician assistants. Physician services can include services provided in an office setting, a clinic, a facility, or in the home. MetroPlus will not cover a home visiting doctor.
Alcohol and Substance Abuse Services	Services includes both inpatient and outpatient care. Inpatient services include but are not limited to: assessment, management of detoxification and withdrawal conditions, group, individual or family counseling, alcohol and substance abuse education, treatment planning, preventive counseling, discharge planning, and services to significant others provided in-home, office or the community. The following care is also provided: outpatient alcoholism rehabilitation services through programs certified by the Office of Alcoholism and Substance Abuse Services (OASAS).
OPWDD (Office for People with Developmental Disabilities) Services	Include: long term therapy services provided by clinic treatment facilities, certified by OPWDD, day treatment services, comprehensive Medicaid Case Management services; and home and community-based waiver program services for the developmentally disabled.
Family Planning Services	Include services for family planning such as fertility testing.
Prescription and Non-Prescription Drugs, Compounded Prescriptions	include drugs on the “New York State List of Medicaid Reimbursable Drugs: Non-Prescription Drugs and Prescription Drugs” (inclusive of those agents such as blood products) as well as supplies which appear on the list of “Allowable Medical and Surgical Supplies” which are ordered by a qualified practitioner.
Chiropractic Services	

X-Ray and other Radiology Services	

Health Education

Health education is provided to Enrollees on an on-going basis through methods such as posting information on the Contractor's web site, distribution (electronic or otherwise) of Enrollee newsletters, health education classes or individual counseling on preventive health and public health topics, such as:

- Injury prevention;
- Domestic violence;
- HIV/AIDS, including availability of HIV testing and sterile needles and syringes;
- STDs, including how to access confidential STD services;
- Smoking cessation;
- Asthma;
- Immunization;
- Mental health services;
- Diabetes;
- Screening for cancer;
- Chemical dependence;
- Physical fitness and nutrition;
- Cardiovascular disease and hypertension;
- Dental care, including importance of preventive services such as dental sealants; and
- Screening for Hepatitis C for individuals born between 1945 and 1965.

Hospice

As a Member of MetroPlus MLTC, if you require and meet the eligibility requirements for hospice services, you may elect the hospice benefit without disenrolling from MetroPlus. These services may be provided in your home or in a residential setting. These services will be covered and billed directly to Medicare and Medicaid as appropriate. MetroPlus will coordinate with your hospice to provide any care that is unrelated to your terminal illness in order to support your needs.

Nursing Home

Nursing Home care is care is care provided to Enrollees by a licensed facility. There may come a time when your doctor, your Primary Care Management Team, and you and your family decide that the best short or long-term care for you is placement in a nursing home. This is because your home is no longer the best place for you to be taken care of safely and comfortably. Your care with MetroPlus

will not end if that time comes. You MetroPlus Care Team will carefully supervise this placement and you will continue to receive care through the plan.

When nursing home care is required, a semi-private room will be provided in a network facility. If your doctor determines it to be medically necessary, a private room will be covered.

Please note, if you have community Medicaid and are ineligible for institutional coverage (as determined by the NYC Human Resources Administration (HRA) or Local Department of Social Services (LDSS)) and you need care in a nursing home, we will have to disenroll you from the plan.

Limitations

- Outpatient OT and ST are limited to 20 visits per year, per therapy and PT is limited to 40 visits per year. (Limitation does not apply to individuals with developmental disabilities.)
- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Coverage of certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
- Nursing Home Care is covered for individuals who are considered a permanent placement, provided you are eligible for institutional Medicaid coverage.
- If you are a veteran, you have the right to receive long term placement at a Veterans' home. If MetroPlus does not have a Veterans' home in our network, you will be allowed to change enrollment into a Managed Long-Term Care Plan that has a Veterans' home in network. MetroPlus will allow you to access the Veterans' home until you have changed MLTC plans.
- If you already have Medicare and/or Medicare supplemental coverage and benefits, they will not change. Medical benefits, for instance your doctor's visits, emergency room care, and hospitalization, are not covered by MetroPlus Managed Long Term Care, but may be covered by other sources.
- Health care services delivered by telehealth are covered by the MetroPlus. Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee. Telehealth provider means:

