RiverSpring Health Plans

RiverSpring Health Plans
Special Needs Plan (SNP) Training

RiverSpring Special Needs Plans

RiverSpring MAP*

Dual SNP (HMO D-SNP)

800-362-2266

Eligibility:

- Has both Medicare and full Medicaid
- Has a chronic health care need and is eligible to live in a nursing home, but is able to live safely at home
- Requires community based long term care services for 120 days or longer

RiverSpring STAR

Institutional and

Institutional Equivalent SNP (HMO I-SNP)

800-580-7000

Eligibility:

- Has Medicare
- Resident or expected to reside in a nursing home for 90 days or longer at time of enrollment
- Resident in community but requires an Institutional level of care

- Lives in our service area – NYC (Manhattan, Bronx, Queens, Brooklyn and Staten Island), Nassau and Westchester
- Has Medicare Part A and Part B

*RiverSpring MAP is a **dual** Medicare and Medicaid plan which provides acute and long term care services.

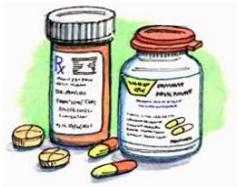
Medicare Coverage

Medicare is a federal health insurance program under the U.S. Social Security Administration that pays for hospital and medical care.

Medicare is divided into “Parts”, with each providing a different type of coverage.

Part A Inpatient Care

Part B Outpatient care



Part D Prescription drug coverage

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Medicare Advantage Plans

RiverSpring Special Needs Plans (SNPs)

Medicare Coverage

Medicare **Part A**
Inpatient Care

- ✓ Hospital
- ✓ Mental Health Facility
- ✓ Skilled Nursing Facility
- ✓ Home Health Care
- ✓ Hospice

Medicare **Part B**
Outpatient Care

- ✓ Doctors' services (office and home visits)
- ✓ Outpatient medical/surgical services and supplies
- ✓ Diagnostic tests
- ✓ Outpatient Therapy
- ✓ Outpatient mental health services
- ✓ Preventive health care services
- ✓ Other medical services
- ✓ Annual Wellness Exams

Medicare **Part C**
Medicare Advantage Plan

Includes all the benefits of

- ✓ Part A
- ✓ Part B
- ✓ Part D

Medicare **Part D**
Prescription Drug Coverage

- ✓ Outpatient Prescription Drugs

Medicare SNP Benefits

*Please refer to the **Evidence of Coverage (EOC)** of each Plan for a complete list and detailed description of the health care benefits covered by each plan.*

- Primary and Specialty Physicians
- Hospital Services
- Prescription Drugs
- Interdisciplinary Care Team
- Care Manager
- Over-the-Counter (OTC) Items + Grocery Benefit
- Chiropractic Care
- Home Health Care
- Durable Medical Equipment (DME)
- Ambulance
- Diagnostic Tests, Labs and Radiology Services
- X-Rays
- Preventative Care
- Skilled Nursing Facility Care
- Prosthetic Care
- Urgently Needed Care
- Outpatient Surgery
- Diabetic Supplies
- Emergency medical services
- Skilled rehabilitation services

RiverSpring Star (HMO I-SNP) Plan

Benefits	2022 – Member Pay	2023- Member Pay
Premiums	$42.40	$38.10
Deductible (Part D)	$480	$505
Emergency	$0 or 20% of Medicare amount (up to $90 max)	$0 or 20% of Medicare amount (up to $95 max)
Over-The-Counter (OTC) + Grocery Benefit	$150 per month. You are allowed to spend ($75.00) of the OTC benefit amount towards food and produce.	$150 per month. You are allowed to spend ($75.00) of the OTC benefit amount towards food and produce.
Skilled Nursing Facility	The plan covers up to 100 days each benefit period, a 3-day prior hospital stay is required. Days 1-20: $0 per day Days 21-100: $194.50 per day Days 101 and beyond: you pay all costs	The plan covers up to 100 days each benefit period, a 3-day prior hospital stay is required. Days 1-20: $0 per day Days 21-100: $0 per day Days 101 and beyond: $0

