



RI MANAGED MEDICAID MODEL MEMBER HANDBOOK

DRAFT - Final Documents to be provided to awarded Contractor

Here's Where to Find Information You Want

Important Phone Numbers

HealthSource RI	1-855-840-4774
RI Department of Human Services	1-855-697-4347
UnitedHealthcare Dental/Rite Smiles	1-866-375-3257
RI Public Transit Authority (RIPTA)	(401) 784-9500, ext. 2012
Non-Emergency Transportation Broker	1-855-330-9131
RI Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH)	1-855-747-3224
RI Legal Services	(401) 274-2652

<MCO> Member Services: <1-xxx-xxx-xxxx>
<days/hours of operation>

My Primary Care Provider Name: _____

Telephone: _____

Address: _____

If we have any significant change to the information found in this Member Handbook, we will let you know at least 30 days before we make the change. Things included would be changes in your benefits and how you get them.

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Welcome to <MCO>

We are glad that you enrolled in <MCO>. This handbook will be your guide to the full range of health care services that you may get. We want to be sure you get off to a good start as a new member. To get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at <Member Services #><TTY>.

How Managed Care Works

The Plan, Our Providers, and You

- You may have heard about the changes in health care. Many consumers get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, many of those services are now available through <MCO>.
- <MCO> has a contract with the Rhode Island Executive Office of Health and Human Services to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs, and other health care facilities make up our provider network. You will find a list in our *Provider Directory*. If you do not have a *Provider Directory*, call <Telephone #> to get a copy or visit our website at <Website>.
- When you join <MCO>, one of our providers will take care of you. Most of the time, that person will be your Primary Care Provider (PCP). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.
- If you need to talk to your PCP after hours or weekends, leave a message and how you can be reached. Your PCP, or the provider covering for him/her, will get back to you as soon as they are able.

Confidentiality

We respect your right to privacy. <MCO> understands the trust needed between you, your family, your doctors, and other care providers. <MCO> will never give out your medical or behavioral health information without your written approval. The only persons that will have your health information will be <MCO>, your Primary Care Provider, other providers who give you care, and anyone who you have asked to talk about your care for you. Your PCP will always

talk to you about referrals to other providers. <MCO> staff has been trained in keeping your information private.

Transition of Care

<MCO> is responsible for making sure that all its members can keep getting the care that they need. You can keep getting care from your provider for 180 days after joining <MCO>. You can see that provider even if that provider is not in our network. After that time <MCO> will work with you so you are referred to the right providers that are in the network.

Member ID Cards

When you join <MCO>, you will get a member ID card in the mail about 10 days after your effective date. Check to make sure the information on your ID card or your family member's ID card is right. If any information is wrong, please call Member Services at <number>.

<insert image of MCO ID card>

You will also get a RI Medicaid (anchor) card in a separate mailing from the State of Rhode Island. Each family member who is enrolled will have their own card.

<insert image of Medicaid (anchor) card>

Always show both ID cards when you go to the doctor, hospital, pharmacy or other provider.

Update Your Information

- **It's very important that we have your correct address**, so you can receive mail from <MCO> and the RI Medicaid Program. Be sure to have your full name on your mailbox (and other family members' last name if it is different than your own). The post office will not deliver mail if the last names on the mailbox do not match the last name on the letter/envelope.
- **It's very important to tell us if you have a change**, in any of these:
 - Name, address, phone number.
 - If you move out of state.
 - If you get married; if you change your last name.
 - If you become pregnant.
 - Family size (adding a new baby or adopting a child, death of a family member who is enrolled, etc.)
 - Change in income that could affect eligibility for Medicaid.
 - If you have other health insurance.
- **You are required to report changes** to Healthsource RI or the RI Department of Human Services (DHS) within 10 days of the change.

How to Tell Us About Changes

Contact **Healthsource RI** to report any of these changes. If you have an account at Healthsource RI, you can go online at www.healthsourceri.com or call 1-855-840-4774 to make a change. You can also visit the Healthsource RI walk-in center at 401 Wampanoag Trail, East Providence, RI 02915. Business hours are Monday – Friday, 8:00 am – 6:00 pm.

If you, your child, or another family member has SSI or became eligible for Medicaid due to a disability, please call the **RI Department of Human Services (DHS)** at 1-855-697-4347. You can also contact your local DHS Office to report changes. Business hours are Monday – Friday, 8:30 am – 4:00 pm.

Renew Your Medicaid Eligibility

RI Medicaid will send you a notice about renewing your eligibility. If you receive this notice, please answer promptly so your health coverage is not stopped. Be sure to answer all notices. If you have questions about your notice, please call Healthsource RI or DHS.

Member Information

We want to make it as easy as possible for you to get the information and services you need from

<MCO>. Check our website or call Member Services for more information. We're here for you!

Member Services: <1-800-XXX-XXXX (TTY 711)>, < days of the week> <times of the day>. After business hours, please leave a message and we will get back to you soon.

Member Services can help you:

- Understand your benefits.
- Get a member ID card, if lost.
- Find a provider or urgent care clinic.
- Make a complaint or file a grievance or appeal

Website: Go to <MCO website> to view plan details and helpful tools.

