Medicaid Advantage Plus 2020 Member Handbook

RiverSpring MAP

(HMO D-SNP)

For more information, call us at:
1-800-362-2266 (TTY 711)
www.RiverSpringMAP.org

Welcome to RiverSpring MAP, a Medicaid Advantage Plus Program

Welcome to RiverSpring MAP (HMO D-SNP) Medicaid Advantage Plus Program. The RiverSpring MAP Medicaid Advantage Plus Program is especially designed for people who have Medicare and Medicaid and who need health and long-term care services like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits RiverSpring MAP covers since you are enrolled in the RiverSpring MAP Program. It also tells you how to request a service, file a complaint or disenroll from RiverSpring MAP Program. The benefits described in this handbook are in addition to the Medicare benefits described in the RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage. Keep this handbook with the RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

HELP FROM MEMBER SERVICES

You can call us any time at the Member Services number below.

There is someone to help you at Member Services:
Monday through Sunday
8am to 8 pm ET
Call 1-800-362-2266 (TTY users call 711)
An on call nurse is available if you need to reach us after hours.

If you have special needs with hearing or vision, we will be happy to accommodate you and help you find the services that meet your needs. RiverSpring MAP also provides information in other languages and has free language interpreter services available for non-English speakers.

ELIGIBILITY FOR ENROLLMENT IN THE RIVERSPRING MAP PROGRAM

The RiverSpring MAP is a program for people who have both Medicare and Medicaid. You are eligible to join the RiverSpring MAP Program if you are also enrolled in RiverSring MAP (HMO D-SNP) for Medicare coverage and:

1) Are age **18** and older;
2) Reside in the plan's service area: Bronx, Kings, New York, Richmond, Queens, Nassau and Westchester counties;
3) Have a chronic illness or disability that makes you eligible for services usually provided in a nursing home;
4) Are eligible for nursing home level of care, as of the time of your enrollment, using the Uniform Assessment System (UAS) or other tool designated by the New York State Department of Health;
5) Are capable to return or remain in your home and community without jeopardy to your health and safety, at the time you join the plan; and
6) Are expected to need one or more of the following Community Based Long Term Care Services for more than 120 days from the date that you join our plan:

a. Nursing services in the home
b. Therapies in the home
c. Home health aide services
d. Personal care services in the home
e. Adult day health care
f. Private Duty Nursing, or
g. Consumer Directed Personal Assistance Services (CDPAS)

An applicant who is an hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), or the State Office For People With Developmental Disability (OPWDD), or is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, a OPWDD Day Treatment Program, or is receiving services from a hospice, may be enrolled with the Contractor upon discharge or termination from the inpatient hospital, facility licensed by the OMH, OASAS or OPWDD, other managed care plan, hospice, Home and Community-Based Services waiver program, CMCM or OPWDD Day Treatment Program.

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in RiverSpring MAP Program. Enrollment in the RiverSpring MAP Program is voluntary.

Enrollment

RiverSpring MAP will accept and process applications in the order received, without restriction and without discrimination as to age, sex, race, creed, physical or mental handicap or developmental disability, national origin, sexual orientation, health status, or cost for health services.

RiverSpring MAP will set up a meeting at your home or a nursing home for our Intake Nurse to conduct a comprehensive assessment to determine if you are eligible, and your health care needs for development of your care plan. The Intake Nurse will contact your physician regarding your interest in enrollment, the services covered, and your plan of care.

The New York State Department of Health, in cooperation with New York Medicaid Choice, have established a Conflict Free Evaluation and Enrollment Center (CFEEC) with a system to complete an evaluation to determine if you are eligible for Community-Based Long Term Care. This evaluation and assessment must be completed and on record prior to enrollment in our plan. You will receive a notice from CFEEC indicating your eligibility: if determined to be eligible, the CFEEC Evaluator will connect you with RiverSpring MAP to begin the enrollment process; if determined to be ineligible, you will have fair hearing rights.

