A plan for life.

NEW YORK STATE MEDICAID MANAGED CARE MEMBER HANDBOOK

NEW YORK STATE | Department of Health | Medicaid

December 2023

NOTICE OF NON-DISCRIMINATION

Capital District Physicians' Health Plan, Inc., CDPHP Universal Benefits, Inc., and Capital District Physicians' Healthcare Network, Inc. (collectively known as CDPHP®) comply with Federal civil rights laws. **CDPHP** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CDPHP provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - » Qualified sign language interpreters
  - » Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - » Qualified interpreters
  - » Information written in other languages

If you need these services, call CDPHP at 1-800-388-2994. For TTY/TDD services, call 711.

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

- Mail: CDPHP Civil Rights Coordinator, 6 Wellness Way, Latham, NY 12110
- Phone: 1-844-391-4803 (for TTY/TDD services, call 711)
- Fax: (518) 641-3401
- In person: 6 Wellness Way, Latham, NY 12110
- Email: https://www.cdphp.com/customer-support/email-cdphp

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

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

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ATTENTION: Language assistance services, free of charge, are available to you. Call (518) 641-3800 or 1-800-388-2994 (TTY: 711).	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (518) 641-3800 o 800-388-2994 (TTY: 711).	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (518) 641-3800 或 1-800-388-2994（聽力障礙電傳：711）。	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 641-3800 (518) أو 1-800-388-2994 (رقم هاتف الصم والبكم: 711)	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (518) 641-3800 또는 1-800-388-2994 (TTY: 711) 번으로 전화하십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (518) 641-3800 или 1-800-388-2994 (телетайп TTY: 711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (518) 641-3800 o il 1-800-388-2994 (TTY: 711).	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (518) 641-3800 ou le 1-800-388-2994 (TTY : 711).	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (518) 641-3800 oswa 1-800-388-2994 (TTY: 711).	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט (518)-641-3800 אדער 1-800-388-2994 (TTY:711).	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (518) 641-3800 lub 1-800-388-2994 (TTY: 711)	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (518) 641-3800 o 1-800-388-2994 (TTY: 711).	Tagalog
লক্ষ্য রাখবেন: আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ। (518) 641-3800 বা 1-800-388-2994 (TTY: 711) নম্বরে কল করুন।	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <(518) 641-3800 ose 1-800-388-2994> <TTY/711>.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε το (518) 641-3800 ή 1-800-388-2994 (TTY: 711).	Greek
خبردار: زبان کی مدد کی خدمات، آپ کو مفت دستیاب ہیں۔ 641-3800 (518) یا 1-800-388-2994 پر کال کریں۔ (TTY: 711).	Urdu

HERE'S WHERE TO FIND INFORMATION YOU WANT

WELCOME TO SELECT PLAN, CDPHP'S MEDICAID MANAGED CARE PROGRAM

We are glad that you chose CDPHP. This handbook will be your guide to the full range of health care services available to you. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at (518) 641-3800 or 1-800-388-2994.

HOW MANAGED CARE WORKS

The Plan, Our Providers, and You

- You may have heard about the changes in health care. Many consumers now get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, now those services may be available through CDPHP.
- CDPHP has a contract with the State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs and other health care facilities make up our provider network. You'll find a list in our provider directory. If you don't have a provider directory, call 1-800-388-2994 to get a copy or visit the Find a Doc feature on our website at www.CDPHP.com.
- When you join CDPHP one of our providers will take care of you. Most of the time that person will be your PCP (Primary Care Provider). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it. Your PCP is available to you everyday, day and night.
- If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services.
- You may be restricted to certain plan providers or services if you have been identified as a restricted recipient. Below are examples of why you may be restricted:
  - getting care from several doctors for the same problem.
  - getting medical care more often than needed.
  - using prescription medicine in a way that may be dangerous to your health.
  - allowing someone other than yourself to use your plan ID card.

Confidentiality

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

HOW TO USE THIS HANDBOOK

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

The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.

When you have a question, check this Handbook or call our Member Services unit. You can also call the managed care staff at your local Department of Social Services. Those numbers are listed in the back of this book.

If you live in Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, or Washington County, you can also call the New York Medicaid Choice Helpline at 1-800-505-5678.

HELP FROM MEMBER SERVICES

There is someone to help you at Member Services:

Monday through Friday, 8 a.m. to 6 p.m.

Call (518) 641-3800 or 1-800-388-2994.

(TTY/TDD machine for hearing impaired at 711.)

Walk-in hours: Monday–Friday, 8:30 a.m. to 4:30 p.m. (Please call for appointment.)

If you call after business hours and need assistance with accessing services for care, you will be connected to our care team. If your call is not urgent or an emergency you also have the option to leave a message and someone will call you back the next business day.

- You can call to get help **anytime you have a question**. You may call us to choose or change your Primary Care Provider (PCP for short), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby or ask about any change that might affect you or your family's benefits.
- If you are or become pregnant, your child will become part of CDPHP on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your local social services office right away if you become pregnant and let us help you to choose a doctor for your **newborn baby** before he or she is born.
- We offer free sessions to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that is best for you.
- If you would like to know more about CDPHP and how we can best help you, please call our member services line, to get more information during that call or to request an in-person meeting at CDPHP.
- **If you do not speak English,** we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can serve you in your language
- **For people with disabilities:** If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:
  - TTY machine (Our TTY phone number is 711.)
  - Information in Large Print
  - Case Management
  - Help in Making or Getting to Appointments
  - Names and Addresses of Providers Who Specialize in Your Disability
- **If you or your child are getting care in your home now**, your nurse or attendant may not know you have joined our plan. **Call us right away** to make sure your home care does not stop unexpectedly.