*Refer to Evidence of Coverage for a detail summary of benefits

RiverSpring Star (HMO I-SNP) Plan Continued

Benefits	2022 – Member Pay	2023- Member Pay
Urgently Needed Services	$65	$60
Physician Specialist Services excluding Psychiatric Services Visits	Prior authorization rules may apply for Physician Specialist Visits	Only the first 3 visits will not require a prior authorization. An authorization is required for all subsequent visits.
Inpatient Hospital and Inpatient Hospital Psychiatric Stays	Deductible: $1,556 Days 1-60: $0 Days 61-90: $389 per day of each benefit period Days 91 and beyond: $778	Deductible: $0 Days 1-60: $0 Days 61-90: $0 per day of each benefit period Days 91 and beyond: $0
Outpatient Diagnostic Procedures, Tests and Lab Services	Authorization is **not** required	• Diagnostic Procedures/Tests: Authorization is **not required** • Routine Lab Services Authorization is **not** required.

*Refer to Evidence of Coverage for a detail summary of benefits

RiverSpring Star (HMO I-SNP) Plan Continued

Benefits	2022 – Member Pay	2023- Member Pay
Podiatry Services	Prior authorization rules may apply.	Authorization is required after 4 regular visits to a podiatrist. Authorization is required after 6 diabetes related visits to a podiatrist.
Durable Medical Equipment (DME)	Authorization is required for each DME item that costs $250 or more.	• An authorization is required for DME equipment (non disposable items that have a useful shelf life of over 1 year) with cost of $500 or more • An authorization is required for DME supplies (disposable items that do not have a useful shelf life of over 1 year) with cost of $250 or more

*Refer to Evidence of Coverage for a detail summary of benefits

RiverSpring Star (HMO I-SNP) Plan Continued

Benefits	2022 – Member Pay	2023- Member Pay
Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	Prior authorization rules may apply.	Authorization required for Medicare-Covered Diabetic Therapeutic Shoes or Inserts We cover specific manufacturers for diabetic supplies and services from Abbott and LifeScan.
Prescription Drug Benefit Manager (PBM). Pharmacy benefit managers, or PBMs, are companies that manage prescription drug benefits on behalf of RiverSpring Star (HMO I-SNP).	MeridianRx (PBM)	Express Scripts (PBM)

*Refer to Evidence of Coverage for a detail summary of benefits

RiverSpring MAP (HMO D-SNP)

Benefits	2022	2023
Premiums	$0	$0
Deductible	$0	$0
Hospital	$0	$0
OTC	$150 per month. You are allowed to spend ($75.00) of the OTC benefit amount towards food and produce.	$150 per month. You are allowed to spend ($75.00) of the OTC benefit amount towards food and produce.
Physician Specialist Services excluding Psychiatric Services Visits	Prior authorization rules may apply for Physician Specialist Visits.	Only the first 3 visits will not require a prior authorization. An authorization is required for all subsequent visits.
Podiatry Services	Prior authorization rules may apply.	Authorization is required after 4 regular visits to a podiatrist. Authorization is required after 6 diabetes related visits to a podiatrist.

*Refer to Evidence of Coverage for a detail summary of benefits

RiverSpring MAP (HMO D-SNP) Continued

Benefits	2022	2023
Outpatient Diagnostic Procedures, Tests and Lab Services	Authorization is not required	Diagnostic Procedures/Tests: Authorization is not required Lab Services: Routine Lab Services Authorization is not required. Some Lab Services might require an authorization.
Durable Medical Equipment (DME)	Authorization is required for each DME item that costs $250 or more.	An authorization is required for DME equipment (non disposable items that have a useful shelf life of over 1 year) with cost of $500 or more An authorization is required for DME supplies (disposable items that do not have a useful shelf life of over 1 year) with cost of $250 or more