physician, physician assistant, dentist, nurse practitioner, registered professional nurse (only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring), podiatrist, optometrist, psychologist, social worker, speech language pathologist, audiologist, midwife, certified diabetes educator, certified asthma educator, certified genetic counselor, hospital, home care agency, hospice, or any other provider determined by the Commissioner of Health pursuant to regulation.

Emergency and Urgent Care Services

An emergency can be any medical or behavioral condition that would lead you to believe that the condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing your health in serious jeopardy.

You are not required to get prior approval from MetroPlus Managed Long Term Care to be treated for emergency medical conditions. **If you need Emergency Services, call 911 right away or visit the nearest hospital or emergency room.** Wherever you have an emergency or urgent situation, get the care first, and then contact your Care Manager as soon as you can.

It's important that you, a family member or a friend call your Care Manager as soon as possible at 1-855-355-MLTC (6582) after an emergency or urgent care service. TTY users can call 711 Your Care Manager can reschedule any planned services you might miss during that time, and start to make any needed changes to your Care Plan. He or she will help you avoid any unnecessary gaps in the services you might need. If you have Medicare and/or Medicare supplemental coverage and benefits and/or Medicaid, your emergency care will be covered by them and by your MLTC plan.

Our Network Providers

Members are required to use our Network Providers for all covered services. Your Care Manager will also coordinate any services you may require that are not covered by MetroPlus Managed Long Term Care. Your Care Manager will work with your doctor and other providers involved in your care to make this process easier for you.

If you have additional Medicare benefits, you have the freedom to choose providers for covered services paid for by Medicare. MetroPlus Managed Long Term Care pays the Medicare co-pays for covered services if Medicare is the primary payor.

Network providers will be paid in full directly by MetroPlus Managed Long Term Care for each service authorized and provided to you with no co-pay or cost to you. If you receive a bill for covered

services authorized by MetroPlus MLTC, you are not responsible to pay the bill; please contact Member Services at 1-855-355-MLTC (6582) (TTY: 711). You may be responsible for payment of covered services that were not authorized by MetroPlus Managed Long Term Care, or for covered services that are obtained by providers outside of the MetroPlus Managed Long Term Care network.

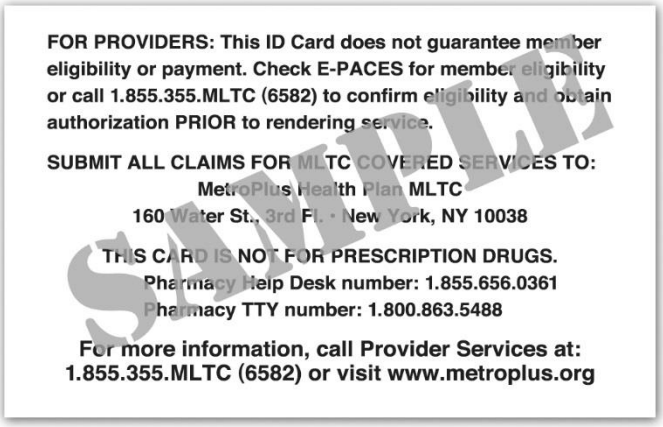
You must pay for services that are not covered by MetroPlus Managed Long Term Care or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them.

Your Care Plan:

Your Care Manager will develop a care plan that is specific to meeting your individual medical, physical, emotional, and social needs, based on the initial comprehensive assessment. Your care plan is based on your comprehensive assessments and identifies your individual needs. Your care plan is reviewed at least every six months but can be reviewed more often if your condition and needs change. You will receive a copy of your care plan.