YOUR HEALTH PLAN ID CARD

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

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

PART I—FIRST THINGS YOU SHOULD KNOW

HOW TO CHOOSE YOUR PCP

- You may have already picked your PCP (Primary Care Provider) to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP for you and your family, you should do so right away**. If you do not choose a doctor within 30 days, we will choose one for you.
- Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services ((518) 641-3800 or 1-800-388-2994) can check to see if you already have a PCP or help you choose a PCP.
- CDPHP provides an online list of all doctors, clinics, hospitals, pharmacies and others who work with us in the Find-A-Doc section of www.CDPHP.com. You can also ask to receive a printed book with this information. If you would like one mailed to you, please call Member Services or you can fill out and return the post card on the back of your member information packet.
- The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP.
  You may want to find a doctor:
  - Whom you have seen before,
  - Who understands your health problems,
  - Who is taking new patients,
  - Who can serve you in your language, or
  - Who is easy to get to.
- Women can also choose one of our OB/GYN doctors to deal with women's health care. Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if needed, and regular care during pregnancy.
- You may also choose to select a PCP within a Behavioral Health clinic.
- We also contract with FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialtycare. Some consumers want to get their care from FQHCs, because the centers have a long history in the neighborhood. Maybe you want to try them, because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or, you can sign up with a primary care physician at one of the FQHCs that we work with. Just call Member Services at 1-800-388-2994 for help.
- In almost all cases, your doctors will be CDPHP providers. There are four instances when you can still see another doctor that you had before you joined CDPHP, even if he or she does not work with our plan. In both cases, however, your doctor must agree to work with CDPHP. You can continue to see your doctor if:
  1. You are more than 3 months pregnant when you join CDPHP and you are getting prenatal care. In that case, you can keep your doctor until after your delivery through postpartum care.
  2. At the time you join CDPHP, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your doctor for up to 60 days.
  3. At the time you join CDPHP, you are being treated for a behavioral health condition. In most cases, you can still go to the same provider. Some people may have to choose a provider that works with the health plan. Be sure to talk to your provider about this change. CDPHP will work with you and your provider to make sure you keep getting the care you need.
  4. At the time you join CDPHP, regular Medicaid paid for your home care and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse or attendant, and the same amount of home care, for at least 90 days.

- If you have a long-lasting illness, like HIV/AIDS or other long term health problems, you may be able to **choose a specialist to act as your PCP (primary care provider)**. Your PCP, after speaking with the CDPHP medical director and a specialist, may issue a referral/authorization to a specialist with experience in treating your condition. That specialist will be able to provide and assist with your primary and specialty care. A referral/authorization will be made, along with a treatment plan approved by CDPHP after talking to your PCP, the specialist, and you. The specialist shall be able to treat you without a referral/ authorization from your PCP, under the terms of the treatment plan.
- If you need to, you can c**hange your PCP** in the first 30 days after your first appointment with your PCP. After that, you can change up to once every 6 months without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to whom your PCP has referred you.
- If your **provider leaves CDPHP**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider if you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with the Plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at (518) 641-3800 or 1-800-388-2994.

HOW TO OBTAIN INFORMATION ABOUT PRACTITIONERS

To learn more about our network physicians, go to Find-A-Doc at www.cdphp.com or request a printed provider directory from member services. Both sources indicate whether a doc-tor is board certified. Member services can also give you more information on a doctor's qualifications. Call them at the number on your ID card.

HOW TO GET REGULAR CARE

"Regular care" means exams, regular check ups, shots or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need.

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

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

  For children and youth, medically necessary means health care and services that are medically 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.
- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know.
- As soon as you choose a PCP, call to make a first appointment. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical back-ground, any problems you have now, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.
- **If you need care before your first appointment**, call your PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the first appointment.)

- Use the following list as an **appointment guide for our limits on how long you may have to wait after your request for an appointment:**
  - Adult baseline and routine physicals: within 12 weeks,
  - Urgent care: within 24 hours,
  - Non-urgent sick visits: within 3 days,
  - Routine, preventive care: within 4 weeks,
  - First pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd),
  - First newborn visit: within 2 weeks of hospital discharge,
  - First family planning visit: within 2 weeks,
  - Follow-up visit after mental health/substance use disorder ER or inpatient visit: 5 days,
  - Non-urgent mental health or substance use disorder clinic visit: 1 week.

HOW TO GET SPECIALTY CARE AND REFERRALS

- If you need care that your PCP cannot give, he or she will REFER you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are plan providers. Talk with your PCP to be sure you know how referrals work.
- If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a dif-ferent specialist.
- There are some treatments and services that your PCP must ask CDPHP to approve *before* you can get them. Your PCP will be able to tell you what they are. If you are having trouble getting a referral you think you need, contact Mem-ber Services at (518) 641-3800 or 1-800-388-2994.
- If we do not have a specialist in CDPHP who can give you the care you need, we will get you the care you need from a specialist outside CDPHP. This is called an **out-of-network referral**. You will need prior authorization from CDPHP. This is true even if the CDPHP network does not have the right specialist to meet your particular health care needs. To ask for an out-of-network referral, call CDPHP at (518) 641-4100 or 1-800-274-2332. Your PCP will be contacted and asked to supply a treatment plan explaining why you need an out-of-plan referral. We will assess the treatment plan and consult with your PCP and the out-of- plan provider and make a decision within three (3) business days. When a decision is made, you will receive a letter from a CDPHP medical director telling you whether your request has been approved or denied. Specific information needed to file an appeal will be explained in the denial letter. If your PCP or CDPHP refers you to a provider outside our network, you are not responsible for any of the costs except any copayments as described in this handbook.
- Sometimes we may not approve an out-of-network referral because we have a provider in the CDPHP's network that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a **Plan Appeal**. See page 16 to find out how.
- Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from a CDPHP's net-work provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a **Plan Appeal**. See Page 16 to find out how.
- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.
- If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:
  - Your specialist to act as your PCP; or

- A referral to a specialty care center that deals with the treatment of your illness.