For enrollment, you will be asked to sign documents including an enrollment agreement, medical release form, and privacy notice acknowledgment. If you meet the established criteria and your Medicaid is currently active, your enrollment will usually become effective the 1st day of the following month. You will receive a personal RiverSpring MAP identification card that will cover Medicare and Medicaid services. Remember, you need to keep your regular Medicaid card to get services that are not covered under RiverSpring MAP.

Denial of Enrollment

You will be denied enrollment to RiverSpring MAP if you:

- Do not meet the eligibility criteria stated above;
- Are enrolled in one of the following: another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, a Hospice, the State OPWDD facility or waiver program, and do not want to disenroll.

Network providers will be paid in full directly by RiverSpring MAP for each service authorized and provided to you with no co-pay or cost to you. If you receive a bill for covered services authorized by RiverSpring MAP, you are not responsible to pay the bill, please contact your Care Manager. You may be responsible for payment of covered services that were not authorized by RiverSpring MAP, or for covered services that are obtained by providers outside of RiverSpring MAP network.

Transitional Care

New enrollees may request to continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider, if the provider meets the plan's provider credentialing process, accepts the plan rate as payment in full, agrees to follow the plan's quality assurance and other policies, and provides medical information about your care to the plan.

If the RiverSpring MAP network provider that you are using for an ongoing course of treatment chooses to no longer participate in the plan, we will provide continued coverage with the existing provider for a transitional period of up to 90 days if the provider accepts the plan rate as payment in full, agrees to follow the plan's quality assurance and other policies, and provides medical information about your care to the plan.

MONTHLY SPENDDOWN

Spend-down or surplus is the amount of net available income determined by the NYC Human Resources Administration (HRA) or Local Department of Social Services (LDSS) that a member must pay to RiverSpring MAP in accordance with the income eligibility requirements for Medicaid. HRA/LDSS will inform you and RiverSpring MAP of the monthly spend-down that you must pay.

You will be expected to pay your spend-down amount to RiverSpring MAP on the 1st of each month starting with the month of enrollment. If you have a problem meeting this responsibility, it is important that you discuss the situation with your Nurse Care Manager.

RiverSpring MAP will notify you in writing if you do not pay your spend-down amount within 30 days after the due date, and has the right to involuntarily disenroll you from the program.

SERVICES COVERED BY RIVERPSRING MAP PLAN

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage. Sections 2 and 3 of RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage explain the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Section 4 of RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined RiverSpring MAP, and you have Medicaid, RiverSpring MAP will pay these amounts. You do not have to pay these deductibles and co-payments except for those that apply to chiropractic care unless you are Qualified Medicare Beneficiary (QMB), and pharmacy items. If there is a monthly premium for benefits (see Section 8 of the RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

Care Management Services

As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a health care professional – usually a nurse or a social worker. Your care manager will work with you and your doctor to decide the services you need and develop a care plan. Your care manager will also arrange appointments for any services you need and arrange for transportation to those services. You will receive at least one monthly telephone contact from your care management team. The assessment nurse, as member of your care management team, will make home visits at least twice a year to complete a comprehensive assessment of your health and to identify any changes or needs you may have. We will work cooperatively with your physician regarding your plan of care, as well as other health care professionals to ensure you receive the services you need.

Additional Covered Services

Because you have Medicaid and qualify for the RiverSpring MAP program, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in the RiverSpring MAP network.

If you cannot find a provider in our plan, you must request prior authorization from RiverSpring MAP before receiving any health services from an out-of-network provider, except for medical emergency or urgently needed care.

The following services require prior authorization from your RiverSpring MAP Nurse Care

Manager. To request prior authorization, you or your doctor should call RiverSpring MAP at 1-800-362-2266; TTY users call 711.