Your Identification Card

As soon as you become a member of our plan, you will receive an ID card that will be used to identify who you are and give you access to the benefits you have under MetroPlus Managed Long Term Care. Your ID card will be attached to the Welcome letter you receive in the mail along with your Provider Directory. When you get your ID card, you should make sure that all of the information on it is correct. Here is a sample ID card to show you what yours will look like:



It is important to show your ID card if you are asked to prove that you are a member of MetroPlus Managed Long Term Care. Carry your ID card with you at all times. Your Medicaid card can still be used for any services that are **not** covered by our plan. You **DO NOT** have to show your MetroPlus ID card before you receive emergency care. In case of emergency, call 911 or go to the nearest emergency room.

If you have questions or your ID card is damaged, lost or stolen, call Member Services right away at 1-855-355-MLTC (6582), (TTY users: 711) Monday through Saturday 8 am - 8 pm. We will mail you a new ID card.

V. Service Authorizations & Action Requirements

As a member of MetroPlus Managed Long Term Care you are covered for specific treatments and services. To get approval for these treatments or services you need to **call your Care Manager or Member Services at 1-855-355-MLTC (6582) or 711 (TTY Users).** Member Services also has free language interpreter services available for non-English speakers. A Member Services representative will answer any questions you have about the process. The decision to authorize the service will be made if the care is medically necessary.

Definitions:

Prior Authorization is a request by you, or a provider on your behalf, for coverage of new service (whether for a new authorization period or within an existing authorization period); or a request to change a service as determined in the care plan for a new authorization period, before such services are provided to you.

Concurrent review is a request by you, or a provider on your behalf, for additional services that are currently authorized in the care plan or for Medicaid covered home health services following an inpatient admission.

Expedited review: You will receive an expedited review of your Service Authorization Request when the plan or your provider indicates the standard timeframe would seriously jeopardize your (the enrollee's) health, life or ability to maintain or regain maximum function. You or your provider may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a concurrent review must be handled as expedited.

For Prior Authorizations, we will decide and notify you as fast as your condition requires, or within 3 business days after we receive the necessary information, but no more than 14 days after we receive the request for services. If Expedited, we will decide and notify you as fast as your condition requires or within 72 hours after we receive the request.

For Concurrent Reviews, we will decide and notify you as fast as your condition requires or within 1 business day after we receive the necessary information, but no more than 14 days after we receive the request for services.

If Expedited, we will decide and notify you as fast as your condition requires but no more than 72 hours after we receive the request.

In the case of a request for Medicaid covered home health services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day after the request for

services falls on a weekend or holiday, seventy-two (72) hours after receipt of necessary information.

You or your provider may request an extension of up to 14 calendar days. MetroPlus may initiate an extension of up to 14 calendar days if the reason is in your best interest and well-documented and justified. You or your doctor may also submit a service authorization request by fax or mail to:

Fax: **212-908-5282**

Mail: **MetroPlus Health Plan MLTC**
160 Water Street, 3rd Floor
New York, NY 10038
Attention: Prior Authorization

The following services require **prior authorization:**

- Personal Care Aide (PCA) or Home Health Aide (HHA)
- 24-hour Aide Service
- Registered Dietician (RD)
- Home Delivered Meals/Congregate meals
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- DME
- Telehealth
- Medical supplies
- Prosthetics and orthotics
- Non-emergency Transportation
- Social Day Care
- Adult Day Health Care
- Dentures and other appliances
- Optometry services
- Eyeglasses and other adaptive equipment
- Podiatry services (outpatient / office visits)
- Personal Emergency Response System
- Placement in LTC facility
- Environmental supports including:
    - Heavy duty house cleaning
    - Pest control / extermination

- Safe Return Bracelets
- Personal Safety devices

Upon receipt of your request, it will be reviewed by your care team and processed as standard or expedited (fast process). You or your doctor can ask for an expedited review if it is believed that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will notify you and your request will be handled under the standard review process. In all cases, we will review your request as fast as possible, but no later than mentioned below.