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

GET THESE SERVICES FROM CDPHP SELECT PLAN WITHOUT A REFERRAL

Women's Health Care

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

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

Family Planning

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

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

Or, you can *use your Medicaid card* if you want to go to a doctor or clinic outside CDPHP. Ask your PCP or call Member Services at (518) 641-3800 or 1-800-388-2994 for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

HIV and STI Screening

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

- You can get an HIV or STI test any time you have an office or clinic visit.
- You can get an HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with any family planning provider. If you want an HIV or STI test, but *not as part of a family planning service,* your PCP can provide or arrange it for you.
- Or, if you'd rather not see one of CDPHP's providers, you can use your Medicaid card to see a family planning provider outside CDPHP's network. For help in finding either a Plan provider or a Medicaid provider for family planning services call Member Services at 518-641-3800 or 1-800-388-2994.
- Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

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

Eye Care

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

New eyeglasses (with Medicaid approved frames) are usually provided once every two years at a participating provider. You should check our Provider Directory or Find-A-Doc on www.CDPHP.com to see if your eye doctor is approved to dispense eyeglasses. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses, or broken eyeglasses that can't be fixed, will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

You may self-refer to Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York.

Behavioral Health (Mental Health and Substance Use)

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

Please note: You can call us with a behavioral health concern 24 hours a day, seven days per week, at 1-888-320-9584. TTY/TDD users, call 711.

Smoking Cessation

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

Maternal Depression Screening

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

Diagnosis and Treatment of Tuberculosis

You do not need a referral to go to a public health agency facility for the diagnosis and/or treatment of TB.

EMERGENCIES

You are always covered for emergencies.

An emergency means a medical or behavioral condition:

- That comes on all of a sudden, and
- Has pain or other symptoms.

An emergency would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.

Examples of an emergency are:

- A heart attack or severe chest pain,
- Bleeding that won't stop or a bad burn,
- Broken bones,
- Trouble breathing, convulsions, or loss of consciousness,
- When you feel you might hurt yourself or others,
- If you are pregnant and have signs like pain, bleeding, fever, or vomiting.
- Drug overdose.

Examples of **non-emergencies** are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles.

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

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

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

If you're not sure, call your PCP or CDPHP.

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

- Tell you what to do at home,
- Tell you to come to the PCP's office, or
- Tell you to go to the nearest emergency room.

If you are **out of the area** when you have an emergency:

- Go to the nearest emergency room.

Remember

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

The emergency room should NOT be used for problems like the flu, sore throats, or ear infections.

If you have questions, call your PCP or CDPHP at (518) 641-3800 or 1-800-388-2994.

URGENT CARE

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

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

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at (518) 641-3800 or 1-800-388-2994. Tell the person who answers what is happening. They will tell you what to do.

NON-EMERGENCY CARE OUTSIDE THE SERVICE AREA

Non-emergency services delivered outside the CDPHP network are not covered unless they are previously authorized. If you are traveling and have a medical need that is urgent but not an emergency—such as a sore throat or infection—call the CDPHP resource coordination department at 1-800-274-2332. They will advise you and approve needed care. Routine preventive care—such as a checkup—is not covered out of the service area.

CARE OUTSIDE OF THE UNITED STATES

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

WE WANT TO KEEP YOU HEALTHY

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

- Classes for you and your family,

- Stop-smoking classes,
- Pre-natal care and nutrition,
- Grief/loss support,
- Breast feeding and baby care,
- Stress management,
- Weight control,
- Cholesterol control,
- Diabetes counseling and self-management training.
- Asthma counseling and self-management training.
- Sexually Transmitted Infection (STI) Testing & Protecting Yourself from STIs
- Domestic Violence Services

Call Member Services at (518) 641-3800 or 1-800-388-2994 to find out more and get a list of upcoming classes.

PART II—YOUR BENEFITS AND PLAN PROCEDURES

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

BENEFITS

Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. CDPHP will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self referral services, including those you can get from within the plan and some that you can choose to go to any Medicaid provider of the service. Please call our Member Services department at (518) 641-3800 or 1-800-388-2994 if you have any questions or need help with any of the services below.

SERVICES COVERED BY CDPHP SELECT PLAN

You must get these services from the providers who are in CDPHP. All services must be medically or clinically necessary and provided or referred by your PCP (primary care provider).

Regular Medical Care

- Office visits with your PCP
- Referrals to specialists
- Eye/hearing exams

Preventive Care

- Well-baby care
- Well-child care
- Regular check-ups
- Shots for children from birth through childhood
- Access to Early and Periodic Screening, Diagnosis and Testing (EPSDT) for enrollees from birth to age 21 years
- Smoking cessation counseling. Enrollees are eligible for unlimited sessions as medically necessary.
- Access to free needles and syringes
- HIV education and risk reduction

Maternity Care

- Pregnancy care
- Doctors/mid-wife and hospital services
- Newborn nursery care
- Screening for depression during pregnancy and up to a year after delivery

Infertility Services

If you are unable to get pregnant, CDPHP covers services that may help. CDPHP covers some prescription drugs for infertility. This benefit is limited to coverage for three cycles of treatment per lifetime. CDPHP will also cover services related to prescribing and monitoring the use of such drugs. The infertility benefit includes:

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

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

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

National Diabetes Prevention Program (NDPP) Services

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

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

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

Eligibility

You may be eligible for diabetes prevention services if you have a recommendation by a physician or other licensed practitioner and are:

- At least 18 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

And, you meet one of the following criteria:

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

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

To learn more about these services, call Member Services at 518-641-3800 or 1-800-388-2994.

Home Health Care

- Must be medically needed and arranged by CDPHP
- One medically necessary post partum home health visit, additional visits covered as medically necessary for high-risk women
- At least two visits to high-risk infants (newborns)
- Other home health care visits as needed and ordered by your PCP/specialist

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

- Must be medically needed and arranged by CDPHP
- Personal Care/Home Attendant—Help with bathing, dress-ing and feeding and help with preparing meals and housekeeping
- CDPAS—Help with bathing, dressing and feeding, help in preparing meals and housekeeping plus home health aide and nursing tasks. This is provided by an aide chosen and directed by you. If you want more information contact Member Services at 1-800-388-2994

Personal Emergency Response System (PERS)

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

Adult Day Health Care Services

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

AIDS Adult Day Health Care Services

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

Therapy for Tuberculosis

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

Hospice Services

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

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

If you have any questions about this benefit, you can call Member Services Department at 518-641-3800 or 1-800-388-2994.

