# RiverSpring at Home

## MANAGED LONG TERM CARE PROGRAM

## MEMBER HANDBOOK


2020 Edition

**RiverSpring at Home**
**Tel: 1 (800) 370-3600**

**80 West 225th Street, Bronx, New York 10463 (Main Office)**
**1630 East 15th Street, Suite 206, Brooklyn, New York 11229**
**80-02 Kew Gardens Road, Suite 403, Kew Gardens, New York 11415**

## TABLE OF CONTENTS

# HELPFUL INFORMATION

If you have questions or need help, you can call us anytime, or write to us.

**RiverSpring at Home**
**80 West 225th Street, Bronx, N.Y. 10463**
**Tel: 1 (800) 370-3600**
**TTY/TDD Relay: 711**

Please feel free to call us if you need help with referrals and changing your doctor, lost your ID card, or if you have questions about benefits and services. If you have special needs, we will help you find the services that meet your needs.

**In an emergency, call 911 immediately, and notify us within 24 hours, if possible.**

**Participant Ombudsman Program:**

The Participant Ombudsman is an independent organization that provides free ombudsman services to long term care recipients in New York State. Independent Consumer Advocacy Network (ICAN), the Participant Ombudsman, can give you free advice about health plan choice, enrollment, access to services, and can help you understand the fair hearing, complaint and appeal rights process.

You can contact ICAN at 1-844-614-8800 (TTY Relay: 711); online at www.icannys.org; or via email: ican@cssny.org

## 1. Welcome

RiverSpring at Home is delighted that you have chosen to join our program. Our program is designed to help you live as independently as possible by offering a range of long term care and health-related services. We are committed to high quality, compassionate care that is appropriate to you and your particular situation.

RiverSpring at Home is a Managed Long Term Care ("MLTC") Plan authorized by New York State ("NYS") and is operated by ElderServe Health, Inc. It bears the financial risk and legal responsibility under contract with NYS. RiverSpring at Home is affiliated with the RiverSpring Health Holding Corp., a NYS not-for-profit corporation that is also the sole corporate member of The Hebrew Home at Riverdale, the highly regarded nursing facility that has been providing exceptional care to elderly and disabled individuals in the New York metropolitan area. Throughout this Member Handbook, RiverSpring at Home will be referred to interchangeably as RiverSpring or Plan.

To be eligible for the RiverSpring at Home Program, you must:

- Be Medicaid eligible (our staff can help you determine whether you are eligible),
- Be at least 18 years old,
- live in the RiverSpring service area, which includes the following counties: Bronx, Kings (Brooklyn), New York (Manhattan), Queens, Richmond (Staten Island), Westchester, Nassau or Suffolk,
- Be determined eligible for MLTC using an eligibility assessment tool designated by NYS Department of Health,
- Be able to return to or remain safely at your home and community,
- Be eligible for nursing home level of care if aged 18–20, or you do not have Medicare, and
- require at least one of the following community based long term care services from RiverSpring for a continuous period of more than 120 days from the effective date of enrollment:
    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.

Please keep this Handbook, which is intended to serve as a reference for you. This Handbook is available printed in other languages, including Chinese, French, Korean, Russian, Spanish, as well as recorded for the visually impaired. We can also help you if you need a sign language interpreter. These services are free.

For the meaning of certain terms used in this Handbook, please refer to Section 13, Definitions. Please call our toll-free telephone number, 1-800-370-3600, and TTY/TDD Relay: 711, with any questions. Our normal business hours are Monday through Friday, from 9:00 a.m. to 5:00 p.m. After hours, your call will be answered by our on-call service,

which is available 24 hours per day, seven days per week. Our address, should you wish to write us, is RiverSpring at Home, 80 West 225th Street, Bronx, NY 10463.

## 2. Benefits of Joining

As a member of RiverSpring at Home, your assigned nurse works with you, your physician and your family to develop a Person Centered Service Plan (or Plan of Care) just for you, that fits your particular needs. We make sure that you receive the services you need. Our experienced health professionals are available 24 hours a day, 7 days a week, 365 days a year. Your care team keeps track of how you are doing, attends to changes in your health, provides care, educates your caregivers how to assure quality services tailored to your needs, teaches you how to best help yourself, answers questions you may have, and helps you obtain other services you may need.

### *Your Person Centered Service Plan (or Plan of Care)*

Your written Plan of Care includes medically necessary covered services, paid for through RiverSpring by Medicaid, and coordination of non-covered services, such as physician visits, to assure quality and coordination of care to meet your needs. Services not covered by RiverSpring, including physician, drugs and other medical services, will be paid directly by Medicaid or Medicare.