We will notify you and your provider in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you do not agree with our decision.

Generally, the standard review time frame for a prior authorization is between 3 and 14 days from when we receive the information about your request.

• Standard review: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
• Expedited (fast) review: We will make a decision and you will hear from us within 72 hours. We will tell you by the 3rd work day if we need more information.
For concurrent reviews, the standard time frame for a pre-authorization is between **1 and 14 days** after we receive your request.

• Standard review: We will make a decision within 1 work days of when we have all the information we need, but no later than 14 days after we received your request.
• Expedited review: We will make a decision within 72 hours of when we have all the information we need.
• In the case of a request for Medicaid covered home health services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, 72 hours after receipt of necessary information.
If your doctor feels that your life, health or ability to get better would be placed at risk by waiting for a standard review time frame, you can request an expedited time frame by contacting your Care Manager.

• For prior authorizations, the expedited review will be completed **within** 72 hours
• For concurrent reviews, the expedited review will be completed **within** 72 hours.

If we need more information to make either a standard or expedited decision about your service request, the timeframes above can be extended up to 14 days. We will:

• Write and tell you what information is needed. If your request is an expedited review, we will call you right away and send a written notice later.
• Tell you why the delay is in your best interest.
• Make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the **end of** original timeframe.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-855-355-MLTC (6582) or writing.
You or someone you trust can file a complaint with the plan if you do not agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

If you are not happy with the decision we make, you can appeal our decision. Please see Section X, Member Complaints and Appeal Process, for instructions on how to do this.

VI. Termination of Coverage

Voluntary Disenrollment

You can request to be voluntarily disenrolled from MetroPlus Managed Long Term Care at any time for any reason. You may disenroll from, or leave, the Plan for any reason by giving a notice in writing or verbally. If your notice is given verbally, MetroPlus Managed Long Term Care will confirm the notice with you in writing. To leave MetroPlus Managed Long Term Care you must let us know that you want to disenroll. MetroPlus Managed Long Term Care will contact you or the person you trust to find out the reason you no longer want to be part of the Plan, but you do not need to give a reason if you do not want to. However, please note that in order to receive community based long term care services, you must be enrolled in a plan or a waiver program. You can receive the services if you are enrolled in a Managed Care plan or a Managed Long-Term Care plan.

You will be asked to sign a disenrollment request form. This form will let you know a tentative date of disenrollment, or the date in which you will no longer be entitled to get services though MetroPlus Managed Long Term Care. MetroPlus Managed Long Term Care will forward your disenrollment request to New York Medicaid CHOICE to process your disenrollment.

Involuntary Disenrollment

MetroPlus Health Plan MUST disenroll you involuntarily (without your consent) for any of the following reasons:

- You no longer live in the service area. You move from Brooklyn, Queens, Manhattan or Bronx.
- You enroll in another Medicaid MLTC, BCHS or OPWDD Day Treatment Program;
- You are absent from the service area (Brooklyn, Bronx, Queens or Manhattan) for more than 30 consecutive days;
- You are hospitalized for 45 consecutive days or have entered an OMH, OPWDD or OASAS residential program for 45 consecutive days or more;
- You clinically require nursing home care, but are not eligible for such care under the Medicaid program’s institutional rules;
- You cannot remain safely at home or in your community;
- You are no longer eligible to receive New York State Medicaid benefits;
- You are incarcerated
- You do not require Managed Long-Term Care services from MetroPlus for more than 120 days as determined by your last reassessment;

- You are not eligible for MLTC because you have been assessed as no longer demonstrating a functional or clinical need for community-based long-term care services or, for non-dual eligible Enrollees, no longer meet the nursing home level of care as determined using the assessment tool prescribed by the Department. An Enrollee whose sole service is identified as Social Day Care must be disenrolled from the MLTC plan. MetroPlus Health Plan shall provide the LDSS or entity designated by the Department the results of its assessment and recommendations regarding disenrollment within five (5) business days of the assessment making such determination.