Dental Care

CDPHP believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Delta Dental, an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. *You do not need a referral from your PCP to see a dentist!*

How to Get Dental Services:

You can see any dentist in the Delta Dental network for your needed care. Delta Dental has a directory of dental providers available for you. The providers in that directory are listed alphabetically by city, provider number, and provider name. To find a Delta Dental provider in your area, find your city and look for your zip code. To find the most current listing of Delta Dental providers in your area, call 1-800-542-9782 (TTY/TDD 711), 8 a.m. to 8 p.m. EST, Monday through Friday. There is an Interactive Voice Response system available 24 hours per day, 7 days per week. Or visit: deltadentalins.com/cdphp-medicaid.

- You will receive a separate Delta Dental ID card that you can show to any Delta Dental provider for dental services.
- You can also go to a dental clinic that is run by an academic dental center without a referral.

Orthodontic Care

CDPHP will cover braces for children up to age 21 who have a severe problem with their teeth, such as not being able to chew food due to severely crooked teeth, cleft palette, or cleft lip.

Vision Care

- Services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, poly-carbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider
- Eye exams, generally every two years, unless medically needed more often
- Glasses (new pair of medicaid approved frames every two years, or more often if medically needed)
- Low vision exam and vision aids ordered by your doctor
- Specialist referrals for eye diseases or defects

Hospital Care

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

Directly Observed Therapy for Tuberculosis Disease

- Provides observation and dispensing of medication, assessment of any adverse reactions to medications and case follow up

Emergency Care

- Emergency care services are procedures, treatments, or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the Emergency Room, in an inpatient hospital room, or in another setting. This is called Post Stabilization Services.
- For more about emergency services, see page 11.

Specialty Care

Includes the services of other practitioners, including:

- Physical therapist—Medically necessary visits ordered by a doctor or other licensed professional will be covered
- Occupational and speech therapists—Medically necessary visits ordered by a doctor or other licensed professional will be covered
- Audiologist
- Midwives
- Cardiac rehabilitation
- Podiatrists

To learn more about these services, call Member Services at the number identified below.

Residential Health Care Facility Services (Nursing Home)

Covered nursing home services include:

- Medical supervision
- 24-hour nursing care
- Assistance with daily living
- Physical therapy
- Occupational therapy
- Speech-language pathology and other services

To get these nursing home services

- The services must be ordered by your physician, and
- The services must be authorized by CDPHP.

Rehabilitation

CDPHP covers short term, or rehab stays, in a skilled nursing home facility.

Long Term Placement

CDPHP covers long term placement in a nursing home facility for members 21 years of age and older. **Long term placement means you will live in a nursing home.**

When you are eligible for long term placement, you must select one of the nursing homes that are in CDPHP's network.

If you want to live in a nursing home that is not part of CDPHP's network, you may transfer to another plan that works with the nursing home you have chosen to receive your care.

Eligible Veterans, Spouses or Eligible Veterans, and Gold Star Parents of Eligible Veterans may choose to stay in a Veterans' Nursing Home.

CDPHP does not have a Veterans' Home in its network. If you are an Eligible Veteran, a Spouse of an Eligible Veteran, or a Gold Star Parent of an Eligible Veteran and you want to live in a Veterans' Home, we will help arrange your admission. You must transfer to another Medicaid Managed Care health plan that has a Veterans' Home in its network.

Determining Your Medicaid Eligibility for Long Term Nursing Home Services

You must apply to your Local Department of Social Services (LDSS) to have Medicaid and/or CDPHP pay for long term nursing home services. The LDSS will review your income and assets to determine your

eligibility for long term nursing home services. The LDSS will let you know about any costs you may have to contribute toward your long term nursing home care.

Questions

If you have any questions about these benefits, call our Member Services Department at (518) 641-3800 or 1-800-388-2994, TTY/TDD 711.

Additional Resources

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

- Independent Consumer Advocacy Network (ICAN) provides free and confidential assistance. Call 1-844-614-8800 or visit www.icannys.org
- New York State Office for the Aging
  - Health Insurance Information, Counseling and Assistance (HIICAP) provides free counseling and advocacy on health insurance questions. Call 1-800-701-0501
  - NY CONNECTS is a link to long term service and supports. Call 1-800-342-9871 or visit www.nyconnects.ny.gov
- Nursing Home Bill of Rights (NHBOR) describes your rights and responsibilities as a nursing home resident. To learn more about NHBOR, visit www.health.ny.gov/facilities/nursing/rights/

Harm Reduction Services

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

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

To learn more about these services, call Member Services at (518) 641-3800 or 1-800-388-2994, TTY/TDD 711.

BEHAVIORAL HEALTH CARE

Behavioral health care includes mental health and addiction treatment and rehabilitation services. All of our members have access to behavioral health services, which include:

Adult Mental Health Care

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

- Crisis intervention services
- Comprehensive Psychiatric
- Emergency Program (CPEP), including extended observation bed
- Assertive Community Treatment (ACT)
- Personalized Recovery Oriented Services (PROS)

Adult Mental Health Care

- Comprehensive Psychiatric Emergency Program (CPEP) including extended observation bed
- Crisis intervention services
  - Mobile Crisis and Telephone Crisis Services
- Crisis Residential Programs
  - Residential Crisis Support: This is a program for people who are 18 years or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.
  - Intensive Crisis Residence: This is a treatment program for people who are 18 years or older and are experiencing severe emotional distress.

Gambling Disorder Treatment Provided by Office of Addiction Services and Supports (OASAS) Certified Programs

Capital District Physicians' Health Plan, Inc. covers Gambling Disorder Treatment provided by Office of Addiction Services and Supports (OASAS) certified programs.