*Refer to Evidence of Coverage for a detail summary of benefits

RiverSpring MAP (HMO D-SNP) Continued

Benefits	2022	2023
Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	Prior authorization rules may apply.	Authorization required for Medicare-Covered Diabetic Therapeutic Shoes or Inserts We cover specific manufacturers for diabetic supplies and services from Abbott and LifeScan.
Behavioral Health Services	Not Covered	Covered Services – please refer to your Evidence of Coverage for a list of covered services.
Pharmacy benefit managers, or PBMs, are companies that manage prescription drug benefits on behalf of RiverSpring Star (HMO I-SNP).	MeridianRx (PBM)	Express Scripts Rx (PBM)

*Refer to Evidence of Coverage for a detail summary of benefits

Goals and Outcomes

Our goal is to maximize health and minimize need for institutionalization. We achieve our goal through:

- Developing, with the members and their PCP, individualized care plans (ICPs) that *efficiently* meet members' needs with clear, identifiable goals.
- Incorporating preventive, medical, mental health, social services and other creative services into the care plan as needed given each individual's particular life situation.
- Monitoring member's health status to assure that the care plan is working as planned.
- Adjusting care plans to meet changing needs, including seamless transition through care settings.
- And, for covered services, assuring that good quality services are provided as ordered.
- Care Management for the member by Nurse Care Manager or the Nurse Practitioner.

Heath Risk Assessment (HRA)

- The HRA includes the Universal Assessment Systems for New York (UAS- NY), depression scale and General Practitioner assessment of cognition (GPCOG).
- The HRA assesses the member's medical, environmental, cultural and cognitive needs.
- The HRA validates the need for an institutional level of care and is a key factor in formulating the Individualized Care Plan (ICP).
- The HRA assessment is used to identify members in terms of medical vulnerability for serious morbid events.

Interdisciplinary Care Team (ICT)

OVERVIEW

The Nurse Care Manager or NP leads the Interdisciplinary Care Team. Participants **may** include:

- Nurse Care Manager
- Member and/or Caregiver
- Primary Care Physician/Specialist
- Social Workers
- Medical Director
- Other clinical team members based on the needs of the member

ROLE OF THE ICT

- Participates in development of the care plan
- Reviews services across care settings for appropriate utilization of care.
- Ensures care plan addresses member's medical, functional, cognitive, cultural and psychosocial needs

Individualized Care Plan (ICP)

The NCM or the NP is the leader of the Interdisciplinary Care Team and is responsible for developing and updating the ICP with the ICT. The Individualized Care Plan is based on:

- Member needs, preferences, and goals
- Address the physical, behavioral, cultural and psychosocial needs of the member
- Input and communication with the Interdisciplinary Care Team
- Health Risk Assessment
- Outcome measures to determine whether goals are met

Cultural Competency

- RiverSpring Health Plans provides effective, individualized and respectful care in a manner sensitive to member's values, beliefs, and needs that are associated with a person's age, gender, sexual orientation, cultural, linguistic, racial, ethnic, and religious backgrounds, and congenital or acquired disabilities.
- RiverSpring Health Plans arranges language assistance services for members with LEP through bilingual staff, interpreters and other translation services, and use of family/ friends at the member's request.
- Members are notified of their right to receive and the availability of, language services through the Evidence of Coverage and other documents provided to members.

Providers are legally obligated to provide meaningful communication with members who have Limited English Proficient (LEP) and their authorized representatives.

- Title VI of the Civil Rights Act of 1964 - Prohibits recipients of federal funding from discriminating on the basis of race, color, national origin, gender, age, sexual orientation and disability
- 14 NYCRR section 633.1 and 633.4 - All persons shall be given the respect and dignity that is extended to others regardless of race; religion; national origin; creed; age; gender; sexual orientation; developmental disability; or health condition. An individual/family member cannot be discriminated based on their ability to speak English and this includes individuals who may be deaf and/or hard-of-hearing.

Participating Provider Network

- Our Provider Network consists of healthcare providers who are contracted to provide health care services to RiverSpring Health Plans D-SNP and I-SNP members.

- Our network includes primary care and specialty physicians who are board certified in their medical specialties. PCPs are important to the member's Interdisciplinary Care Team (ICT).

- Our network covers the entire spectrum of covered services including physicians, hospitals, lab and X-ray services, rehabilitation facilities, dialysis centers, mental health facilities, skilled home care and durable medical equipment companies, among the most common.