MetroPlus Health Plan MAY disenroll you involuntarily (without your consent) for any of the following reasons:

- You do not pay for/or make satisfactory arrangements approved by MetroPlus Managed Long Term Care to pay spenddown amount owed to MetroPlus Health Plan after a (30) thirty-day grace period;
- You knowingly fail to complete and submit any necessary consents or releases as requested by MetroPlus Health Plan;
- You give MetroPlus Health Plan false information that deceives the Plan, or you engage in fraudulent conduct regarding any substantive or major aspect of your plan membership;
- You, your family member or informal caregiver participate in any activity which jeopardizes the environment, engages in conduct or behavior which can jeopardize your health, safety or the health or safety of others.

Any involuntary disenrollment requires approval from New York Medicaid CHOICE (Maximus), if approved New York Medicaid CHOICE (Maximus) will notify you in writing the effective date of your disenrollment and your fair hearing rights.

The effective date of disenrollment from MetroPlus will be the first day of the month following the month in which the disenrollment request is received and is processed by the New York Medicaid Choice. Generally, a signed request form must be received by MetroPlus by the 15th of the month for a disenrollment to become effective the next month. MetroPlus will continue to provide services until the effective disenrollment date.

VII. Medicaid Spenddown

What Is Spenddown?

This is a program that allows certain people to qualify for Medicaid coverage even though they receive income higher than the Medicaid level.

The New York City Human Resources Administration (NYC-HRA) determines if you have a spenddown and will notify you of your spenddown amount.

MetroPlus will make all reasonable efforts to collect such amounts, including writing a letter to you requesting payment**. If you fail to pay or fail to make satisfactory payment arrangements with us after a thirty (30) day grace period, we will involuntarily disenroll you from MetroPlus Managed Long Term Care.**

VIII. Rights and Responsibilities

Rights

As a MetroPlus Managed Long Term Care member you have the right to:

- Get medically necessary care;
- Be treated with respect and dignity at all times;
- Privacy of your medical record and treatment;
- Protection against discrimination or unfairness no matter your health status, race, color, sex, national origin, sexual orientation, age, marital status or religion;
- Receive information in a language you understand, with verbal translation available free of charge;
- Receive a copy of your medical records and request the records be changed or corrected;
- Receive information on available treatment options and alternatives, presented in a language and manner you understand, free from any form of restraint, force, discipline, inconvenience, or retaliation;
- Participate in treatment decisions about your health care and your right to refuse treatment;
- Receive information needed to give informed consent before starting treatment;
- Complain to the New York State Department of Health or the local Department of Social Services and the right to use the New York State Fair Hearing system or in some cases request a New York State External Appeals or appoint someone (relative, friend, lawyer, etc.) to speak for you if you are not able to speak for yourself about care and treatment;
- A fair hearing and external appeal;
- Have authorized services continue when requesting a fair hearing;
- Make advance directives and plans for your care; and
- Seek assistance from the Participant Ombudsman program.

Responsibilities

As a MetroPlus Managed Long Term Care member you are responsible for:

- Using our provider network for all covered services and obtaining authorizations when necessary;
- Maintaining eligibility;
- Cooperating with your Care Manager and service plan;
- Notifying the plan when you go away or will be out of town;
- Cooperating with and being respectful to MetroPlus Managed Long Term Care staff;
- Notifying the plan about your needs and concerns; and

- Making all required payments to the plan.
- If you have Medicaid with a spenddown, agree to pay your monthly spenddown amount

IX. Participant Ombudsman

MetroPlus will cooperate with, and may not inhibit, the Participant Ombudsman in the exercise of its duties.