This benefit covers both in-person and telehealth treatment options. It also includes coverage for outpatient and if necessary, inpatient, or residential programs administered by OASAS.

Crisis Residence Services for Children and Adults

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

Residential Crisis Support

This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.

Intensive Crisis Support

This is a treatment program for people who are age 18 or older who are having severe emotional distress. To learn more about these services, call Member Services at 1-800-388-2994 (TTY: 711).

Substance Use Disorder Services for Adults Age 21+

- Crisis Services
  - Medically Managed Withdrawal and Stabilization Services
  - Medically Supervised Inpatient Withdrawal and Stabilization Services
  - Medically Supervised Outpatient Withdrawal and Stabilization Services
- Inpatient Rehabilitation Services
- Residential addiction treatment services
  - Stabilization in Residential Setting
  - Rehabilitation in Residential Setting
  - Reintegration

- Outpatient addiction treatment services
  - Outpatient Clinic
    - Intensive Oupatient Treatment
    - Ancillary Withdrawal Services
    - Medication Assisted Treatment
  - Outpatient Rehabilitation Services
  - Opiod Treatment Programs (OTP)

Mental Health Care for Individuals Under Age 21

All eligible children under age 21:

- Comprehensive Psychiatric Emergency Program (CPEP), including extended observation bed
- Partial hospitalization
- Inpatient psychiatric services
- Individual and group counseling through OMH clinics
- Crisis Intervention
- Youth Peer Support (YPS)
- Psychiatric services
- Psychological services
- Injections for behavioral health related conditions
- Children and Family Treatment and Support Services (CFTSS), including:
  - Other Licensed Practitioner (OLP)
  - Psychosocial Rehabilitation (PSR)
  - Community Psychiatric Supports and Treatment (CPST)
  - Family Peer Support Services (FPSS)
  - Crisis Intervention
  - Youth Peer Support (YPS)

Applied Behavior Analysis (ABA) Services

Capital District Physicians' Health Plan, Inc. (CDPHP) covers Applied Behavior Analysis (ABA) therapy provided by:

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

Who can get ABA?

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

The ABA services include:

- Assessment and treatment by a physician, licensed behavioral analyst, or certified behavior analyst assistant
- Individual treatments delivered in the home or other setting
- Group adaptive behavior treatment
- Training and support to family and caregivers

Eligible children under age 21 (minimum age of 18-20):

- Assertive Community Treatment (ACT)
- Continuing day treatment
- Personalized Recovery Oriented Services (PROS)

Children's Crisis Residence

This is a support and treatment program for people under age 21. These services help people cope with an emotional crisis and return to their home and community.

Addiction Care for Individuals Under Age 21

- Crisis services
  - Medically managed withdrawal management
  - Medically supervised withdrawal management (inpatient/outpatient**)
- Inpatient addiction treatment services (hospital or community based)
- Residential addiction treatment services
  - Stabilization in residential setting
  - Rehabilitation in residential setting
- Outpatient addiction treatment services
  - Intensive outpatient treatment
  - Outpatient rehabilitation services
  - *Outpatient withdrawal management
  - Medication assisted treatment
- Opioid Treatment Programs (OTP)
- Community Habilitation
- Day Habilitation
- Caregiver/ Family Advocacy and Support Services
- Adaptive and Assistive Technology (formerly Adaptive and Assistive Equipment)
- Respite Services (Planned Respite and Crisis Respite)
- Prevocational Services—must be age 14 and older+
- Supported Employment—must be age 14 and older
- Vehicle Modifications
- Environmental Modifications
- Palliative Care
  - Expressive Therapy
  - Massage Therapy
  - Bereavement Service
  - Pain and Symptom Management
- Non-Medical Transportation

Children's Home and Community Based Services

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

Children's HCBS

- Are provided where children/ youth and families are most comfortable—at home or in the community
- Support children and youth as they work toward goals and achievements
- Help children and youth be successful at home, in school, and in other environments
- Offer personal, flexible services to meet the health, mental health, substance use treatment and/or developmental needs of each child/youth

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

- Community Habilitation
- Day Habilitation
- Caregiver/Family Advocacy and Support Services
- Adaptive and Assistive Technology (formerly Adaptive and Assistive Equipment)
- Respite Services (Planned Respite and Crisis Respite)
- Prevocational Services—must be age 14 and older +
- Supported Employment—must be age 14 and older
- Vehicle Modifications
- Environmental Modifications
- Palliative Care
  - Expressive Therapy
  - Massage Therapy
  - Bereavement Service
  - Pain and Symptom Management
- Non-Medical Transportation

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

- If you are getting care management from a Health Home Care Management Agency (CMA), you can stay with your CMA. CDPHP will work with your CMA to help you get the services you need.
- If you are getting care management from the Children and Youth Evaluation Service (C-YES), starting October 1, 2019, CDPHP will work with C-YES and provide your care management. To learn more about these services, call Member Services at 1-800-388-2994 (TTY:711)

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

CDPHP will cover Article 29 IVFCA Health Facility services for children and youth under age 21.

- 29-I VFCA Health Facilities
- Work with families to promote well-being and positive outcomes for children in their care
- Use trauma informed practices to meet the unique needs of each child
- Only serve children and youth referred by the local district of social services

Core Limited Health-Related Services: Core Limited Health Related Services will be covered for children and youth placed with a 29-I VFCA Health Facility.

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

And

Other Limited Health-Related Services Other Limited Health Related Services provided by 29-I VFCA Health Facilities will be covered for eligible children and youth.

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

CDPHP will cover Core Limited Health Related Services for children and youth placed with a 29-I VFCA Health Facility.

CDPHP will cover Other Limited Health Related Services provided by 29-I VFCA Health Facilities to eligible children and youth.

To learn more about these services, call Member Services at (518) 641-3800 or 1-800-388-2994.