- Find a provider or pharmacy.
- Search for a drug on the Preferred Drug List.
- Get benefit details.

View or download a Member Handbook.

We speak your language

If you speak a language other than English, we can provide an interpreter or print materials in your language. If you call Member Services we can connect you with a representative who speaks your language or an interpreter. If you need an interpreter for a medical, behavioral health or dental appointment, we can arrange for one. Please call Member Services <telephone #> at least 72 hours before your appointment. If you need an American sign language interpreter, please call at least 2 weeks prior to your appointment.

<MCO's> *Provider Directory* indicates if a provider speaks other languages in addition to English. To check the Provider Directory, visit <provider directory link>.

Need Print Material in Other Formats?

If needed, we can provide printed material in other formats, including print materials in a larger font, audio or Braille. Please contact Member Services <telephone #> to request materials in other formats.

Your Primary Care Provider (PCP)

Your Primary Care Provider (PCP) is the health care professional who knows you best. He/she works with you to keep you and your family healthy.

You have options.

You can choose your PCP from the following types of providers:

- Family doctor or general practitioner
- Internal medicine doctor (Internist, Geriatrician)

- Pediatrician
- Obstetrician/Gynecologist (OB/GYN)
- Nurse Practitioner (NP)
- Physician's Assistant (PA)

Choosing your PCP.

Check to see if your doctor is in <MCO's> network. If you don't already have a PCP when you join <MCO>, you can choose one from our network. Each member of your family can have his or her own PCP.

Our *Provider Directory* lists all the primary care providers in our network. It also tells you where the provider's office is, the phone number, the languages spoken, the hours the office is open, if they are accepting new patients and if their office is handicap accessible. To see the directory, go to our website at: <MCO website> or call Member Services to ask for a copy or for help picking a PCP. We also have a printed *Provider Directory* available upon request that lists all <MCO> providers by specialty and location.

After you select a PCP, please call Member Services to let us know. If you do not choose a PCP, we will choose one for you.

What your PCP can do for you:

- Give you regular checkups and screenings
- Arrange tests
- Keep your medical records
- Recommend and refer you to specialists
- Write prescriptions
- Help you get behavioral health services
- Answer questions about your health care

Changing your PCP.

You can change your PCP or your child's PCP at any time, however, there's value in staying with the same PCP. As you get to know one another and develop trust, you can work through your health issues with your PCP. If you need to change your PCP, call <Member Services> .

If your PCP leaves the <MCO> network, we will send you a letter to let you know. You can choose another PCP from our network. There are times when <MCO> will let you continue to get care from your PCP or specialist for some time after he/she has left our network. This is called "continuity of care." If you are pregnant or being treated for an ongoing medical condition, we can work with your provider, so he/she can continue to treat you longer. We will work with you and your provider to make sure you safely change to another provider.

Getting Care

Making an Appointment with your PCP

Call your Primary Care Provider's office to schedule an appointment.

Annual Checkups

You don't have to be sick to go to your PCP (doctor). Yearly checkups with your PCP are important to keep you healthy. Plus, your PCP will make sure you get the necessary screenings, tests and shots you need. If you have a health problem, it's easier to treat when found early. Talk to your PCP about what is right for you and your family.

Specialty Care

Your doctor (PCP) may refer you to a specialist. Some services may require a referral from your PCP before getting care. Those services are [<insert MCO specific services requiring a referral>](#).

Specialists are doctors with special training and work in a particular field of medicine. Specialists include: Cardiologist (heart doctor); obstetricians/gynecologists who treat women's health needs including family planning and pregnancy; Ophthalmologist (eye doctor); Podiatrist (foot doctor); and Dermatologist (skin doctor).

You do not have to see the specialist your PCP suggests. You can ask your PCP for the name of another specialist. Or you are free to pick any network provider for specialty care. Not seeing the specialist will not affect your future treatment by your PCP. You have a right to refuse the treatment a specialist recommends. If that happens, contact your PCP to talk about other options.

Urgent Care

Urgent care centers are available when you need to see a provider for a non-life-threatening condition, but your PCP isn't available, or it is after clinic/office hours. Common health issues that may be treated in an urgent care center include:

- Sore throat
- Ear infection
- Minor cuts or burns
- Flu
- Low-grade fever
- Sprains

If you or a family member has an urgent problem, call your PCP first. Your PCP can help you get the right kind of care. Your PCP may tell you to go to an urgent care center (or the emergency room).

Emergency Services

An emergency is a life-threatening illness or injury. It can cause serious pain or harm to your health if you do not receive treatment right away. Some examples of emergency conditions include:

- Serious illness or trauma
- Broken bones
- Bleeding that will not stop
- Heart attack
- Poisoning
- Severe cuts or burns
- Behavioral health emergency such as drug overdose or threat of harm to self or others

You can go to any hospital for emergency care. <MCO> covers any emergency care you need throughout the United States and its territories. Within 24 hours after your visit, you should call your PCP and let them know about your visit. You may need follow-up care.

If you need emergency care, call 911 or go to the nearest hospital. Emergency care does not require a referral from your PCP or a prior authorization from us.