Clinical Practice Guidelines

- RiverSpring Health Plans believes that the members' physicians, who know them well, are best suited to determine the best course of treatment in most cases. When needed, we reference Evidence-Based Clinical Practice Guidelines (CPG) and Nationally Recognized Protocols for both D-SNP and I-SNP.

- The Medical Director promotes clinical practice guidelines and collaborates with community physicians to ensure the delivery of age-appropriate, evidence-based care to members.

- We encourage any participating physician to contact the plan about any concerns regarding any members. We specifically chose not have a voicemail function in order to ensure that any concerns are handled by an appropriate individual in a timely manner.

Performance and Health Outcomes

RiverSpring Health Plans invests heavily in trying to assure that members receive quality services that are effective and compliant with all requirements:

- The plan monitors to assure that members have up to date assessments and care plans and that members in the hospital have appropriate discharge planning for smooth transitions to the home;
- The plan monitors high risk members to assure that the most intensive and highest level clinical input is included in developing approaches to resolving difficult issues;
- The plan staff does active internal audits to assure compliance with our requirements and to test that care plans are implemented as planned and our contracted plan auditor does others.

The plan has an active quality assurance department; however, all departments and all staff are involved in quality and effectiveness.

SNP Grievance and Appeals Definitions

A **Grievance -** is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested.

A **Initial Determination** – Is a coverage determination/organization determination is a decision made by the plan, on a request for coverage (payment or provision) of an item, service or drug.

An **Appeal -** is the procedures that deals with the review of an adverse initial determination made by the plan on health care services or benefits under Part C or D where the enrollee believes he or she is entitled to receive.

An **Integrated Appeal (For MAP only)** – is the procedure that deals with, or result from adverse integrated organization determinations by the plan on the benefits both under Part C and under state Medicaid rules the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services, or on any amounts the enrollee must pay for a services. Integrated appeals do not include appeals related to Part D benefits.

Plan Classification	Part C Classification	Part D Classification
Coverage Request	Request for Organization/Reconsideration	Request for Coverage Determination/Redetermination
Initial Determination	Organization Determination	Coverage Determination
Appeal (Level 1)	Reconsideration	Redetermination

Who Can File a Grievance, Initial Determination or Appeal

- The enrollee is not required to use any specific language to indicate what they are requesting. Plans must determine whether the matter or the issue is a grievance, coverage request, appeal, or combination of more than one category and inform the enrollee (verbally or in writing) if the issue is a grievance or an appeal.
- Individuals who represent enrollees may either be appointed or authorized representative to act on behalf of the enrollee in filing a grievance, requesting an initial determination, or in dealing with any levels of the appeal process. The plan must obtain an Appointment of Representative (AOR) form or an equivalent written notice prior to initiating any of the process mentioned above.
- Members or their authorized appointed representatives may file verbally or in writing a grievance, request an initial determination and deal with any levels of appeals process*.
- A grievance, initial determination or and Appeal can be filed in person, or by calling RSHP at 1-800-771-0088. Coverage/organization determination may also be filed in writing to:

For Coverage Decisions for (Part C):	Grievances Appeals:	For Coverage Decision (Part D):
RiverSpring Health Plans	RiverSpring Health Plans	RiverSpring Health Plans
Attention: Medical Management	Attention: Medical Management	Attention: Medicare Reviews
80 West 225th street	80 West 225th street	P.O. Box 66571
Bronx, NY 10463	Bronx, NY 10463	St. Louis, MO 63166

* Some exclusions may apply when filling an appeal verbally or in person

Classifying Coverage Requests, Grievances, & Appeals

Examples of Grievances	Examples of Coverage Requests	Examples of Appeals
• An enrollee's involuntary disenrollment initiated by the plan • A change in premiums or cost sharing arrangements from one contract year to the next; • Lack of quality of the care received; • Plan benefit design; • Difficulty contacting the plan via phone; • Interpersonal aspects of care; • General dissatisfaction about a co-payment amount, but not a dispute about the amount the enrollee paid or is billed	Calls requesting or indicating they want a drug, service, or item • Wants to continue care with a provider who is no longer contracted with the plan (out of network coverage) • Wants to continue receiving services already received in accordance with the original organization determination (this is a request for a new set of services) • States that their drug was rejected at the pharmacy but they need it • States that a drug is not excluded from Part D coverage for the indication for which it is being prescribed	• An enrollee disputes the calculation of a co-payment or believes the plan should be responsible for co-pay amount • The plan denied a request for a drug, service or item and the enrollee disputes this