Other Covered Services

- Durable Medical Equipment (DME)/Hearing Aids/Prosthetics/Orthotics
- Court Ordered Services
- Case Management
- Help getting social support services
- FQHC
- Family Planning including Long Acting Reversible Contraception
- Services of a podiatrist when medically needed

BENEFITS YOU CAN GET FROM CDPHP OR WITH YOUR MEDICAID CARD

For some services, you can choose where to get the care. You can get these services by using your CDPHP membership card. You can also go to providers who will take your Medicaid Benefit card. You do not need a referral from your PCP to get these services. Call us if you have questions at (518) 641-3800 or 1-800-388-2994.

Family Planning

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

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

HIV and STI Screening

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

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

TB Diagnosis and Treatment

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

BENEFITS USING YOUR MEDICAID CARD ONLY

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

Transportation

Non-Emergency: If you need bus, taxi, ambulette or public transportation to get to medical appointments, you or your provider must contact your local Department of Social Services or Medical Answering Services (MAS). If possible, when calling MAS, you or your provider should call at least three days before your medical appointment, and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing. Please contact the number for your county listed below:

County	Non-Emergency Transportation Manager (MAS)
Albany	1-855-360-3549
Columbia	1-855-360-3546
Fulton	1-855-360-3550
Greene	1-855-360-3545
Montgomery	1-855-360-3548
Rensselaer	1-855-852-3293
Saratoga	1-855-852-3292
Schenectady	1-855-852-3291
Schoharie	1-855-852-3290
Warren	1-855-360-3541
Washington	1-855-360-3544

If you require an attendant to go with you to your doctor's appointment or if your child is the member of the plan, transportation is also covered for the attendant or parent or guardian.

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

If you have questions about transportation, please call Member Services at (518) 641-3800 or 1-800-388-2994.

Pharmacy

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

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

Developmental Disabilities

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

Other Medicaid Services

- Pre-school and school services programs (early intervention)
- Early start programs

HEALTH HOME CARE MANAGEMENT

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

A Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your health care;
- Work with the people you trust, like family members or friends, to help you plan and get your care;
- Help with appointments with your PCP and other providers; and
- Help manage ongoing medical issues like diabetes, asthma, and high blood pressure.

To learn more about Health Homes, contact Member Services at (518) 641-3800 or 1-800-388-2994.

SERVICES *NOT* COVERED

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

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Services from a provider that is not part of CDPHP, unless it is a provider you are allowed to see as described else-where in this handbook or CDPHP or your PCP sent you to that provider
- Services for which you need a referral (approval) in advance and you did not get it
- Chiropractic is not a covered service for adults under Medicaid managed care. However, chiropractic services are covered for children under the age of 21 as per Early Periodic Screening Diagnosis and Treatment (EPSDT) program requirements when such services are ordered by a physician.

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

- Non-covered services (listed above),
- Unauthorized services,
- Services provided by providers not part of the plan.

If you have any questions, call Member Services at (518) 641-3800 or 1-800-388-2994.

IF YOU GET A BILL

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call CDPHP at (518) 641-3800 or 1-800-388-2994 right away. CDPHP can help you understand why you may have gotten a bill. If you are not responsible for payment, CDPHP will contact the provider and help fix the problem for you.

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

If you have any questions, call Member Services at (518) 641-3800 or 1-800-388-2994.

SERVICE AUTHORIZATION

Prior Authorization:

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

- Experimental procedures,
- Certain medications,
- Out-of-network care for medically necessary services.

Asking for approval of a treatment or service is called a **service authorization request.**

To get a service authorization request for medical treatments or services, you need to have your PCP contact the CDPHP resource coordination department at (518) 641-4100 or 1-800-274-2332.

Remember, please see the section titled, "How to Get Specialty Care And Referrals," which explains the requirement for your PCP to refer you to see a specialist.

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

What happens after we get your service authorization request:

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

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

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

We will fast track your review if:

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

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

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

Timeframes for prior authorization requests:

- **Standard review:** We will make a decision about your request within three work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests:

- **Standard review:** We will make a decision within one work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision within one work day of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within one workday if we need more information.

Special timeframes for other requests:

- If you are in the hospital or have just left the hospital and you are asking for home health care, we will make a decision within 72 hours of your request.
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your request.
- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.
- If you are asking for an outpatient prescription drug we will make a decision within 24 hours of your request.
- A step therapy protocol means we require you to try another drug first, before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision with 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days of your request.

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-388-2994 or writing to CDPHP, 6 Wellness Way, Latham, NY 12110.

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

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

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

Other Decisions About Your Care:

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

Timeframes for other decisions about your care:

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

Electronic Notice Option:

CDPHP and our vendors can send you notices about service authorizations, plan appeals, complaints and complaint appeals electronically, instead of by phone or mail.

We can send you these notices to you through our secure online member account portal.

If you want to get these notices electronically, you must ask us. To ask for electronic notices contact us by phone, online, fax, or mail:

Phone. . . . . 1-800-388-2994.TTY/TDD users call 711
Online. . . . . https://www.cdphp.com/members
Fax. . . . . .(518) 641-3507
Mail. . . . . 6 Wellness Way, Latham, NY 12110

When you contact us, you must:

- Tell us how you want to get notices that are normally sent by mail,
- Tell us how you want to get notices that are normally made by phone call, and
- Give us your contact information (mobile phone number, email address, fax number, etc.).

CDPHP will let you know by mail that you have asked to get notices electronically.

HOW OUR PROVIDERS ARE PAID

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at (518) 641-3800 or 1-800-388-2994 if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a **salary**. The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many—or even none at all. This is called **capitation**.
- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an **incentive** fund. At the end of the year, this fund is used to reward PCPs who have met the stan-dards for extra pay that were set by the Plan.
- Providers may also be paid by **fee-for-service**. This means they get a Plan-agreed-upon fee for each service they provide.

FILING A CLAIM

Even though you should not be billed for services covered through CDPHP, if you do receive covered services and pay for them out of your own pocket, you may file a claim with us to be reimbursed. Please send the itemized bill and a receipt to: CDPHP, 6 Wellness Way, Latham, NY 12110. Claims should be sent within 90 days of receiving care.