Benefit	Description of Covered Services
Adult Day Health Care	Include medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure activities, dental, pharmaceutical, and other ancillary services. Services furnished in approved SNF or extension site.
Care Management (Service coordination)	Care management is an individually designed intervention that helps the member get access to needed services and is designed to ensure the member's health and welfare and increase the member's independence and quality of life.
Community First Choice Option (CFCO) (Effective 1/1/2020, upon official notification from New York State Department of Health)	Assistive Technology: Items, equipment, product systems or instruments of technology that increase a member's independence or substitutes for otherwise authorized human assistance e.g. personal care services. Skill Acquisition, Maintenance and Enhancement: Services intended to maximize a member's independence and/or promote integration into the community by addressing member's ADL and IADL skills. May include assessment, training, cueing, or hands-on assistance with tasks. Community Transitional Services: Include tasks related to setting up a household for a member transitioning from institutional to community setting. Moving Assistance: Include moving belongings to the member's community residence. Environmental Modification: Include internal and external adaptations to a member's residence that are beyond what is covered under social and environmental support. Vehicle Modification: Include modifications to vehicle that is the primary means of transportation for the member, and that are necessary to increase the member's independence and inclusion in the community.
Consumer Directed Personal Assistance Services (CDPAS)	Include some or total assistance with personal hygiene, dressing, feeding, meal preparation, housekeeping, home health aide and nursing tasks. A member, or a person acting on member's behalf (known as a designated representative), self directs and manages the member's personal care and other authorized services. The services are provided by an aide chosen and directed by the member or designated representative.

Benefit	Description of Covered Services
Dental Services	Include Medicaid covered preventive, prophylactic and other dental care, such as routine exams, cleaning, x-rays, fillings, and other services to check for any changes or abnormalities that require treatment. You do not need a referral from your PCP to see a dentist.
Durable Medical Equipment Not Covered by Medicare	Include devices and equipment other than medical/surgical supplies, enteral/parenteral formula, and prosthetic or orthotic appliances with the following characteristics: can withstand repeated use for protracted period of time; are used for medical purposes; are generally not useful in the absence of illness or injury, and are usually fitted, designed or fashioned for a particular individual's use.
Hearing Services	Include medically necessary hearing services and products to alleviate disability caused by hearing loss or impairment.
Home Health Care Services Not Covered by Medicare	Include the provision of skilled services not covered by Medicare (e.g. physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and/or home health aide services as required by an approved plan of care.
Home Delivered and Congregate Meals	Include congregate and home delivered meals to members who cannot prepare or obtain nutritionally adequate meals.
Inpatient Mental Health Care	Include voluntary or involuntary admissions for inpatient mental health services over the Medicare 190-day lifetime limit.
Medical and Surgical Supplies, Enteral and Parenteral Formula, Nutritional Supplements and Hearing Aid Batteries	These are generally one-time use items routinely paid under Durable Medical Equipment category of fee-for-service Medicaid. Coverage of enteral formula and nutritional supplements are limited to nasogastric, jejunostomy, or gastrostomy tube feeding, to individuals who cannot obtain nutrition through any other means.
Medical Social Services	Include assessment, arranging and providing aid and counseling related to maintaining members at home.
Nursing Home Care Not Covered by Medicare	Include skilled nursing facility days provided by a licensed facility in excess of the first 100 days in the Medicare Advantage benefit period.
Nutrition	Include assessment of nutritional needs and food patterns, development and evaluation of treatment plans, nutritional education and counseling.

Benefit	Description of Covered Services
Outpatient Rehabilitation	Medicaid covered occupational therapy, physical therapy and speech therapy – see Limitations below.
Prosthetics	Medicaid covered prosthetics, orthotics and orthopedic footwear.
Personal Care	Include medically necessary assistance with activities such as personal hygiene, dressing, feeding, nutritional and environmental support function tasks (meal preparation and housekeeping). Personal care services must be ordered by the member's physician and provided by a qualified person in accordance with the member's plan of care.
Personal Emergency Response Services	An electronic device that enables certain high-risk members to reach out for help during an emergency.
Private Duty Nursing	Provided by a person possessing a license and current registration from the NYS Department of Education to practice as a registered professional nurse or licensed practical nurse. Include medically necessary continuous or intermittent skilled nursing services provided in the member's home in accordance with the ordering physician's written treatment plan.
Social and Environmental Supports	Include services and items to support a member's medical needs and included in the member's plan of care. May include home maintenance tasks, homemaker/chore services, housing improvement, and respite care.
Social Day Care	Structured, comprehensive program to provide functionally impaired members with socialization, supervision, monitoring, personal care, and nutrition in a protective setting.
Transportation (Non-Emergency)	To access necessary medical services covered by the plan or Medicaid fee-for-service. Includes public transportation, taxi, livery, ambulette, ambulance (when clinical criteria are met), or other means appropriate to your medical condition, and a transportation attendant to accompany the member, if necessary.
Vision Services	Include eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes, low vision aids and services. Exam for refraction is limited to every two (2) years unless justified as medically necessary. Eyeglasses are limited to every two (2) years unless lost, damaged or destroyed.