Your written Plan of Care covers the services you need, how often you need them, and for how long. It identifies, evaluates and helps you manage physical, emotional and social factors that affect your well-being. Your Plan of Care is reviewed at least every six months, and more often, as your condition requires. As your needs change, the Plan of Care will change to meet those needs. Your nurse will review the Plan of Care and discuss any changes with you.

All covered services require prior approval by RiverSpring, except for certain pre-approved covered services. We will co-ordinate with you to arrange both covered and non-covered services. For example, if you make an appointment to see a physician, we will arrange and pay for transportation to and from the physician's office, although the physician bills Medicare or Medicaid directly for the visit.

### *Coordinating your care with your physician*

As long as your physician is willing to collaborate with us in planning your care, we are happy to work with him or her. If your physician is unwilling to work with us, we can assist you in selecting from a list of physicians who are interested in working closely with RiverSpring to assure coordination and focus on improving your quality of life.

### *You will be assigned a Nurse Care Manager*

Your Nurse Care manager ("NCM"), and RiverSpring care team, is responsible for working with you, your physician, your care providers, and any family you designate, in coordinating and making sure you receive services as indicated in your Plan of Care. You will receive an initial assessment of your health care needs and periodic reassessments to assure that your Plan of Care reflects any needed changes based on changes in your condition. Your NCM will monitor your progress to assure that your Plan of Care remains

appropriate to your needs; coordinate with your physician; manages and coordinates both your covered and non-covered services; helps schedule your medical appointments and arrange non-emergency transportation to these appointments; arranges for any medically necessary medical equipment and supplies, and needed modifications to your home as specified in your Plan of Care. You are welcome to call your NCM with any questions or concerns.

## 3. Covered and Non-Covered Services

Covered services are those medically necessary services available through membership in RiverSpring at Home and are paid for by RiverSpring. These services are provided directly or through contracted providers. You are not responsible for payment of covered services, as long as they are authorized in your Plan of Care.

Non-covered services are not in the MLTC covered benefit package. You do not need prior approval from RiverSpring for non-covered services, however we encourage you to have your NCM coordinate these services for you. You may choose any provider for non-covered services. Your providers for these services bill Medicare or Medicaid as they would regularly. Your NCM will be happy to assist you if you want to change providers.

| **Covered Services** |
|---|
| • Care Management - the development, with you, of a Plan of Care that meets your needs with the assurance that you receive the services in your Plan of Care; the monitoring of your health so that we can adjust the services prescribed as your needs change; the coordination of your care while under hospice; and the coordination of all your health needs<br>• Adult Day Health Care - a program of outpatient medical day care where you can receive preventive, diagnostic, therapeutic, rehabilitative or palliative services under the medical supervision of a physician<br>• Audiology, Hearing Aids and Batteries - evaluation of your hearing ability and treatment for your hearing loss through hearing aids<br>• Consumer Directed Personal Assistance Services - provision of some or total assistance with personal care services, home health aide services and nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative<br>• Durable Medical Equipment*, Medical/Surgical Supplies - medical equipment and devices to treat your specific medical conditions or to support you with activities of daily living<br>• Dentistry - diagnosis and provision of essential dental services for preventive and prophylactic treatment of tooth decay and other conditions of the oral cavity<br>• Enteral and Parenteral Supplements - food products to supplement your diet if you cannot obtain nutrition by other means. Enteral formula is limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism<br>• Home Care*:<br>➢ Nursing - skilled nursing services necessary for the treatment and maintenance of your health |

- Home Health Aide - a trained person who performs health care tasks and assists you with personal hygiene, housekeeping and related functions under the supervision of a nurse or therapist
- Physical Therapy - diagnosis and treatment of your health conditions to rehabilitate and restore your maximum movement and functional ability
- Occupational Therapy - assessment and treatment to develop, recover or maintain your basic motor functions to maximize your ability to live independently at home
- Speech Therapy - assessment and treatment for your speech, language, communication, swallowing disorders
- Medical Social Services - assessment of your psychosocial needs, and interventions to help you fully utilize medical care and services