YOU CAN HELP WITH PLAN POLICIES

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at (518) 641-3800 or 1-800-388-2994 to find out how you can help.

Technology Assessment

When new technologies are first introduced to the marketplace, CDPHP may not cover them until we have had the opportunity to ensure that they are medically necessary and have been proven safe and effective. We have a formal process in place to do this. First, we check to be sure they are approved by the FDA or another appropriate regulatory agency. We also need evidence that the service or product in question can improve health outcomes at least as well as existing technologies. This research is performed by members of a CDPHP medical technology assessment team and a CDPHP medical director. These professionals review up-to-date information from at least two sources (including medical literature, board-certified consultants, physician workgroups, professional societies, and government agencies). Drugs that are new to the medical community are reviewed by the CDPHP pharmacy and therapeutics committee.

INFORMATION FROM MEMBER SERVICES

Here is information you can get by calling Member Services at (518) 641-3800 or 1-800-388-2994.

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

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

KEEP US INFORMED

Call Member Services at (518) 641-3800 or 1-800-388-2994 whenever these changes happen in your life:

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

We can either update these changes for you or tell you who to contact for these changes.

If you no longer get Medicaid, check with your local Department of Social Services. You *may* be able to enroll in another program.

DISENROLLMENT AND TRANSFERS

If you want to leave the plan

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

Some examples of good cause include:

- Our health plan does not meet New York State require- ments and members are harmed because of it
- You move out of our service area
- You, the plan, and the LDSS all agree that disenrollment is best for you
- You are or become exempt or excluded from managed care
- We do not offer a Medicaid managed care service that you can get from another health plan in your area
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk
- We have not been able to provide services to you as we are required to under our contract with the State

To change plans:

- Call the Managed Care staff at your local Social Services Department
- If you live in Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, or Washington County, call the New York Medicaid Choice Helpline at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans or disenroll.

- Children entering or being discharged from foster care may change plans at any time even if it is after the first 90 days of enrollment

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

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

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

You Could Become Ineligible for Medicaid Managed Care

- You or your child may have to leave CDPHP if you or the child:
  - Moves out of the County or service area,
  - Changes to another managed care plan,
  - Joins an HMO or other insurance plan through work,
  - Goes to prison, or
  - Otherwise loses eligibility.
- Your child may have to leave CDPHP or change plans if he or she:
  - Joins a Physically Handicapped Children's Program, or
  - Is placed in foster care by an agency that has a contract to provide that service for the local Department of Social Services.
  - Is placed in foster care by the local Department of Social Services in an area that is not served by your child's current plan.

If you have to leave CDPHP or become ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home. Call New York Medicaid Choice at 1-800-505-5678 right away if this happens.

We Can Ask You to Leave CDPHP

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

- Refuse to work with your PCP in regard to your care,
- Don't keep appointments,
- Go to the emergency room for non-emergency care,
- Don't follow CDPHP's rules,
- Do not fill out forms honestly or do not give true information (commit fraud),
- Cause abuse or harm to plan members, providers or staff, or
- Act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems.

PLAN APPEALS

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request.** This process is described earlier in this

handbook. The notice of our decision to deny a service author-ization request or to approve it for an amount that is less than requested is called an **Initial Adverse Determination.**

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

Your provider can ask for reconsideration:

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

You can file a Plan appeal:

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

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services at (518) 641-3800 or 1-800-388-2994 if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impair-ment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

Aid to Continue while appealing a decision about your care:

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

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

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

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

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- Any specific information we said we needed in the Initial Adverse Determination notice.

To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling (518) 641-3800 or 1-800-388-2994.

Give us your information and materials by phone, fax, mail, CDPHP Secure Member Portal or in person:

Phone	(518) 641-3800 or 1-800-388-2994
Fax	(518) 641-3507
Mail	CDPHP Appeals Department 6 Wellness Way, Latham, NY 12110
Online	www.cdphp.com/members *(Sign in to the secure portal)*
In Person	6 Wellness Way, Latham, NY 12110

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. After your call, we will send you a form which is a summary of your phone Plan Appeal. If you agree with our summary, you should sign and return the form to us. You can make any necessary changes before sending the form back to us.

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

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

  1) a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.

  2) two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

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

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

  1) a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and

  2) that recommends an out of network provider with the correct training and experience who is able to provide the service.

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

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call CDPHP at (518) 641-3800 or 1-800-388-2994 if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination.**
- **If you think our Final Adverse Determination is wrong:**
  - You can ask for a Fair Hearing. See the Fair Hearing section of this handbook.
  - For some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
  - You may file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Plan Appeals:

- **Standard Plan Appeals:** If we have all the information we need we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.
- **Fast track Plan Appeals:** If we have all the information we need, fast track Plan Appeal decisions will be made in two working days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
  - We will tell you within in 72 hours if we need more information.
  - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
  - We will tell you our decision by phone and send a written notice later.

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

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

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

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

You or your representative may also ask us to take more time to make a decision. This may be because you have more infor-mation to give the plan to help decide your case. This can be done by calling (518) 641-3800 or 1-800-388-2994 or writing.

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your Plan Appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

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

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:

1) not medically necessary;

2) experimental or investigational;

3) not different from care you can get in the plan's network; or

4) available from a participating provider who has correct training and experience to meet your needs.

The original denial will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care:

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

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

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

External Appeals

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

1) not medically necessary;

2) experimental or investigational;

3) not different from care you can get in the plan's network; or

4) available from a participating provider who has correct training and experience to meet your needs.

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

Before you ask for an External Appeal:

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

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

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at (518) 641-3800 or 1-800-388-2994 if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov.
- Contact the health plan at (518) 641-3800 or 1-800-388-2994

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

You can get a faster decision if:

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

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

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

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

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

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

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

Fair Hearings

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

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving CDPHP.
- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a com-plaint with CDPHP. If CDPHP agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.
- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:

- Reduce, suspend or stop care you were getting; or
- Deny care you wanted;
- Deny payment for care you received; or
- Did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care.