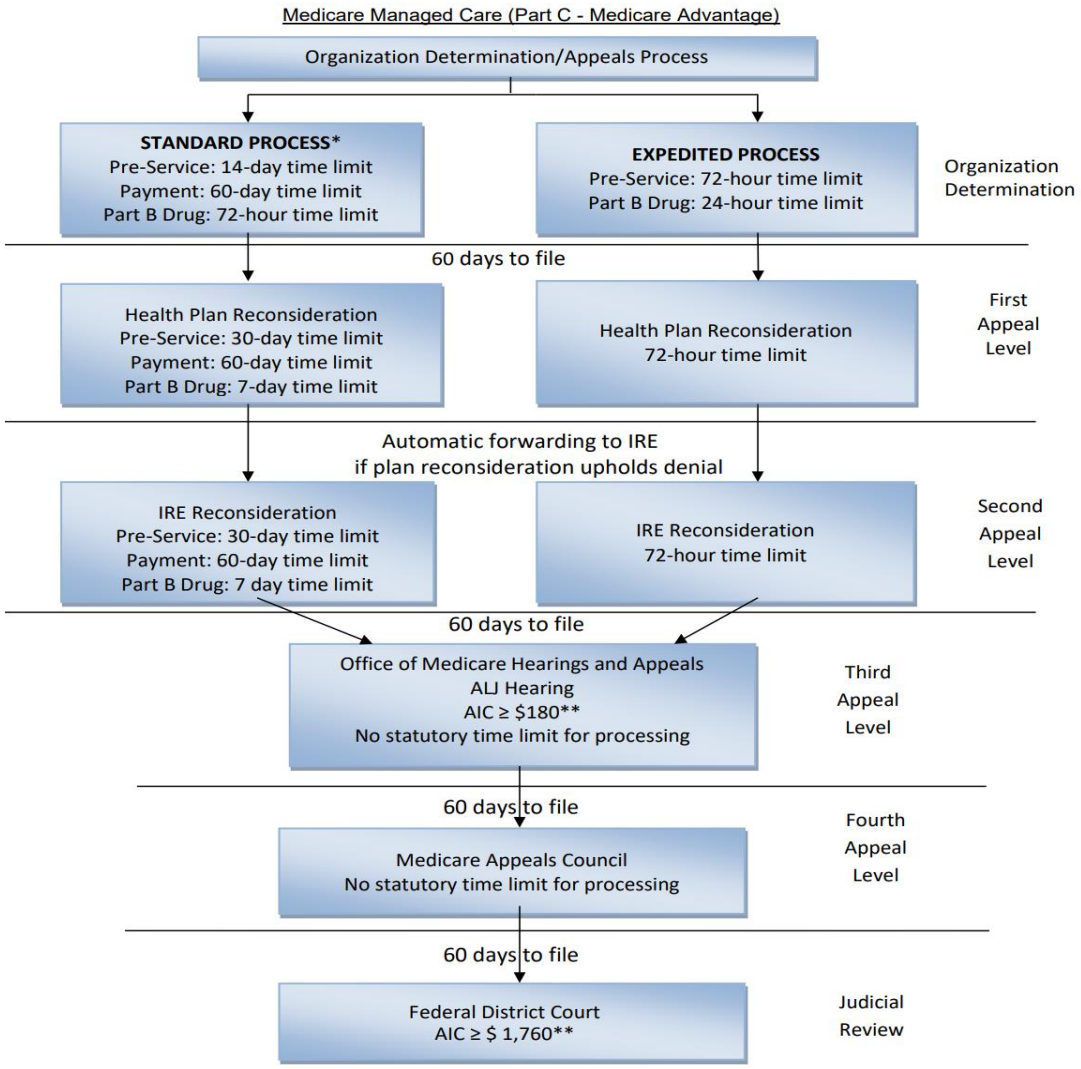
I-SNP / D-SNP
Coverage/Organization Determination