- Home Delivered or Congregate Meals - meals in accordance with your Plan of Care
- Non-emergency Transportation – transportation to and from scheduled medical appointments for you to obtain necessary medical care and services that are in your Plan of Care
- Nursing Home Care*° - inpatient care provided to you by a licensed facility, including short-term rehabilitation, post-acute care, and long term custodial care
- Nutrition - assessment of your dietary intake and eating habits to help you with dietary changes and promote healthier eating
- Optometry and Eyeglasses - eye examination and the prescription and fitting of eyeglasses and other vision aids to correct your vision
- Personal Care - assistance with activities ordered by your physician for you, including personal hygiene, dressing, feeding, nutritional and environmental support tasks
- Personal Emergency Response System - electronic devices to enable you to obtain help in an emergency at your home
- Physical, Occupational, Speech or other Therapies in a setting other than the home* - (see descriptions under Home Care), are limited to forty (40) visits of physical therapy and twenty (20) visits of occupational and speech therapy per calendar year, except for children under 21 and the developmentally disabled
- Podiatry* - examination and provision of routine foot care for conditions due to localized illness, injury or other symptoms involving your feet
- Private Duty Nursing - medically necessary, continuous and skilled nursing services at your home or under certain conditions, at a hospital or nursing home, by properly licensed registered professional or licensed practical nurses, for a limited period of time
- Prosthetics and Orthotics* - appliances and devices for you to replace a missing body part or to support/restrict motion in an injured or deformed part of the body
- Respiratory Therapy* - evaluation and treatment of your respiratory problems, including ensuring safe oxygen use
- Social Day Care - structured day program where you can receive social, recreational, cultural activities and meals in a supervised setting
- Social and Environmental Supports, including home modifications, appliances and assistive devices - includes home maintenance and improvement, chore services and respite care, to support your medical needs as contained in your Plan of Care
- Telehealth Delivered Services – the use of electronic information and communication technology to deliver health care services

* Medicare coverage may apply

° Institutional Medicaid eligibility rules apply

| Non-Covered Services |
| --- |
| • Alcohol and Substance Abuse Services<br>• Chronic Renal Dialysis<br>• Emergency Transportation<br>• Family Planning Services<br>• Hospital Services, Inpatient and Outpatient<br>• Laboratory Services<br>• Mental Health Services<br>• Office for Persons with Developmental Disabilities (OPWDD) Services<br>• Physician Services, including in an office setting, a clinic, a facility, or in the home<br>• Prescription, Non-prescription and Compounded Prescription Drugs<br>• Radiology and Radioisotope Services<br>• Rural Health Clinic Services |

***Services that Do Not Need Prior Approval***

There are three (3) services for which you do not need prior approval from RiverSpring:

- Audiology - routine hearing examinations, once per year;
- Dentistry - routine dental examinations up to two times per year and emergency dental care;
- Optometry and Eyeglasses - routine optometry examination; includes eyeglass frames up to $100 once every two years.

***Nursing Home Care***

Your NCM can arrange for you to stay in a semi-private room in a nursing home in our network, should you, your family, your physician, and your care team determine that a nursing home stay is best for you. We do not cover non-medical services, such as telephone charges. If you should require permanent placement in a nursing facility, your Medicaid eligibility will have to be converted from "community" to "institutional". If the Local Department of Social Services ("LDSS") or Human Resources Administration ("HRA") determines that you are ineligible for institutional Medicaid coverage, RiverSpring is required to initiate the involuntary disenrollment process.

***Money Follows the Person (MFP)/Open Doors***

MFP/Open Doors is a program that can help you move from a nursing home back into your home or residence in the community. You may qualify for MFP if you:

- Have lived in a nursing home for three months or longer
- Have health needs that can be met through services in your community

MFP/Open Doors has Transition Specialists and Peers who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- Providing information about services and supports in the community

- Finding services offered in the community to help you be independent
- Visiting or calling you after your move to make sure that you have what you need at home

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

***Veterans Protection***

If you are a veteran, spouse of a veteran, or a Gold Star parent, and desire to receive care from a veteran's home, please speak to your NCM about how to access this service.

## 4. How to Join

Enrollment in RiverSpring is voluntary. Enrollment or denial of enrollment in our program must be approved by New York Medicaid Choice (NYMC), or other entity designated by NYS Department of Health.

***Enrollment Eligibility***

To be able to enroll you must be:

- At least 18 years old;
- Live in the borough of Bronx, Brooklyn, Manhattan, Queens or Staten Island, or the county of Westchester, Nassau or Suffolk;
- Eligible for Medicaid ;
- At time of enrollment, able to return to or remain safely at your home and community without jeopardy to your health and safety or that of others; and
- Must be expected to require at least one (1) of the following Community Based Long Term Care Services covered by RiverSpring for a continuous period of more than 120 days from the effective date of enrollment:
    - Nursing services in the home;
    - Therapies in the home;
    - Home health aide services;
    - Personal care services in the home;
    - Adult day health care;
    - Private duty nursing; or
    - Consumer Directed Personal Assistance Services.

**Conflict Free Evaluation and Enrollment Center (CFEEC):**

The CFEEC is a subdivision of NYMC, which evaluates whether you need long term care services and determines whether you are eligible for MLTC. The CFEEC is available Monday to Friday, 8:30 am to 8:00 pm, or Saturday, 10:00 am to 6:00 pm, at 1-855-222-8350; TTY: 1-888-329-1546; or via email CF.Evaluation.Center@health.ny.gov.