Early Periodic Screening Diagnostic Treatment (EPSDT)

EPSDT stresses preventive and complete care. As they grow, infants, children and younger people should see their PCP often. It is important that they receive all suggested preventive services and any medical treatment needed to help healthy growth.

Children up to age 21 should receive regular well-child check-ups of their physical and mental health, growth, development, and dietary status. A well-child check-up includes:

- A complete health and growing history, including both physical and mental health development assessments;
- Physical exam;
- Age-appropriate shots;
- Vision and hearing tests;
- Dental exam;
- Laboratory tests, including blood lead level assessments at certain ages; and
- Health education

Your child's PCP will let you know how often you will need to bring your child in for a visit.

Behavioral Health Services

Behavioral health services include mental health and treatment for substance use problems. <MCO> is contracted with <name of BH vendor if appropriate> to provide these services. To find a behavioral health provider, call <vendor> at <behavioral health phone number>. This number is also on your <MCO> member ID card. Member Services representatives are available 24 hours a day, seven days a week to help you. Your call is confidential. Check the *Provider Directory* for a list of behavioral health providers. If you are not sure what type of help you need or the type of provider, our Member Services representative can help you.

If <MCO> does not cover a counseling or referral services because of moral or religious objections, we will let you know that the service is not covered by us. We will also tell you how you can obtain information from the Executive Office of Health and Human Services (EOHHS) about how to get these services.

Dental

Dental services for children are provided through Rite Smiles. Rite Smiles is a dental plan for children who are eligible for RI Medicaid born after May 1, 2000. To find a dentist who participates with the Rite Smiles program, check the website for UnitedHealthcare Dental/Rite Smiles (<https://www.uhc.com/ritesmiles>) or call United Healthcare Dental Member Services at 1-866-375-3257. All other members should use their Rhode Island Medicaid card (Anchor card) when going to a Medicaid Dental provider.

Appointment Availability

Appointment	Access Standard
After Hours Care Telephone	24 hours 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within twenty-four (24) hours
Routine Care Appointment	Within thirty (30) calendar days
Physical Exam	180 calendar days
EPSDT Appointment	Within 6 weeks
New member Appointment	Thirty (30) calendar days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within ten (10) calendar days

Special Programs to Keep You Healthy

If you have health condition for a long time, like diabetes or heart disease, you may benefit from

our care management programs. Our nurse care managers can help you understand your options, how to stay healthy and keep a better quality of life. Care management helps members with special needs get the services and care they need. Care managers work with the health plan, providers and outside agencies. Call our Medical Management Department at <1-800-XXX-XXXX>. **Getting a Second Opinion**

A second opinion is when you want to see another provider to get his or her opinion or recommendation for your health concern or problem. You can get a second opinion from a network provider for any of your covered benefits. This is your choice. You are not required to get a second opinion. A second opinion from an out-of-network provider is available with a prior authorization.

Out of Network/Out of Area Care

Other than emergency services and urgently needed care, all covered benefits, care, and services provided out of area need to be approved by <MCO> first. Sometimes you may need care from a provider who is not in our network. This provider is out-of-network. To see an out-of-network provider you will need prior authorization from <MCO> before you make an appointment. Your PCP should submit the request for review. Call Member Services to learn more and if it will be covered in full. You may have to pay for those services.

Prior Authorizations

Sometimes your provider must get permission from <MCO> before giving you a certain service. This is called prior authorization or prior approval. This is the provider's responsibility. If the provider does not get prior authorization, you will not be able to get the service.

Non-Emergency Medical Transportation

Transportation may be available for medical, dental or other health-related appointments. If family, friends or neighbors cannot drive you to appointments, you have several options.

✓ Rhode Island Public Transit Authority (RIPTA)

RIPTA has fixed-route bus services to most communities in Rhode Island. Routes are available online at www.ripta.com or by calling Customer Support at 401-781-9400. RIPTA also offers flex services and the ADA Disabled Program.

✓ Non-Emergency Medical Transportation Broker

Non-Emergency Medical Transportation is a covered benefit in RI Medicaid. The contracted vendor for these services is MTM, Inc. Please contact MTM at 1-855-330-9131 (TTY 711), Monday- Friday, 8:00 am to 5:00 pm to arrange for rides to medical, dental or other health-related appointments. Bus tickets for appointments need to be requested seven (7) business days prior to the appointment.

Van or taxi rides to medical appointments may be available for members who qualify. Please allow 48 hours prior to your appointment. For example:

- Call Monday for a ride on Wednesday;
- Call Tuesday for a ride on Thursday;
- Call Wednesday for a ride on Friday, Saturday or Sunday;
- Call Thursday for a ride on Monday;
- Call for Friday for a ride on Tuesday.

✓ **Mileage Reimbursement**

If you qualify for transportation and you or someone else can drive you, you may get money for gas. There are several rules and requirements.

Please contact MTM for more information. <MCO> Member Services can also help with setting up or coordinating transportation if you need it.