The Participant Ombudsman is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. These services include, but are not necessarily limited to:

- providing pre-enrollment support, such as unbiased health plan choice counseling and general program-related information,
- compiling enrollee complaints and concerns about enrollment, access to services, and other related matters,
- helping enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the State level, and assisting them through the process if needed/requested, including making requests of plans and providers for records, and
- informing plans and providers about community-based resources and supports that can be linked with covered plan benefits.

MetroPlus will, upon request, provide the Participant Ombudsman entity with a current list of Participating Providers in MetroPlus Health Plan's MLTC Plan.

At this time, the Participant Ombudsman is the Independent Consumer Advocacy Network (ICAN), an independent network of consumer advocacy organizations. ICAN is available to answer long-term care enrollee's questions regarding enrollee rights, Medicare, Medicaid and long term care services. You can also call ICAN to get free, independent advice about your coverage, complaints, and appeals options. They can help you manage the appeal process. Contact ICAN to learn more about their services.

ICAN can be reached at:

Phone: 1-844-614-8800 (TTY Relay Service: 711)
Web: www.icannys.org or email: ican@cssny.org

X. Member Complaints, Appeals, & Fair Hearings

MetroPlus Health Plan will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by MetroPlus Health Plan staff or a health care provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint or to appeal a plan action, please call: 1-855-355- MLTC (6582) (TTY: 711) or write to: MetroPlus Health Plan, Complaints Manager, 160 Water Street, 3rd Fl, New York, NY 10038. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two timeframes.

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your

appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When MetroPlus Health Plan denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal.

If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request

that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 1-855-355-MLTC (6582) (TTY: 711) or writing to MetroPlus Health Plan, Complaints Manager, 160 Water Street, 3rd Fl, New York, NY 10038. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while your appeal is being decided. We must continue your service if you make your request no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later.

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

Although you may request a continuation of services while your appeal is under review, if the appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases you may request an "expedited" appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 72 hours. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

Your benefits will continue until you withdraw the Fair Hearing; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

- Online Request Form: http://otda.ny.gov/oah/FHReq.asp

- Mail a Printable Request Form:
  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 22023
  Albany, New York 12201-2023

- Fax a Printable Request Form: (518) 473-6735

- Request by Telephone:
  Standard Fair Hearing line – 1 (800) 342-3334
  Emergency Fair Hearing line – 1 (800) 205-0110
  TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:
  New York City
  14 Boerum Place, 1st Floor
  Brooklyn, New York 11201

For more information on how to request a Fair Hearing, please visit:
http://otda.ny.gov/hearings/request/

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to

deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

Service Authorizations & Action Requirements

Definitions

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee's behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such service is provided to the Enrollee.

Concurrent Review: review of a request by an Enrollee, or provider on Enrollee's behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Expedited Review: An Enrollee must receive an expedited review of his or her Service Authorization Request when the plan determines or a provider indicates that a delay would seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.

General Provisions

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered health care professional when such determination is based on an assessment of the Enrollee's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit when coverage is dependent on an assessment of the Enrollee's health status, and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals, and out-of-network services.

The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance.

The Contractor shall utilize the Department's model MLTC Initial Adverse Determination and 4687 MLTC Action Taken notices.

Timeframes for Service Authorization Determination and Notification

1. For Prior Authorization requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

    a. Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request
    b. Standard: Fourteen (14) days after receipt of request for Service Authorization Request.

2. For Concurrent Review Requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

    a. Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request
    b. Standard: Fourteen (14) days of receipt of the Service Authorization Request
    c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

3. Up to 14 calendar day extension. Extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.

    a. The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination and help the enrollee by listing potential sources of the requested information.

4. Enrollee or provider may appeal decision – see Appeal Procedures.

5. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.
    a. The Contractor must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee's service request will be reviewed in the standard timeframe.