If you want to join a MLTC plan for the first time, or if you have not been in a plan for 45 days or longer, the initial eligibility determination for MLTC will be made by the CFEEC, or other entity designated by NYS Department of Health. If you wish to enroll in RiverSpring at Home, you need to inform the CFEEC of your choice.

You do not need a CFEEC Evaluation if you are already receiving Medicaid home care outside of a managed care plan or if you are transferring from another MLTC plan.

### *Populations Excluded from Enrollment*

The following individuals cannot receive benefits through the MLTCP:

- Residents of psychiatric facilities;
- Residents of residential health care facilities at time of enrollment (except under the Nursing Home Transition enrollment protocol of NYS Department of Health);
- Individuals expected to be Medicaid eligible for less than six (6) months
- Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services;
- Individuals eligible only for breast and cervical cancer services;
- Individuals receiving hospice services at time of enrollment;
- Individuals residing in a state Office of Mental health facility;
- Individuals residing in an Office for People with Developmental Disabilities (OPWDD) facility or treatment center;
- Individuals eligible for family planning expansion program;
- Individuals under sixty-five (65) years of age in the Centers for Disease Control and Prevention breast and cervical cancer early detection program and need treatment for breast and cervical cancer, and are not otherwise covered under creditable health coverage;
- Residents of intermediate care facilities for the mentally retarded (ICF/MR);
- Individuals who could otherwise reside in an ICF/MR, but chose not to do so;
- Residents of alcohol/substance abuse long term residential treatment programs;
- Individuals eligible for Emergency Medicaid;
- Individuals in the OPWDD Home and Community Based Services section 1915(c) waiver program;
- Individuals in the following section 1915(c) waiver programs: Traumatic Brain Injury, Nursing Home Transition and Diversion, and Long Term Home Health Care Program (until such as final approval is given to the Long Term Home Health Care Program 1915[c] waiver amendment);
- Residents of Assisted Living Programs (ALP);
- Individuals in receipt of Limited License Home Care Services; and
- Individuals in the Foster Family Care Demonstration.

### *Denial of Enrollment*

Your enrollment may be denied for any of the following reasons:

- If you do not meet any of the above eligibility requirements;
- If your physician will not collaborate with us and you do not want to change your physician;
- If you had been previously disenrolled involuntarily, and the circumstances for such involuntary disenrollment have not changed;
- If you are currently enrolled in another Medicaid managed care plan, a home and community-based services waiver program, a comprehensive Medicaid case management program (CMCM), an Office for Persons With Developmental

Disabilities (OPWDD) Day Treatment Program, or are receiving services from a hospice and do not wish to end your enrollment in one of these programs;

- If you are an inpatient or resident of a hospital or residential facility operated by the State Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), or the State OPWDD (enrollment may only begin upon discharge to your home).

### *The New Member Process and Assessment*

Anyone may let us know of your interest in learning more about RiverSpring. We work with you, your physician, your family member(s), NYMC in the enrollment process.

If a CFEEC evaluation is required, we will refer you to the CFEEC for eligibility determination. If you are transferred to us by the CFEEC, or if a CFEEC evaluation is not required, we will arrange a meeting to discuss the RiverSpring Program with you. If you are interested and eligible for Medicaid, which we can help you determine, a nurse from our Intake Department will visit you at your home to complete a comprehensive clinical assessment using the NYS approved form to evaluate your health and environment to develop your initial Plan of Care. After discussion with you, and with your written permission, the nurse will contact your physician to explain our program and request collaboration, including his/her input and written approval of the proposed Plan of Care. If you would like to join RiverSpring but your physician is unwilling to collaborate with us, we can help you to choose another physician.

### *Enrollment Agreement*

Enrollment in RiverSpring at Home is voluntary. You may withdraw your application either orally or in writing by noon on the 20th day of the month prior to the effective date of your enrollment. If you decide to join, you will sign an Enrollment Agreement. During the enrollment process, we will explain how to access services and give you a list of RiverSpring network providers. You will also receive a RiverSpring identification card. Remember to keep any regular Medicaid, Medicare and third party insurance cards, to use for services not covered by RiverSpring but may be covered by these other insurance programs, such as doctors, hospitals and pharmacy prescriptions. Your enrollment must be approved by NYMC.

### *Effective Dates of Enrollment*

Your enrollment takes effect on the first day of the month following the month in which NYMC approves your application.

## 5. Authorization of Services

We develop a Plan of Care tailored to your needs. This Plan of Care determines the covered services that we will pay for. If you seek a service that is not in your current Plan of Care, or if you would like to change the amount, frequency or duration of a covered service you are receiving, you must obtain prior approval.