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

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

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

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

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

1. By phone – call toll-free 1-800-342-3334
2. By fax – 518-473-6735
3. By internet – www.otda.state.ny.us/oah/forms.asp
4. By mail – NYS Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   Managed Care Hearing Unit
   P.O. Box 22023
   Albany, New York 12201-2023

When you ask for a Fair Hearing about a decision CDPHP made, we must send you a copy of the **evidence packet**. This is infor-mation we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call (518) 641-3800 or 1-800-388-2994 to ask for it.

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

COMPLAINT PROCESS

Complaints:

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

You can call Member Services at (518) 641-3800 or 1-800-388-2994 if you need help filing a complaint, or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services. We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, New York 12237

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with the Plan:

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

To file a complaint about medical services or mental health or substance use disorder services by phone, call Member Services at (518) 641-3800 or 1-800-388-2994, Monday through Friday, 8 a.m. to 6 p.m. If you call us after hours, leave a message. We will call you back the next work day. If we need more infor-mation to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to CDPHP, Attn: Member Services Department, 6 Wellness Way, Latham, NY 12110.

What happens next:

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

- Who is working on your complaint
- How to contact this person
- If we need more information

You can also provide information to be used reviewing your complaint in person or in writing. Call CDPHP at (518) 641-3800 or 1-800-388-2994 if you are not sure what information to give us.

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

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than seven days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in three work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals:

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

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;
- The complaint appeal must be made in writing. If you make a complaint appeal by phone it must be followed up in writing. After your call, we will send you a form, which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

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

- Who is working on your complaint appeal;
- How to contact this person;
- If we need more information.

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

If we have all the information we need you will know our decision in 30 work days. If a delay would risk your health you will get our decision in two work days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.

Complaints to New York State

You may also file a complaint anytime by contacting:

New York State Department of Health
Corning Tower Building
Empire State Plaza
Albany, NY 12237
1-800-206-8125

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of CDPHP Select Plan, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from CDPHP.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.

- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use the CDPHP complaint system to settle any complaints, or you can complain to the NY State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
- Receive information about CDPHP and managed care in a manner that does not disclose you are enrolled in Medicaid managed care.

Your Responsibilities

As a member of CDPHP Select Plan, you agree to:

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

ADVANCE DIRECTIVES

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

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

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

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

IMPORTANT WEBSITES

CDPHP ..... www.cdphp.com

New York State Department of Health. ..... www.health.ny.gov

New York State Office of Mental Health ..... www.omh.ny.gov

New York State Office of Addiction Services and Supports ..... www.oasas.ny.gov

New York State Department of Health HIV/AIDS Information ..... http://www.health.ny.gov/diseases/aids/

New York State HIV Uninsured Care Programs .... http://www.health.ny.gov/diseases/aids/general/resources/adap/index.htm

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

IMPORTANT PHONE NUMBERS

Your PCP . . . . . _____

Member Services . . . . . (518) 641-3800 or 1-800-388-2994

Member Services TTY/TDD. 711

Resource Coordination . . . . . (518) 641-4100 or 1-800-274-2332

CDPHP Behavioral Health Services 1-888-320-9584

CDPHP Behavioral Health Services TTY/TDD 711

New York State Department of Health (Complaints) 1-800-206-8125

New York Medicaid Choice 1-800-505-5678

NY State of Health 1-855-355-5777

Office of Addiction Services and Supports (Complaints) 1-800-553-5790

Ombudsman program contact (CHAMP) 1-888-614-5400

Email: Ombuds@oasas.ny.gov

New York State Domestic Violence Hotline 1-800-942-6906

Spanish 1-800-942-6908

Hearing Impaired 1-800-810-7444

OMH Customer Relations and Complaints . . . . . toll-free 1-800-597-8481

New York State HIV/AIDS Hotline 800-541-AIDS (2437)

Spanish 800-233-SIDA (7432)

TDD 800-369-AIDS (2437)

HIV Uninsured Care Programs 800-542-AIDS (2437)

TDD Relay, then 1-518-459-0121

Partner Assistance Program. 800-541-AIDS (2437)

Child Health Plus - Free or low-cost health insurance for children 855-693-6765

Social Security Administration 800-772-1213

Americans with Disabilities Act (ADA) Information Line. 800-514-0301

TDD 800-514-0383

OASAS Complaints . . . . . (518) 473-3460

Independent Consumer Advocacy Network (ICAN) 1-844-614-8800

TTY Relay Service: 711

Web: www.icannys.org

Email: ican@cssny.org

Local County Departments of Social Services:

Albany County, 162 Washington Ave., Albany, NY 12210 . . . . . (518) 447-7500
Columbia County, 25 Railroad Ave., Hudson, NY 12534 . . . . . (518) 828-9411*
Fulton County, 4 Daisy Lane, Johnstown, NY 12095 . . . . . (518) 736-5600*
Greene County, 411 Main St., Catskill, NY 12414 . . . . . (518) 943-3200*
Montgomery County, County Office Building, P.O. Box 745, Fonda, NY 12068 . . . . . (518) 853-4646*
Rensselaer County, 1801 Sixth Ave., Troy, NY 12180 . . . . . (518) 266-7982
Saratoga County, 152 West High St., Ballston Spa, NY 12020 . . . . . (518) 884-4148
Schenectady County, 797 Broadway, Schenectady, NY 12308 . . . . . (518) 388-4470
Schoharie County, County Office Building, P.O. Box 687, Schoharie, NY 12157 . . . . . (518) 295-8334*
Warren County, 1340 State Route 9, Lake George, NY 12845 . . . . . (518) 761-7627
Washington County, 383 Broadway, Fort Edward, NY 12828 . . . . . (518) 746-2300*

*Ask for managed care unit.

Local Pharmacy . . . . . _____

Your nearest Emergency Room: . . . . . _____