Other Timeframes for Action Notices

1. When the Contractor intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:

   a. the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or
   b. the Contractor may mail notice not later than date of the Action for the following:

      i. the death of the Enrollee;
      ii. a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);
      iii. the Enrollee's admission to an institution where the Enrollee is ineligible for further services;
      iv. the Enrollee's address is unknown, and mail directed to the Enrollee is returned stating that there is no forwarding address;
      v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or
      vi. the Enrollee's physician prescribes a change in the level of medical care.

   c. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)-(b).

      i. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a non-business day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals

   d. The Contractor must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,

   e. When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

Contents of Action Notices

1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.
2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:

    i) the date the restriction will begin;
    ii) the effect and scope of the restriction;
    iii) the reason for the restriction;
    iv) the recipient's right to an appeal;
    v) instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
    vi) the right of Contractor to designate a primary provider for recipient;
    vii) the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;
    viii) the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
    ix) the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;
    x) the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
    xi) the name and telephone number of the person to contact to arrange a conference;
    xii) the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
    xiii) the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;
    xiv) the right of the recipient to examine his/her case record; and
    xv) the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This information is generally referred to as “claim detail” or “recipient profile” information.

Filing Complaints with the NYS Department of Health

If at any time you are dissatisfied with how MetroPlus has treated you or how we have handled your grievance or appeal, you may contact the Department of Health directly at:

New York State Department of Health
Bureau of Managed Long-Term Care
One Commerce Plaza, Room 1620
Albany, NY 12210
Telephone: 1-866-712-7197

Required Plan Documentation for Appeals

MetroPlus Managed Long Term Care will keep a file on each appeal (both expedited and standard) that includes:

- A copy of the notice of action
- The date the appeal was filed
- A copy of the appeal
- Member/provider requests for expedited appeals and the plan's decision
- The date of receipt of and a copy of the enrollee's acknowledgment letter of the appeal (if any)
- Necessary documentation to support any extension
- The determination made by the plan, including the date of the determination
- In the case of clinical determinations, the credentials of the personnel who reviewed the appeal

Information Upon Request

The following information can be requested by calling MetroPlus Managed Long Term Care Member Services at 1-855-355-MLTC (6582).

- Information on the structure and operation of MetroPlus Managed Long Term Care;
- List of names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the plan;
- Copy of the most recent annual certified financial statement of the plan, including a balance sheet and summary of receipts and disbursements prepared by a CPA;
- Procedures for protecting the confidentiality of medical records and other enrollees;
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and improvement program;
- Description of procedures followed by MetroPlus Managed Long Term Care in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;
- Specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the plan might consider in its utilization review process;
- Written application procedures and minimum qualification requirements for health care providers.

Consumer Directed Personal Assistance Services

As part of your managed long-term care services, you may be eligible to self-direct your care. Consumer Directed Personal Assistance Services (CDPAS) is a specialized program where a member or a person acting on a member's behalf (known as a designated representative) self directs and manages the member's personal care and other authorized services.

CDPAS members have greater flexibility and freedom in choosing their personal aide services, home health services and/or skilled nursing services that they are eligible to receive. The member and/or designated representative is responsible for hiring, training, supervising, and if necessary terminating the employment of his or her aide.

To learn more about CDPAS, including your eligibility for this program, contact your Care Manager.

Any restriction, reduction, suspension or termination of authorized CDPAS (including CDPAS itself) or denial of a request to change CDPAS is considered an adverse determination which may be appealed by the Enrollee and for which the Enrollee may request a fair hearing or external appeal upon a final adverse determination.

XI. Glossary

ADULT DAY HEALTH CARE is care and services provided to you outside of the home, under a doctor's care, if you require some medical services but are not homebound. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental pharmaceutical, and other ancillary services. Enrollee participation in an ADHC and authorization for a limited service or payment option do not constitute a need for CBLTCS and eligibility for plan enrollment.

APPLICANT is someone who wants to be enrolled in a managed long-term care plan.

CMS is the U.S. Centers for Medicare and Medicaid Services, formerly known as Health Care Financing Administration (HCFA).