**Prior Authorization** is required when you or someone on your behalf requests a new service or to change a service as determined in the Plan of Care for a new authorization period, before such service is provided. **Concurrent Review** is required when you or a

provider on your behalf requests more of the same services that are currently authorized in your Plan of Care or for Medicaid covered home health care services following an inpatient admission. Either request may be considered by a standard or expedited review. You may request an expedited review, however, whether the review will be expedited depends on whether RiverSpring or your provider determines that a delay would seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function. Contact your NCM to make a request for expedited review (see Section 11 - Service Authorizations & Action Requirements).

If you are transitioning from a Medicaid community-based MLTC program, RiverSpring will continue to provide services authorized under your pre-existing service plan for a minimum of 90 days.

## 6. Selecting Providers

You may choose your own provider for physician and other services that are not covered by the RiverSpring at Home. This allows you to maintain your relationship with your primary care physician while gaining the RiverSpring care team to help coordinate your care.

A list of RiverSpring providers – our Provider Network – is given to you during the enrollment process. You must use these carefully selected and highly qualified RiverSpring providers for covered services. They are committed to the RiverSpring mission of helping you to be as independent as possible. If a network provider you are using leaves the network, we will assist you in selecting another network provider. RiverSpring wants you to be happy with your provider. If you would like to change a provider, or use a provider that is not in our network, let your NCM know and we will be happy to assist you, either in selecting another network provider or contacting the out-of-network provider regarding participation in our network. For both, our permission is required and is dependent upon factors including the provider's agreement to accept RiverSpring's payment and follow our policies and procedures. We will ask your opinion of your network providers and provide confidential feedback to them in an effort to assure that services are of high quality.

If you are currently receiving a Medicare-covered service, you can continue using that provider. If that service is also a MLTC covered service, RiverSpring recommends that you use a provider in our network so that you will not have to change providers if Medicare coverage limits are met and RiverSpring becomes responsible for primary payment for the care. If the provider of your choice is not in our network, please contact your NCM to discuss your options.

## 7. Access to Services

RiverSpring provides access to care 24 hours a day, 7 days a week, 365 days a year. You can access services by calling the Member Services Department at 1-800-370-3600 or TTY/TDD Relay: 711. RiverSpring performs the important function of coordinating the services you require, whether or not they are covered services. While you are not required to do so, RiverSpring requests that you notify us of any provider and type of services within 2 business days before or after receiving the service, so that it can be

included in your Plan of Care. If we are notified in advance, we can arrange appropriate transportation to and from the service. You must use network transportation services in order for us to cover the transportation.

To schedule transportation, please call us 2 days in advance of the trip so that we can make the necessary arrangements.

### *To Request a Change in Your Plan of Care for Covered Services*

Your Plan of Care specifies the services you will receive. If you want to change your Plan of Care, for example, if you want to change the day on which a service is scheduled, or, if you feel you need an additional service, you should discuss this with your NCM during regular business hours, Monday through Friday between 9:00 am and 5:00 pm by calling 1-800-370-3600. You may also call after hours and your request will be given to your NCM on the next business day. Your NCM will consult with your physician as necessary to assure that you receive medically necessary services, and, if we agree with your request, we will change your Plan of Care to reflect this decision.

If you are unhappy with a physician's order or with a provider's' service delivery or access to service, you may use the complaint and appeals process outlined in Section 11.

### *Urgent Care*

If you need urgent care, please call your physician. Urgent care is any service that is medically necessary in order to prevent a serious deterioration in your health resulting from an unforeseen illness or injury, when you must be seen sooner than a routine medical visit can be scheduled.

Let us know as soon as possible that you have received urgent care so we can make any necessary changes in your Plan of Care.

### *Emergency Care*

Emergency Services mean medically necessary services required to evaluate and stabilize an emergency medical condition. An emergency means that you have a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to: (1) result in placing your health in serious jeopardy, or, in the case of a behavioral condition, place the health of you or others in serious jeopardy; (2) seriously impair your bodily functions; (3) result in serious dysfunction of any bodily organ or part of you; or (4) seriously disfigure you.

You are not required to get prior approval from RiverSpring for treatment of emergency medical conditions, but it is important to let us know you have received them as soon as possible. You or a family member or friend should call RiverSpring at 1-800-370-3600 so that we can adjust scheduled services right away and make sure services fit any change in your needs.

If you require Emergency Services, please call 911. Listen to the questions carefully, answer their questions and follow instructions carefully. If 911 determines that you have a medical emergency, they will take you to the nearest hospital emergency room.

### *Getting Help During Non-Business Hours*

We always encourage you to call your NCM for any assistance – your NCM knows you and your needs best. If you have an urgent need for service or assistance after hours or on weekends or holidays, just call us at the 24-hour toll-free number, 1-800-370-3600, and our on-call NCM will help you.