Category	Filing Time Frame for Member	Expedited Timeframe for Plan	Standard Timeframe for Plan	Extension for Plan
Part D Coverage Determination (Initial Request)	NA	24 hour time limit of receipt of coverage determination request	72 Hour of receipt of coverage determination request	NA
Part C Organization Determination (Initial Request) Pre Service	NA	72 hours of receipt of organization determination request	14 calendar days of receipt of organization determination request	up to 14 days may be requested
Part C Organization Determination (Initial Request) (Payment)	NA	NA New [*D-SNP Only - 72 hours of receipt of organization determination request]	- 95% Clean Claims - 30 calendar days. - All other claims 60 calendar days from the date it received the request. *only for non-contracted providers	NA

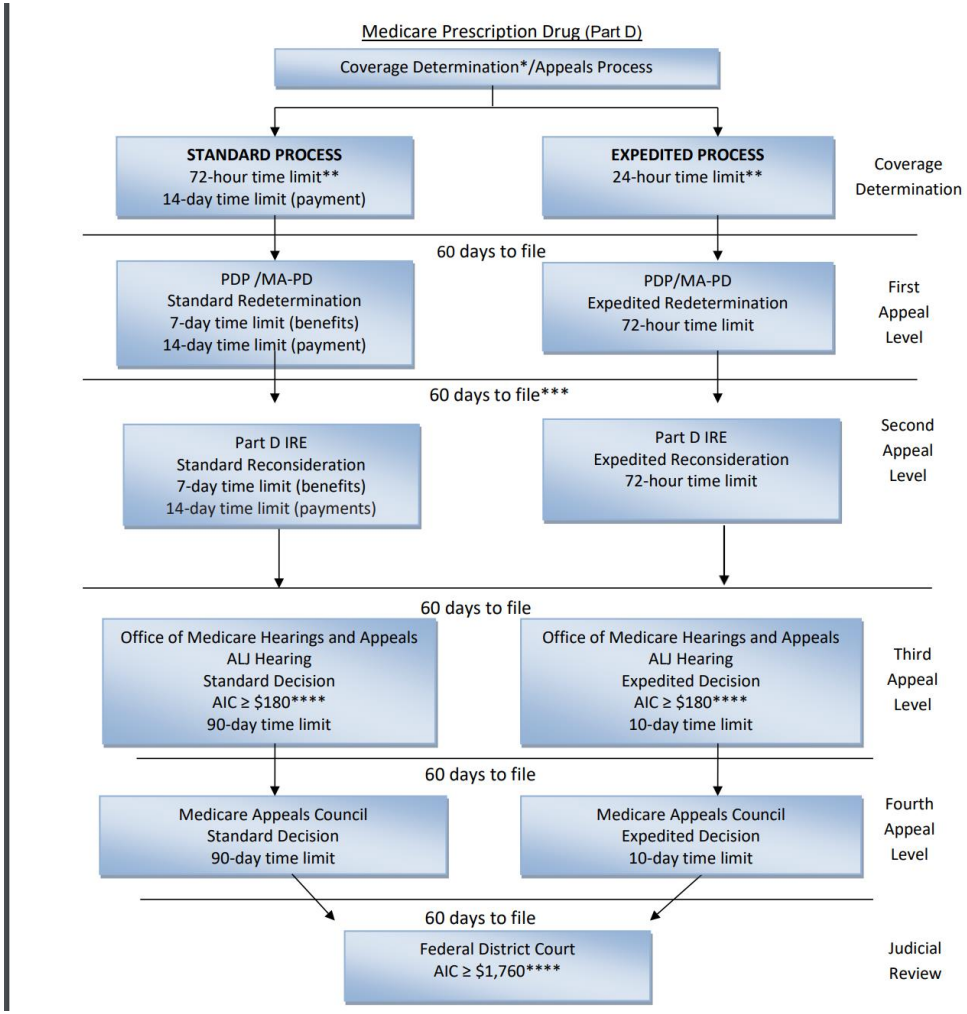
Grievances/Appeals Timeframes

Category	Filing Time Frame for Member	Expedited Timeframe for Plan	Standard Timeframe for Plan	Extension for Plan
Grievance	60 calendar days New [*D-SNP Only – Anytime]	24 hours	30 calendar days of the receipt of the grievance	up to 14 days may be requested
Part D Level 1 Appeal	60 business days	72 hours of receipt of appeal request	7 calendar days of receipt of appeal request	NA
Part D Claim (Payment) Level 1 Appeal	60 business days	N/A	14 calendar days of receipt of appeal request	N/A
Part C Pre-Service Level 1 Appeal*	60 calendar days	72 hours of receipt of appeal request	30 calendar days of receipt of appeal request.	up to 14 days may be requested
Part C Claim (Payment) Level 1 Appeal	60 calendar days	NA ***[*D-SNP only: 72 hours of receipt of post service Payment requests]***	60 calendar days from the date it received the request ***[*D-SNP only: payment cases must be adjudicated within 30 days]***	[*D-SNP only -up to 14 days may be requested]

Part C Appeal Flow Chart



Part D Appeal Flow Chart



Marketing

- RiverSpring Health Plans does not discriminate against potential enrollees on the basis of health status, anticipated need for health care, disability or perceived disability, or need for services. RiverSpring Health Plans complies with requirements under the regulation implementing Section 1557 of the Affordable Care Act of 2010 - Nondiscrimination Communication Requirements, Multi Language taglines and Grievance Procedures.

- RiverSpring Health Plans will not directly or indirectly engage in door-to-door solicitation, telephone, or other cold call marketing activities. RiverSpring Health Plans will not solicit referrals or require Participating Network Providers to engage in marketing practices on behalf of RiverSpring Health Plans. RiverSpring Health Plans will not distribute materials or assist potential enrollees in completing application forms in hospital emergency rooms, in provider offices, or other areas where health care is delivered unless requested by the individual.