Covered Benefits

You are eligible to receive these benefits with your <MCO> ID card. You do not have any cost sharing responsibilities. However, if a provider tells you a service is not covered by <MCO>, and you still get the service, you will have to pay for it. There are some services that are not covered.

You should not be balanced billed by your provider for a covered service. Call <MCO> Member Services if you receive a bill.

Description of Benefits from <MCO>. For more detail on what is covered, call Member Services at <Telephone #>.

Covered service/benefit	Coverage
Provider services	Includes the services of primary care physicians, specialists, obstetrician-gynecologists (OB/GYN) and other network providers.
Services of other practitioners	Includes the services of practitioners certified or licensed by the State of Rhode Island, i.e., nurse practitioners, physician's assistants, social workers, registered dietitian nutritionists, psychologists, and certified nurse midwives.
Annual wellness check-ups and preventive screenings, immunizations	Covered when provided by primary care providers (PCPs) in the MCO network.
Eye care	Includes medically necessary treatment for illness and injury to the eye. For adults: Routine eye exams and one pair of glasses are covered once every 24 months; For members with diabetes, eye exams are covered once every 12 months. For children under age 21: eye exam and glasses are covered as needed.
Foot care	Covered with a referral by a MCO physician/provider.

Group/Individual education classes	The following group classes are covered: childbirth education, parenting, smoking cessation, diabetes, asthma, nutrition, lactation consultation etc.
Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) services	Screening, diagnosis and treatment services for children and young adults up to age 21. Includes the initial and follow-up visits. Includes inter-periodic screens as <i>medically</i> indicated.
Special Education	Services Covered for children with special needs or developmental delays as stated in the child's Individual Education Plan (IEP) are covered but not provided by <MCO>.
Lead Program	Covered — includes home assessment and non-medical case management. Services <i>are provided by the state Department of Health or lead centers for lead-poisoned children and not</i> <MCO>.
School-Based Clinic Services	Covered if Medically Necessary at all designated sites.
Family Planning Services	Includes over-the-counter (OTC) family planning supplies including foam, condoms, spermicidal jelly or cream, and sponges. Screenings for sexually transmitted infections (STIs) and HIV are covered. You can go to any provider, including out-of-network providers, for these services.
Prenatal and post-partum care	Covered by MCO physician/provider.
Nutrition services	Covered by licensed Registered Dietitian Nutritionists (RDNs) for certain medical conditions. Referral by a MCO physician is required.
Therapies	Covered as medically necessary. Includes physical therapy, occupational therapy, speech and language therapy, hearing therapy, respiratory therapy.
Lab tests, diagnostic services, radiology services	Covered when ordered by a MCO physician/provider.
Prescription drugs	Covered when ordered by a MCO physician/provider. Must use generic drugs first. There are a limited number of brand drugs that are approved; most require prior authorization. Check the drug formulary at <MCO website>.
Non-prescription drugs (OTC)	Covered when your MCO physician/provider writes a prescription for one of the OTCs listed on our formulary. Also referred to as “over-the-counter” drugs. Includes family planning supplies and nicotine cessations supplies.
Durable Medical Equipment	Covered when ordered by a network provider. Includes surgical appliances, prosthetic devices, orthotic devices, assistive technology and other medical supplies.

Hospital care, inpatient	Covered as medically necessary. Includes Medicaid covered services delivered in an inpatient hospital setting.
Hospital care, outpatient	Covered as medically necessary. Includes Medicaid covered services delivered in an outpatient hospital setting. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting.
Emergency room services	Emergency room services are covered both in and out of state for emergency situations. Prior authorization is not needed for emergency care.
Emergency transportation	Covered as medically necessary.
Behavioral Health services	Includes community-based mental health and substance use counseling and treatment services.
Behavioral Health services, intensive	Covered as needed. Behavioral Health and Substance Use Disorder treatment includes but is not limited to the following: community-based narcotic treatment, methadone, detoxification, emergency services intervention, observation/crisis stabilization, acute inpatient services, acute residential treatment, partial hospital programs, mental health psychiatric rehabilitation residences (MHPRR), day programs, intensive outpatient treatment programs, assertive community treatment (ACT), integrated health homes (IHH), community mental health center services, home-based treatment services (HBTS), applied behavior analysis (ABA), personal assistance services and supports (PASS) and respite. Residential treatment does not include room and board. Services also include administratively necessary days ordered by the Department of Children, Youth and Families.
Court-ordered mental health and substance use services	Services are provided in-plan; includes transitional care management services after court-order services end.
Preventive home health services	Covered when ordered by a MCO physician/provider. Prior authorization may be required. Services include homemaker services, minor environmental modifications, physical therapy, home assessment, and personal care services.
Home care services	Covered services provided under a home care plan authorized by a physician including full-time, part-time, or intermittent care by a licensed nurse or home health aide (certified nursing assistant) for patient care and including, as authorized by a physician, physical therapy, occupational therapy, respiratory therapy, and