### *Covered Services Not Included in the Plan of Care*

Except when no prior approval is required, if a covered service is obtained without a prior physician's order or RiverSpring approval, neither Medicaid nor RiverSpring will pay the provider, so it is *very important* that you discuss with your NCM any services you think are needed in your Plan of Care.

### *Services Outside the Service Area*

If you have any changes in your health status while you are outside of our service area, you should call your NCM or RiverSpring's 24-hour toll free number and ask to speak with a nurse, who will try to assist you in coordinating the services you need.

Any time you plan to be away from the area, notify your NCM so that we can help you arrange for services that are medically necessary while you are away, suspend your regularly scheduled services until you return, and make sure that the services are available upon your return when you need them. You may not be absent from the service area for more than 30 consecutive days and remain in the RiverSpring Program. We are required to involuntarily disenroll you if you are absent for more than 30 consecutive days (see Section 8, Termination of Coverage).

### *Additional information*

The following information is available to you upon your request:

- The names, business addresses and official positions of the Board of Directors and officers of RiverSpring at Home.
- RiverSpring's most recent annual certified financial statements.
- RiverSpring's written procedures for protecting the confidentiality of medical records and other member information.
- RiverSpring's written procedures for making decision about the experimental or investigational nature of medical devices or treatments in clinical trials.
- RiverSpring' written procedures for making service authorization decisions.
- RiverSpring's written application procedures and minimum qualifications for health care providers to be considered for participation in our provider network.
- A written description of our organizational arrangements and ongoing procedures for the quality assurance program.

## 8. Termination of Coverage

You may choose to leave RiverSpring (voluntarily disenroll) and there may be circumstances under which you will be disenrolled from RiverSpring (involuntarily disenrolled). When you are disenrolled, RiverSpring will no longer pay for services for you - our coverage will stop. However, until your disenrollment takes effect, you remain a member of RiverSpring and we continue to provide the services in your Plan of Care, you must continue to use RiverSpring network providers and obtain prior approval for covered services. RiverSpring will assist you in transitioning to another plan that meets your needs, and will continue to cover services in your Plan of Care until the disenrollment is effective and help you establish other care arrangements. You may not be disenrolled because you have had an adverse change in your health or due to the cost of providing services.

### *Voluntary Disenrollment*

If you decide you would like to disenroll from RiverSpring, you may begin the process at any time by telling us in writing or verbally. 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 are no longer entitled to receive services through RiverSpring. IF NYMC processes your request by the tenth of the month, the effective date of your disenrollment will be as of the first day of the following month. If the process is later than the tenth of the month, the effective date of disenrollment will be as of the first day of the second month following your disenrollment request.

If, after enrolling in RiverSpring, you enroll in or receive services from another Medicaid prepayment plan, a HCBS waiver program, an OPWDD Day Treatment or Comprehensive Medicaid Case Management program, this will be considered voluntary disenrollment.

### *Involuntary Disenrollment*

RiverSpring is required to begin the disenrollment process if *any* of the following situations applies to you:

- We determine that you no longer live in the service area;
- You are absent from the service area for more than 30 consecutive days;
- You are hospitalized or have entered an OMH, OWPDD, or OASAS residential program for 45 consecutive days or longer;
- You clinically require nursing home care but are not eligible for nursing home care under Medicaid Institutional rules;
- You are no longer eligible to receive Medicaid benefits;
- You are assessed as no longer demonstrating a functional or clinical need for community-based long term care services or, if you do not have Medicare and no longer meet the nursing home level of care as determined using the assessment tool prescribed by NYS Department of Health; or
- You are incarcerated.

RiverSpring may disenroll you if:

- You, your family or other in your immediate environment engage in conduct or behavior that jeopardizes your health or safety or the safety of others, or seriously impairs our ability to furnish services to you or other members;
- You fail to pay or fail to make satisfactory arrangements to pay the spend-down/surplus amount as determined by the Local Department of Social Services (LDSS), owed to RiverSpring after a thirty-day grace period;
- You knowingly fail to complete and submit any necessary consent or release;
- You provide RiverSpring with false information, otherwise deceive us, or engage in fraudulent conduct in relation to your RiverSpring membership.

Any involuntary disenrollment requires 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 will assist you in transitioning to another MLTC plan that fits your needs.

## 9. Medicaid Spend-Down

What you are required to pay to RiverSpring directly depends on the determination made by Medicaid. LDSS or HRA reviews your financial status and determines the amount of your monthly income that you must "spend-down" in order to meet the income requirements for Medicaid eligibility. If Medicaid determines that you must spend-down a certain amount – pay this amount to RiverSpring each month - LDSS or HRA will inform you and us of the exact amount of your spend-down that must be paid each month to us.