CARE PLAN (or **Plan of Care**) is a written record of your health care goals and the details of the services you receive. This is based on the first meeting you have with a nurse when you join the plan, as well as conversations with you, your family, and/or people you trust. We will monitor how well the plan is working for you and may make changes depending on your health status.

CARE MANAGEMENT means a process that assists the Enrollee to access necessary covered services as identified in the Person-Centered Service Plan (PCSP). Care management services include referral, assistance in or coordination of services for the Enrollee to obtain needed medical, social, educational, psychosocial, financial and other services in support of the PCSP, irrespective of whether the needed services are included in the Benefit Package.

CHHA stands for Certified Home Health Agency.

COMMUNITY BASED LONG TERM CARE SERVICES (CBLTCS) means health care and supportive services provided to individuals of all ages and functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. CBLTCS is comprised of services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, Personal Care Services.

DHHS is the Department of Health and Human Services of the United States.

DURABLE MEDICAL EQUIPMENT (DME) includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula and hearing aid batteries.

ENROLLEE is a person enrolled in MetroPlus Managed Long Term Care.

GRIEVANCE is a complaint by you or a provider on your behalf about the care and treatment you receive. This does not include a change in scope, amount or duration of the services you receive. A grievance can be made verbally or in writing.

HOME CARE includes services provided to you at home, including services like nursing, home health aides, nutritional services, social work services, physical therapy, occupational therapy, and speech/language pathology.

HOME HEALTH AIDE is someone who carries out health care tasks under the supervision of a registered nurse or licensed therapist. They may also provide assistance with personal hygiene, housekeeping, and other related tasks if you have health care needs in your home.

HRA is the New York City Human Resources Administration. It is a Mayoral Agency of the New York City government in charge of most of the city's social services programs, such as food assistance and emergency rental assistance.

INSTITUTIONAL LONG-TERM SERVICES AND SUPPORTS (ITLSS) mean Residential Health Care Facility (Nursing Home) services as included in the Benefit Package and provided by the plan when medically necessary.

LDSS is a Local Department of Social Services. In New York City, the LDSS is called the NYC Human Resources Administration.

LONG TERM PLACEMENT (Permanent Placement) STATUS means the status of an individual in a Residential Health Care Facility (RHCF) when the entity designated by the State determines that the individual is not expected to return home based on medical evidence affirming the individual's need for long term (permanent) RHCF placement.

MEDICAL SOCIAL SERVICES cover the aid you may receive from a social worker to help deal with social problems related staying in your home. These services will be included in your plan of care.

NURSING SERVICES includes all types of nursing services provided to you based on your doctor's recommendation. This can include direct care, or instructions from the nurse to your family or caretaker on how to help with your treatment.

PERSONAL CARE provides assistance you need with activities like personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care has to be medically necessary, ordered by your doctor, and provided by a qualified person as stated in your plan of care.

PRIVATE DUTY NURSING SERVICES are medically necessary services provided to Enrollees at their permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies (CHHAs).

PCP stands for Primary Care Physician and means the main doctor who cares for you.

SOCIAL AND ENVIRONMENTAL SUPPORTS are services and items that support your medical needs and are included in your plan of care. These services and items include things like home maintenance tasks, homemaker/chore services, housing improvement, and respite care.

SOCIAL DAY CARE is a structured program which provides socialization, supervision and monitoring, and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. This may also include personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.

SOCIAL SERVICES are programs provided by the LDSS, Social Security Administration, and other sources that provide benefits which include financial assistance, medical assistance, food stamps, or other support programs. Social services also provide support and address problems in your living environment and daily activities that will assist you with remaining in the community.

TELEHEALTH is the use of technology to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee.

UAS-NY (UNIFORM ASSESSMENT SYSTEM FOR NEW YORK) (NFLC) is the comprehensive assessment tool used by New York State Managed Long Term Care programs to identify the needs and level of services of members. Eligibility for MLTC is determined utilizing this tool. Members must score a 5 or above to be eligible for the program.