	<p>speech therapy. Home care services include laboratory services and private duty nursing for a patient whose medical condition requires more skilled nursing than intermittent visiting nursing care. Home care services include personal care services, such as assisting the client with personal hygiene, dressing, feeding, transfer and ambulatory needs. Home care services also include homemaking services that are incidental to the client's health needs such as making the client's bed, cleaning the client's living area, such as bedroom and bathroom, and doing the client's laundry and shopping. Homemaking services are only covered when the member also needs personal care services. Home care services do not include respite care, relief care, or day care.</p>
Home health services	<p>Home health care is supportive care provided in the home. Care may be provided by licensed healthcare professionals who provide medical treatment needs or by professional caregivers who provide daily assistance to ensure the activities of daily living (ADLs) are met. For patients recovering from surgery or illness, home care may include rehabilitative therapies.</p>
Rehabilitation services	<p>Physical, occupational, and speech/language therapy provided in licensed outpatient rehabilitation centers and ordered by a MCO physician.</p>
Adult day health	<p>Covered for frail seniors and other adults who need supervision and health services during the daytime when medically necessary. Prior authorization is required.</p>
Nursing home care, skilled nursing facility care	<p>Covered for Rhody Health Partners and Rhody Health Expansion members for 30 consecutive days. All skilled and custodial care covered.</p>
Hospice services	<p>Covered when ordered by a network provider. Services are limited to those services covered by Medicare.</p>
Services for members with HIV/AIDS or at high-risk for HIV	<p>Medical and non-medical case management services. Benefits/entitlement counseling and referral activities to help member to obtain get to public and private programs.</p>
Transplant services	<p>Covered when ordered by a Health Plan physician.</p>
Gender Dysphoria Treatment	<p>Some services may require Prior Approval.</p>

Benefits from RI Medicaid

Covered service/benefit	Coverage
Dental Services	<p>Includes routine dental check-ups and treatment for adults and children.</p> <p>Children born before May 1, 2000 receive dental benefits through UnitedHealthcare Dental & the RIte Smiles program. Emergency dental services are covered in-plan by <MCO>.</p> <p>For older children and adults, dental services are provided using the Medicaid (anchor) card.</p>
Non-emergency medical transportation	<p>Includes coverage for bus tickets, van or taxi ride to Medicaid covered or health plan prior approved medical, dental, or other health care provider appointments if no other transportation is available. Must be scheduled in advanced.</p>

Extended Family Planning Benefits

This benefit is for women who have:

- Qualified for RIte Care;
- Were pregnant and are now sixty days postpartum or sixty days post-loss of pregnancy;
- Are subject to losing eligibility for Medicaid.

Eligible women may receive for *up to twenty-four months* of the following schedule of family planning-related benefits:

Covered service/benefit	Coverage	Copay
Prescription and Non-Prescription Family Planning Methods	Covered, including these drugs: emergency contraceptive pills, specific oral contraceptives, contraceptive patches, Depo-Provera, cervical caps, and diaphragms. Over-the-counter (OTC) family planning supplies, including foam, condoms, spermicidal jelly or cream and sponges, are covered with a prescription from your doctor.	\$1.00
Outpatient Hospital Services and Surgery-related Services	Tubal ligation (sterilization). IUD insertion and removal.	\$15.00

Outpatient Procedures (in the office or clinic) – Office Visit	One comprehensive GYN visit and up to 5 additional family-planning method related office visits. Tubal ligation (sterilization). IUD insertion and removal.	\$2.00
Referrals to Free Clinics for Other Medical Services Contact the Rhode Island Department of Health at 401.222.2320 for a list of clinics and counseling locations that can provide these services to you	Referral for other services as needed. For example, referrals to the state's: Sexually transmitted disease clinic for treatment Confidential HIV testing and counseling sites	None
Gynecological Services (Well Woman Care)	Includes annual GYN exam, one comprehensive visit and up to 5 family-planning visits annually.	\$2.00
Laboratory	Includes pregnancy testing, annual pap smear, sexually transmitted disease testing, anemia testing, dipstick urinalysis, and urine culture	None

Out-of-Network Services

Covered service/benefit	Coverage
Emergency care	Covered in the United States and its territories. No prior authorization needed.
Family planning services	Members can see <MCO's> providers or out-of-network providers for family planning services. No referral is needed.
All Other Services	Require prior authorization from <MCO>. Call Member Services at <telephone #>.

Non-Covered Services

- Experimental procedures
- Abortion, except to preserve the life of the woman or in cases of rape or incest
- Private rooms in hospitals, unless medically necessary
- Cosmetic surgery
- Infertility treatment services
- Medications for sexual or erectile dysfunction

Member Rights and Responsibilities

As a member of <MCO>, you have a **RIGHT**:

- To receive information about <MCO>, its services, providers and members' rights and responsibilities
- To be treated with respect and dignity and right to privacy.
- To participate with your providers in decision-making about your health care, including the right to refuse treatment.
- To privacy of all records and communications as required by law. (<MCO> employees follow a strict confidentiality policy regarding all member information.)
- To respectful, personal attention without regard to your race, national origin, gender, gender identity, age, sexual orientation, religious affiliation, or preexisting conditions.
- To an open discussion of appropriate home and community services or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To get a second medical opinion for medical and surgical concerns.
- To voice grievances, complaints or appeals about <MCO> or the care provided by its providers and/or agencies.
- To make recommendations about <MCO>'s Member Rights and Responsibilities policies.
- To refuse treatment, and if you do, it will not affect your future treatment.
- To receive information on available treatment options and alternatives.
- To be free from any form of coercion, discipline, or retaliation.
- To request and receive a copy of your medical records, and request that they be amended or corrected.
- To be given health care services.
- To exercise your rights, and that the exercise of those rights does not negatively affect the way <MCO> and its providers treat you.