If Medicaid determines that you have no spend-down obligation, then you do not pay RiverSpring anything each month.

The amount you must spend-down or pay directly to RiverSpring may change with your periodic Medicaid eligibility certification process or admission into a Nursing Facility.

If you must spend-down a particular amount, that amount must be paid by the first of each month starting with the month of enrollment. Please make your payment payable to the order of ElderServe Health and send it to ElderServe Health, Inc., 80 West 225th Street, Bronx, NY 10463.

If you have a problem meeting this responsibility, it is important that you discuss the situation with your NCM. If you do not pay your spend-down amount within 30 days after the date it is due, we will notify you in writing of your arrears in payment. We have the right to involuntarily disenroll you from the program for failure to make payments that are due.

## 10. Rights and Responsibilities

As a member of RiverSpring, 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 if they are not available in our network;
- Complain to the NYS Department of Health by phone at 1-800-206-8125, or in writing to: MLTC – Technical Assistance Center, NYS Department of Health, Bureau of Managed Long Term Care, 16th floor, One Commerce Plaza, Albany, NY 12237, or by emailing mltctac@health.ny.gov, or complain to your Local Department of Social Services, and 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; 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, you have the responsibility to:
- Receive all covered services through RiverSpring, using RiverSpring 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 Health when you go away or are out of town;
- Inform RiverSpring staff 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;
- If you cannot notify us in advance, notify RiverSpring within 2 business days of receiving either non-covered services or pre-approved covered services;
- Take responsibility if you refuse treatment or do not follow RiverSpring instructions; and
- Make every effort to pay your Medicaid surplus amount owed, if any.

## 11. Member Complaint and Appeal Process

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

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

To file a complaint or to appeal a plan action, please call: 1-800-360-3700 (TTY: call 711) or write to: RiverSpring Health Plans, Quality Assurance Department, 80 West 225th Street, Bronx, NY 10463. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

### *What is a Complaint?*

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

### *The Complaint Process*

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

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

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

### *How do I Appeal a Complaint Decision?*

If you are not satisfied with the decision we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must

file a complaint appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial decision.

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

### *What is an Action?*

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

### *Timing of Notice of Action*

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

### *Contents of the Notice of Action*

Any notice we send to you about an action will:

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

If we are restricting, reducing, suspending or terminating an authorized service, the

notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

### *How do I File an Appeal of an Action?*

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

### *How do I Contact my Plan to file an Appeal?*

We can be reached by calling 1-800-370-3600 (TTY: call 711) or writing to RiverSpring Health Plans, Quality Assurance Department, 80 West 225th Street, Bronx, NY 10463. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

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

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

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

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

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an

extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

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

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

### *Expedited Appeal Process*

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

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

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

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

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

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

### *State Fair Hearings*

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

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

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

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

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

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

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

  Mail a Printable Request Form:

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

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

- Request by Telephone:

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

- Request in Person:

  **New York City (Office of Temporary and Disability Assistance)**
  14 Boerum Place, 1st Floor
  Brooklyn, New York 11201

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

### *State External Appeals*

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

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

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

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

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

## *SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS*

### Definitions

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

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

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

**General Provisions**

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

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

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

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

**Timeframes for Service Authorization Determination and Notification**

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

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

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

    a. Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request
    b. Standard: Fourteen (14) days of receipt of the Service Authorization Request
    c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary

information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

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

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

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

5. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.

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

**Other Timeframes for Action Notices**

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

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

        i. the death of the Enrollee;
        ii. a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);
        iii. the Enrollee's admission to an institution where the Enrollee is ineligible for further services;
        iv. the Enrollee's address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;

v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or
vi. the Enrollee's physician prescribes a change in the level of medical care.

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

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

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

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

**Contents of Action Notices**

1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.

2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:

a. the date the restriction will begin;
b. the effect and scope of the restriction;
c. the reason for the restriction;
d. the recipient's right to an appeal;
e. instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
f. the right of Contractor to designate a primary provider for recipient;

g. the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;
h. the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
i. the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;
j. the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
k. the name and telephone number of the person to contact to arrange a conference;
l. the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
m. the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;
n. the right of the recipient to examine his/her case record; and
o. the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This information is generally referred to as “claim detail” or “recipient profile” information.

## 12. Important Information about Advance Directives

You have a right to make your own health care decisions. Sometimes, as a result of a serious accident or illness, that may not be possible. You can plan ahead of time for such situations by preparing an Advance Directive that will help insure that your health care wishes are followed. There are different types of Advance Directives:

Health Care Proxy: This document enables competent adults to protect their health care wishes by appointing someone they trust to decide about treatment on their behalf when they are unable to decide for themselves.