Limitations

- Outpatient Physical therapy is limited to 40 Medicaid visits per year, and Occupational and Speech therapies are limited to 20 Medicaid visits per therapy per year, except for children under age 21 or if you have been determined developmentally disabled by the Office for People With Developmental Disabilities or if you have a traumatic brain injury.
- Enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
- Nursing Home Care is covered for individuals who are considered a permanent placement provided you are eligible for institutional Medicaid coverage.

Getting Care Outside the Service Area

If you plan to be away from home or when you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider. Please notify Member Services as early as possible so that we can help arrange any appropriate services that you may need in the area you will be visiting. You can use your Medicare or Medicaid card or any other health insurance card to access non-covered services in the service area and outside of the service area if the health care provider accepts Medicare or New York State Medicaid. Our plan does not cover urgently needed care or any other care if you receive the care outside of the United States.

Emergency Service

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Emergency services include health care procedures, treatments or services needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol.

<u>If you have a medical emergency</u>:

- Get help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center.

- As soon as possible, you or someone on your behalf should notify RiverSpring MAP and your physician so that we and/or your physician can follow-up on your emergency care and help you obtain any services you may need after your condition is stabilized.

Payment for medical emergency services:

- You can receive emergency services from any provider, whether or not the provider is part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you paid for the services yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.

- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.

- If the provider is owed anything, we will pay the provider directly.

- If you have already paid for the service, we will pay you back.

SERVICES NOT COVERED BY RIVERSPRING MAP PLAN

There are some Medicaid services that RiverSpring MAP does not cover. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-800-362-2266 if you have a question about whether a benefit is covered by RiverSpring MAP or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy
Most prescription drugs are covered by RiverSpring MAP (HMO D-SNP) Medicare Part D as described in section 6 of the RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Medicare.

Certain Mental Health Services, including:
- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospital Care not covered by Medicare
- Rehabilitation Services to those in community homes or in family-based treatment
- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Mental Retardation and Developmental Disabilities Services, including:
- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services

- Methadone Treatment
- Comprehensive Medicaid Case Management
- Directly Observed Therapy for TB (Tuberculosis)
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- HIV COBRA Case Management

FAMILY PLANNING

Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).

SERVICES NOT COVERED BY RIVERSPRING MAP PROGRAM

You must pay for services that are not covered by RiverSpring MAP or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by RiverSpring MAP or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Conversion or Reparative Therapy
- Services of a Provider that is not part of the plan (unless RiverSpring MAP sends you to that provider or issued to you a written prior authorization for that provider)

If you have any questions, call Member Services at 1-800-362-2266.

Service Authorizations and Actions

When RiverSpring MAP determines that services are covered solely by Medicaid, we will make decisions about your care following these rules:

Prior Authorization:

Some covered services require **prior authorization** (approval in advance) from RiverSpring MAP before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Adult Day Health Care
- Community First Choice Option Services
- Consumer Directed Personal Assistance Service
- Non-routine Dental Services
- Durable Medical Equipment
- Hearing Aids
- Home Delivered and Congregate Meals

- Home Health Care
- Medical Social Services
- Mental Health Care, Inpatient over Medicare limit and Outpatient
- Nursing Home Care not covered by Medicare
- Nutrition Services
- Outpatient Rehabilitation Services, including Physical, Occupational, Speech and Respiratory Therapies
- Personal Care Services
- Personal Emergency Response System
- Private Duty Nursing Services
- Prosthetics and Orthotics
- Social and Environmental Supports
- Social Day Care
- Substance Abuse Services, Inpatient and Outpatient
- Vision Care
- Transportation

When you ask for approval of a treatment or service, it is called a **service authorization request**. To get a service authorization request, you or your doctor may call your Nurse Care Manager or Member Services at 1-800-362-2266, or write to us at: RiverSpring MAP, 80 West 225th St., Bronx, NY 10463

Services will be authorized in a certain amount and for a specific period of time. This is called an **authorization period**.