You have a **RESPONSIBILITY** to:

- To report changes such as, address, income, family size, etc. to the State (Healthsource RI or the Department of Human Services) within 10 days of the change.
- To choose a PCP and primary care site. Your PCP will coordinate all of your medical care. You may change your PCP at any time by calling <MCO> Member Services.
- To have all of your medical care provided by, or arranged by, a provider in the <MCO> network.
- To carry your <MCO> member ID and your Rhode Island Medicaid card with you
- To provide, to the extent possible, information that <MCO> and its practitioners and providers need to care for you.
- To learn about your health problems and understand the health plan treatment you and your provider agree on.
- To follow the plans and instructions for care that you have agreed on with your providers.
- To talk with your PCP about all specialty care. If you need a specialist, your PCP will work with you to make sure you get quality care.
- To call your PCP first for help if you have an urgent medical condition. If an emergency is life threatening, call 911 right away or go to the nearest emergency room.

Call <MCO> Member Services if you have any questions about your rights and responsibilities.

Advance Directives

When you can no longer make health care decisions for yourself, there are documents that will help make your wishes known. These are called living wills and durable power of attorney.

- A living will is a set of instructions. It says what should happen if you become seriously ill and are unable to communicate.
- Durable power of attorney lets another person make health care decisions for you. You choose who this person will be. It could be your spouse, a family member, or a friend.

Advance directives explain the treatment you want if you become seriously ill or injured. Advance directives can be written or spoken. Ask your primary care provider about these options. You also can find more information and related forms at the Rhode Island Department of Health website, www.health.ri.gov/lifestages/death/about/endoflifedecisions/.

Complaints, Grievances, and Appeals

You have a right to make a complaint, file a grievance or an appeal. If you are unhappy about the care or services you receive, we want to know about it, so we can help fix the problem.

Can someone else complain or file a grievance or appeal for me?

Yes. Your doctor, another provider, friend, family member or anyone you want, can ask for you. First you must let us know in writing that you are allowing that person to work with us. Members can complete an *Authorized Representative form* that gives the person permission to help with your complaint, grievance or appeal. <MCO> **must** get the completed form before we can talk to the person you've identified. Keep a copy of your Authorized Representative form. The form is valid for one year from the date you sign it unless you tell us you no longer want to allow someone to act on your behalf. To get an Authorized Representative form, call Member Services.

Complaints

You or your authorized representative have the right to file a complaint at any time. Please call your <MCO> Member Services. We can address your questions or concerns about benefits, services, access to appointments, wrong bills you receive or other issues. If possible, we will resolve your problem at the time of your call. If that is not possible, we will ask for more information and get back to you within <MCO specified timeframe> calendar days after your complaint is filed. At any time, we may ask you for more information.

You, or your authorized representative, can also file a complaint or grievance in writing.

Send them to:

<MCO>

Attn: <department>
<address>
<address>

Grievances

A grievance is a dissatisfaction about any matter other than a service not being covered. Examples of a grievance include:

- You are not satisfied with the way we responded to your complaint
- You disagree with us asking for more time to make an authorization decision
- You have concerns of quality of care or services provided
- You feel a provider or their employee was rude
- You feel a provider did not respect your member rights

You may file a grievance at any time. We will respond to your grievance within 90 calendar days. Sometimes we need more information or time to decide. If we need more time, we will contact you to let you know.

You or your authorized representative can file a grievance in writing or over the phone at any time. Filing a grievance will not affect your health coverage.

Appeals

An appeal is a request to change a decision made by <MCO> for medical care, services, or drugs that you or your provider believe you should receive. It could also be a request for services or supplies that are not included in your covered benefits that you or your provider believe you should receive. You or an authorized representative can file an appeal in writing, in person, or by calling <MCO> Member Services. Requests to review services that were denied by us must be made within 60 calendar days of our decision to deny a service or supply. We will review the care or services that were denied or the coverage decision that was made.

Send written appeals to:

<MCO>
Attn: <department>
<address>
<address>

Qualified <MCO> staff decide on appeals that are not about medical issues. Qualified health care professionals decide on appeals about medical issues. about your appeal within 30 calendar days of our receiving it. We may ask you for an additional 14 calendar days if we need more to look into your appeal.

Commented [CK(-C1): Delete "Period" (.) and delete "about your appeal"

You have a right:

- You have a right to ask for and get copies of all documents related to your appeal. You may add information about the appeal to your file in writing or in person.
- You have a right to continue to have Medicaid covered services while your appeal is under review. To have these Medicaid covered services continue, you must call or tell us within 10 calendar days of the denial. If your appeal is denied, you may have to pay for the cost of any continued benefits you received. If your appeal is approved and you did not request that your services be continued while your appeal was being decided, we will authorize or provide services within 72 hours.
- You have a right to a fast (expedited) appeal if your provider feels a delay in your care or treatment might be a risk to your life or cause you severe pain. You or your provider should call <MCO> Member Services to request a fast appeal.