- RiverSpring Health Plans will not market for an upcoming plan year prior to October 1. Starting October 1, RiverSpring Health Plans can market current and prospective years and will ensure marketing materials will clearly indicate what plan year is being discussed.

Participating Provider Network

RiverSpring Contracts Department is responsible for ensuring that participating providers, facilities and vendors are actively licensed and credentialed.

- This includes ensuring that all applicable licensures and certifications are active without restrictions from any governing or professional bodies, in compliance with CMS and DOH regulatory credentialing standards.

Recredentialing occurs on a three-year (3) cycle and as necessary, e.g. when the Plan becomes aware of poor outcome from a regulatory survey or adverse events

- Substantiated concern or sanction with providers results in actions such as corrective action plan from provider/vendor or recommendation of termination or non-renewal from participation with the Plan.

Compliance

Suspect Something, Say Something

Fraud, Waste and Abuse (FWA) is a significant concern for RiverSpring Health Plans and the entire health insurance industry.

Any RiverSpring Health Plans director, officer, manager or staff member, or any other person affiliated with RiverSpring Health Plans, who suspects FWA is required to report the suspected FWA. A report of suspected FWA may be made directly to the Compliance Department, as below or to anyone in authority at the plan:

- **Compliance Hotline:** 1-855-265-6106
- **E-mail:** Reportfraud@elderservehealth.org

Anyone who reports FWA may do so anonymously. Information received or discovered will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., State and Federal authorities, Medical Directors and/or Senior Management).

RiverSpring Health Plans has a strict policy of non-retaliation and non-intimidation against anyone who in good faith reports suspected FWA or another compliance issue.

Health Insurance Portability and Accountability Act (HIPAA)

- RiverSpring Health Plans complies with both with HIPAA and NY State laws related to personally identifiable or protected health information.

- Our *Privacy Officer* is: **Jenny Ling**
  Compliance Officer
  1-347-842-3528

- Our *Security Officer* is: **Damon Ramaglia**
  Vice President of IT
  1-347-842-3584