Do Not Resuscitate (DNR) Order: You have the right to decide if you want emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want cardiopulmonary resuscitation, you should make your wishes known in writing. Your Primary Care Physician (PCP) can provide a DNR order for your medical records. You can 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, You can also complete the back of your NYS driver’s license or non-driver ID card to let others know of and how you want to donate your organs.

Living Will: You can give specific instructions about treatment in advance of situations where you may be unable to make important health care decisions on your own.

It is your choice whether you wish to complete an Advance Directive and which type of Advance Directive is best for you. You may complete any, all, or none of the Advance Directives listed above. The law forbids discrimination against providing medical care based on whether a person has an Advance Directive or not. For more information, please speak to you NCM or your PCP. The RiverSpring enrollment packet will contain Advance Directive forms. You do not need to use a lawyer, but you may wish to speak with one about this important issue. You can change your mind at any time. Contact your NCM if you wish to make any changes.

## 13. Definitions

Care Management: Care management services include referral, assistance in or coordination of services for you to obtain needed medical, social, educational, psychosocial, financial and other services in support of the PCSP, irrespective of whether the needed services are Covered Services.

Covered Services: The health and health-related services that are listed in Section 3 and that are not reimbursed by Medicare.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person affected with such condition in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any of bodily organ or part of such person; or (d) serious disfigurement of such person.

Fee-for-service Medicaid: The traditional provider reimbursement in which the provider is paid according to the service performed.

Involuntary Disenrollment: When, in certain specific circumstances, your membership in RiverSpring at Home may be cancelled, even if you are not choosing to disenroll.

Local Department of Social Services ("LDSS"): The local agency that must concur with the determinations made by a Managed Long Term Plan of Care before an individual may be enrolled or denied enrollment into the program, or involuntarily disenrolled from the program. This agency also determines the monthly income spend-down due by the member, if any. In New York City, LDSS is the Human Resources Administration ("HRA").

Managed Long Term Care ("MLTC"): Program designed for people who are chronically ill or disabled and eligible for MLTC. Programs must be approved by NYS to operate, and receive a pre-determined rate of payment from Medicaid to provide medically necessary covered services to its members. MLTC programs bear financial risk and legal responsibility under contract with NYS and enrollment agreements with its members.

Medically Necessary: A service is considered medically necessary if it is needed to prevent, diagnose, correct or cure conditions in an individual that cause acute suffering,

endanger life, result in illness or infirmity, interfere with the individual's capacity for normal activity or threaten some significant handicap.

Network Providers: Service providers carefully chosen by and contracted with ElderServe Health to provide Covered Services to RiverSpring members.

Nurse Care Manager: Each member is assigned a NCM who will work closely with the member and the member's physician to develop and implement an individualized Plan of Care.

Person Centered Service Plan (or Plan of Care): is a written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to an Enrollee in order to achieve such goals. The person centered individual service plan is based on the assessment of the member's health care needs and developed in consultation with the member and his/her information supports. The plan includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level and support systems. Effectiveness of the person centered service plan is monitored through reassessment and a determination as to whether the health care goals are being met. Non-covered services which interrelate with the covered services identified on the plan and services of informal supports necessary to support the health care goals and effectiveness of the covered services should be clearly identified on the person centered service plan or elsewhere in the care management record.

Physician's Order: A written document signed by your physician authorizing medically necessary services.

Prior Approval: Except for certain pre-approved Covered Services, all Covered Services require RiverSpring's advance or prior approval. Your NCM will review your health care needs and confer with your physician to determine those Medically Necessary and authorized Covered Services in your Plan of Care.

Spend-down: The amount, if any, determined by Medicaid that you must pay to ElderServe Health each month in order to qualify for Medicaid benefits and be eligible for the RiverSpring program if your monthly income exceeds the Medicaid allowable maximum.

| | |
|---|---|
| ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-370-3600 TTY:711 | English |
| ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-370-3600 TTY: 711. | Spanish |
| 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-370-3600 TTY: 711. | Chinese |
| ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-370-3600 (رقم هاتف الصم والبكم TTY:711 | Arabic |
| 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-800-370-3600 TTY: 711.번으로 전화해 주십시오. | Korean |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-370-3600 (телетайп: TTY: 711). | Russian |
| ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-370-3600 TTY: 711. | Italian |
| ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-370-3600 TTY: 711. | French |
| ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-370-3600 TTY: 711. | French Creole |
| אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-370-3600 TTY: 711. | Yiddish |
| UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 370-3600 TTY: 711 | Polish |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-370-3600 TTY: 711. | Tagalog |
| লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-800-370-3600 TTY: 711. | Bengali |
| KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-370-3600 TTY: 711. | Albanian |
| ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-370-3600 TTY: 711. | Greek |
| خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 800-370-3600 TTY: 711 | Urdu |