Urgent (Fast) Appeals

You can ask us for an urgent or “fast” appeal if waiting up to 30 calendar days for a decision would cause severe pain or could be a risk to your life without immediate medical attention. When your provider feels a delay in your care or treatment might be a medical emergency, you or your provider should call <MCO Member Services> to request a fast appeal. We will respond to your fast appeal within 72 hours of receiving it. We may need to extend our review time for up to 14 days. If we need to extend our timeframe, we will notify you within 2 calendar days of our decision to extend the timeframe.

If you disagree with our decision to take more time, you may file a **GRIEVANCE** with us. If we deny your request for a fast appeal, we will decide on your appeal within 30 calendar days of receiving your appeal.

External Appeals

After you complete the appeal process with your MCO, and you are still not satisfied, you can request that an Independent Review Organization (IRO) review your appeal for medical services. Requests for external appeals must be received within four months from the date of your appeal decision. Call <MCO's Member Services> for help or for written directions on how to file an external appeal.

State Fair Hearing

If you are not satisfied with the outcome of the MCO's appeal decision, you may request a State Fair Hearing. Your request must be within one hundred and twenty (120) calendar days from the date of your appeal decision. The State Fair Hearing is facilitated by the Executive Office of Health and Human Services (EOHHS). You have a right to have Medicaid covered services continue while you are going through a State Fair Hearing. If the State Fair Hearing appeal is denied, you may be responsible for the cost of any continued benefits you received. To request a State Fair Hearing, you can either:

- Call 401-462-2132 (TDD 401-462-3363), after you have finished the MCO's internal appeal process, or
- Fax your request to 401-462-0458, or
- Email your request to: OHHS.AppealsOffice@ohhs.ri.gov, or

- Mail your request to: EOHHS Appeals Office, Virks Building, 3 West Road, Cranston, RI 02920.

Complaints About the Appeal Process

You can file a complaint at any time during the appeal process with the Office of the Health Insurance Commissioner (OHIC) through the consumer helpline:

RI Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH)
1210 Pontiac Avenue, Cranston, RI 02920
Telephone: 1-855-747-3224
Website: www.rireach.org
Email: rireach@ripin.org

For help with your complaint, grievance or appeal, you may also call RI Legal Services at 401-274-2652.

Other Health Plan Information

How to disenroll from <MCO>

You may change your health plan during the state's annual open enrollment period or within 90 calendar days of joining <MCO>. If you wish to disenroll at any other time, you may do so for any of the following reasons: poor quality of care, poor continuity of care (such as lack of access to your PCP or necessary specialty services), discrimination, lack of access to transportation, moving out of state, or for other good reasons. Visit www.eohhs.ri.gov to get a Request to Change Health Plans form. The Rhode Island Executive Office of Health and Human Services (EOHHS) will decide if you can change plans.

Coordination of Benefits (COB)

If you or any member of your family have another health plan, that plan is your primary insurance. <MCO> would be your secondary health plan. Call Member Services if you have other insurance or if that coverage has ended

CurrentCare ®

The more information your providers have about your medical history, the better they can care for you. You may see more than one provider. You may have had visits to a hospital, provider's office, or community clinic. Each of these providers can do a better job caring for you if they have access to all of your medical records in one place. CurrentCare® is a database that can give them those records. It is Rhode Island's electronic health network. If you sign up, you give permission to your providers to see your health information in the database. This keeps all of

your providers informed and allows them to easily coordinate your health care. If you want to sign up for CurrentCare, call 1-888-858-4815. There is no cost to join.

Rhode Island All-Payer Claims Database

<MCO> is required by law to report data about its members' health care use and costs. This information will be put in the Rhode Island All-Payer Claims Database. It will be used by policy makers to make better health care decisions. You have the choice:

1. If you want your family's data in the records, you do not have to do anything.
2. If you want to have your data left out, please go to www.riapcd-optout.com. If you cannot get online, please call Rhode Island's Health Insurance Consumer Support at 1-855-747-3224. If you have a question or want to learn more, email riapcd@ohic.ri.gov.

Fraud, Waste and Abuse

If you suspect or know that fraud, waste, or abuse is occurring, report it immediately. Fraud happens when a member or provider does something that is not honest so that he/she or another person experiences positive results or some type of benefit or incentive. Waste happens when there is an overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system. Abuse happens when appropriate business and medical practices are not followed, and the result is an unnecessary cost to the Medicaid program. Reporting fraud, waste, and abuse will not affect how you will be treated by <MCO>. You have the choice to remain anonymous when you make the report. Provide as much information as possible; this will assist those investigating the report.