You will also need to get prior authorization if you are getting one of these services now, but need to get more of the care during an authorization period. This includes a request for Medicaid covered home health care services following an inpatient hospital stay. This is called **concurrent review**.

What happens after we get your service authorization request:

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

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**. 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, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to 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 request will be handled under the standard review process. 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 Action Appeals section).

Timeframes for prior authorization requests:

- Standard review: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

- Fast track review: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests:

- Standard review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.

- Fast track review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 72 hours after we received your request. We will tell you within 1 work day if we need any more information.

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

- Write and tell you what information is needed. If your request is 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 as quickly as we can when we receive the necessary information, but no later than 14 days from the **end of** original timeframe.

If you are not satisfied with our answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.
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 1-800-362-2266 or writing.

You or someone you trust 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 1-866-712-7197.

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 take these other actions.

Timeframes for notice of other actions:

- In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting within an authorization period, we must tell you at least 10 days before we change the service.
- 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 necessary information 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. **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.**

WHAT TO DO IF YOU HAVE A COMPLAINT ABOUT OUR PLAN OR WANT TO APPEAL A DECISION ABOUT YOUR CARE

As a Dually-Eligible member of our plan, the way you make complaints and appeals about your services will depend on whether RiverSpring MAP (HMO D-SNP) determines that the services are covered by Medicare or Medicaid.

- For complaints and appeals about a service that is covered by Medicare (e.g. chiropractic services), or Medicaid (e.g. personal care services, private duty nursing, non-emergency transportation, dental services, etc.), you will follow the rules outlined in Chapter 9, Sections 3, 4, 5,6, 10 and 11 of RiverSpring MAP (HMO D-SNP)'s Evidence of Coverage.

- For complaints and appeals about a service that is covered only by Medicare Part D prescription drugs, you will follow the rules outlined in Chapter 9, Section 7 of RiverSpring MAP (HMO D-SNP)'s Evidence of Coverage.

RiverSpring MAP (HMO D-SNP) will explain the complaints and appeals processes available to you depending on the complaint you have. Call member services at 1-800-362-2266 to get more information on your rights and the options available to you.

DISENROLLMENT FROM RIVERSPRING MAP (HMO D-SNP) PROGRAM

RiverSpring MAP (HMO D-SNP) will not pursue disenrollment based on age, sex, race, creed, physical or mental handicap or developmental disability, national origin, sexual orientation, health status, or cost for health services.

You Can Choose to Disenroll:

You can ask to leave the RiverSpring MAP Program at any time for any reason.

To request disenrollment, you may begin the process at any time by writing or calling us. You should discuss your wish with your NCM. You will sign a Disenrollment Form that will let you know the projected date upon which you will be no longer entitled to receive services through RiverSpring MAP. The effective date of your disenrollment will be as of the first day of the following month, or no later than the first day of the second month following your disenrollment request. It could take up to six weeks to process, depending on when your request is received.

You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require Community Based Long Term Care (CBLTC) services, like personal care, you must join another MLTC plan or Home and Community Based Waiver program, in order to receive CBLTC services.

You Will Have to Leave RiverSpring MAP Program if you:

- No longer are in RiverSpring MAP (HMO D-SNP) for your Medicare coverage
- Need nursing home care, but are not eligible for institutional Medicaid
- Are out of the plan's service area for more than 30 consecutive days
- Permanently move out of the RiverSpring MAP service area
- No longer require a nursing home level of care
- No longer require CBLTC services
- Join a Long-Term Home Health Care Program, a Home and Community Based Services Waiver program, or are enrolled in a program or become a resident in a facility that is under the auspices of the Offices for People With Developmental Disabilities, or Alcoholism and Substance Abuse Services.

We Can Ask You to Leave the Plan:

We will ask that you leave RiverSpring MAP if
- You or family member or caregiver behaves in a way that prevents the plan from providing the care you need
- You knowingly provide false information or behave in a deceptive or fraudulent way.
- You fail to complete or submit any consent form or other document that is needed to obtain services for you
- Fail to pay or make arrangements to pay money owed to the plan (spenddown/surplus/NAMI)

RiverSpring MAP will work with you to attempt to resolve these issues. If the issues are not

resolved, then RiverSpring MAP will notify New York Medicaid Choice of our request for disenrollment.

Any involuntary disenrollment requires the approval of LDSS or HRA. If approved, LDSS or HRA will notify you in writing of the effective date of your disenrollment and your fair hearing rights. RiverSpring MAP will continue to provide or arrange for the provision of the covered services to you until the effective date of your disenrollment. RiverSpring MAP will assist you in transitioning to another plan that fits your needs.

Re-Enrollment Provisions

If you voluntarily disenroll, you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled, RiverSpring MAP may not accept your request for re-enrollment.

Rights and Responsibilities

As a member of RiverSpring MAP, you have the right to:

- Receive medically necessary care;
- Timely access care and services;
- Privacy about your medical record and when you get treatment;
- Get information on available treatment options and alternatives presented in a manner and language you understand;
- Get information in a language you understand; you can get verbal translation services free of charge;
- Get information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get a copy of your medical records and ask that the records be amended or corrected;
- Take part in decision about your health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to get the service you need from us, including how you can get covered benefits from out-of-network providers;
- Complain to the NYS Department of Health or HRA/LDSS, to use the NYS Fair Hearing System and/or request a NYS External Appeal, where appropriate;
- Appoint someone to speak for you about your care and treatment;
- Make advance directives and plans about your care; and
- Seek assistance from the Participant Ombudsman program.

Your exercise of these rights will not adversely affect the way you will be treated.

As a member of RiverSpring MAP, you have the responsibility to:

- Receive all covered services through RiverSpring MAP, using RiverSpring MAP network providers;
- Follow your plan of care and request changes as needed;

- Obtain prior authorization for covered services, except for pre-approved services;
- Be seen by your physician if a change in your health status occurs;
- Share complete and accurate health information with your health care providers;
- Maintain Medicaid eligibility;
- Notify RiverSpring MAP when you go away or are out of town;
- Inform RiverSpring MAP NCM of any change in your health and let us know if you do not understand or are unable to follow instructions;
- Cooperate with and be respectful of RiverSpring staff;
- Take responsibility if you refuse treatment or do not follow RiverSpring MAP instructions; and
- Make every effort to pay your Medicaid surplus amount owed, if any.

Advanced Directives

There may come a time when you can't decide about your own healthcare. 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 Primary Care Provider (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 get these documents. They do not change your right to quality healthcare benefits. The only purpose is to let others know what you want if you can't speak for yourself.

- Healthcare 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 he or she knows what you want.

- Cardiopulmonary Resuscitation and Do Not Resuscitate (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 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.

Information Upon Request

You Will Be Provided with the Following Information Upon Your Request:

- List of the Names, Business Addresses and Official positions of the membership of the Board of Directors, Trustees, Officers, Controlling persons of RiverSpring MAP.
- The most recent annual certified financial statement of RiverSpring MAP.
- Information relating to Consumer Complaints in regard to RiverSpring MAP.
- Written description of the organization of RiverSpring MAP.
- Description of RiverSpring MAP procedures with regard to protecting the confidentiality of medical records and other member information and the quality assurance program.
- Health Practitioners' affiliations with hospitals.
- Description of criteria utilized regarding approval or denial of services.
- Application and qualification requirements for health care providers to participate in RiverSpring MAP.
- A copy of your RiverSpring MAP program record (upon written request).

RiverSpring Health Plans

1-800-362-2266 (TTY 711)
8 a.m. to 8 p.m. ET; 7 days a week.

www.RiverSpringMAP.org