Some examples of fraud, waste or abuse are:

- Sharing, loaning, changing or selling a health plan or Rhode Island Medicaid ID card so someone else can get health care services.
- Using someone else's health plan or Rhode Island Medicaid ID card to get health care services.
- Using a provider's prescription pad to alter or forge a provider's prescription to receive drugs.
- Receiving benefits in both Rhode Island and another state.
- Lying about how much money you make or where you live to become eligible for benefits.
- Selling or giving prescriptions to others that were prescribed to you.
- Providers or hospitals that bill you or your health plan for services that were never provided.

There are many ways to report fraud, waste, and abuse:

- Call <MCO> Member Services or write <MCO> a letter;

- Call the <MCO> Compliance Hot line at <800.XXX.XXXX>;
- Contact the RI Office of Program Integrity at (401) 462-6503;
- RI Department of Human Services Fraud hotline for reports on CCAP, SNAP, RI Works and GPA at (401) 415-8300;
- Department of RI Attorney General for reports on Medicaid fraud, Patient Abuse or Neglect, or Drug Diversion at (401) 222-2556 or (401) 274- 4400 ext. 2269.

Parity

Behavioral health and substance use disorder services are considered essential health benefits. <MCO> ensures that financial requirements (such as co-pays and deductibles) and treatment limitations (such as limits on visits) that apply to mental-health or substance use disorder benefits are no stricter than the limits that insurance plans place on medical or surgical benefits. If you think that your ability to get behavior health services is different than getting medical services, call <MCO Member Services> and tell them you have a parity complaint.

Definitions

Appeal: An appeal is a special kind of complaint you make if you don't agree with a decision to deny a request for health care services. You may also file an appeal if you disagree with a decision to stop or reduce services that you are receiving. For example, you may ask for an appeal if <MCO> does not pay for an item or service you think you should be able to get. There is a specific process that we must use when you ask for an appeal.

Complaint: a concern about benefits, services, access to appointments, wrong bills you receive or other issues. If possible, we will resolve your problem at the time of your call.

Coordination of Benefits (COB): If you have another health plan, that plan is your primary insurance. <MCO> would be your secondary health plan. Call Member Services if you have other insurance or if that coverage has ended.

Copayment: a payment made by a member for health services in addition to that made by an insurer.

Durable Medical Equipment (DME): Bought or rented items such as hospital beds, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment ordered by a health care provider to be used in a patient's home.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a lay person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Also known as ambulance services or paramedic services, are emergency services which treat illnesses and injuries that require an urgent medical response and transport to acute care facility.

Emergency Room Care: Care given for a medical emergency when you believe that your health is in danger.

Emergency Services: An emergency is a potential life-threatening illness or injury. It can cause serious pain or harm to you if you do not receive treatment right away.

EPSDT: Early, Periodic, Screening, Diagnostic and Treatment

Excluded Services: Items or services that <MCO> does not cover.

Grievance: A complaint about the way your health plan is giving care or dissatisfaction about anything other than a service not being covered. Examples of a grievance include: dissatisfied with the way your health plan responded to your complaint; your health plan asking for more time to make an authorization decision; you have concerns about quality of care or services you got; you feel a provider, or their employee was rude, or you feel a provider did not respect your member rights. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

Habilitation Services & Devices: Health care services that help you keep, learn, or improve skills needed for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-therapy, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all your health care costs in exchange for a premium.

Home Health Care: Skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical

equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services supplied in the home.

Medically Necessary: Direct care, services or supplies that are needed for the diagnosis or treatment of your medical condition, behavioral health, or prevention of worsening of your condition. They must meet the standards of good medical practice and aren't for the convenience of you or your doctor.

Network: A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

Non-participating Provider: A health care provider or supplier who is not contracted with your health plan.

Physician Services: Services provided by an individual licensed under state law to practice medicine or osteopathy.

Plan: Managed care entity that manages the delivery of health care services.

Prior Authorization: Health plan approval necessary before you get care.

Participating Provider: A healthcare provider or supplier who is contracted with the Plan and agrees to accept health plan members. Also known as network or in-network provider.

Premium: The amount paid for health insurance every month.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that, by law, require a prescription.

Primary Care Physician/Provider: A doctor (MD or DO), nurse practitioner, physician assistant who is trained to give you basic care. Your primary care provider (PCP) is the person you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy.

Referral: Request from your PCP to your health plan to approve appointment and/or treatment to a specialist.

Rehabilitation Services & Devices: Services ordered by your PCP to help you recover from an illness or injury. These services are given by nurses and physical, occupational, and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.

Skilled Nursing Care: A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Specialist: A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

Urgent Care: Care that you get for a sudden illness or injury that needs medical care right away but is not life threatening. Your primary care doctor generally provides urgently needed care.

Notice of Non-discrimination

<MCO> complies with applicable Federal civil rights laws and does not discriminate or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free services to help you communicate with us, such as written information in other languages, formats or large print or you can ask for an interpreter. To ask for help, please call our Member Service Department at <toll-free telephone #, TTY >. We are here to help you <hours of operation>.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: <Entity Name, Address, Phone #, TTY, FAX #, Email>. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, <Entity Name Member Services> is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

English: ATTENTION: If you speak [English], language assistance services, free of charge, are available to you. Call 1-800-459-6019 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-459-6019 (TTY: 711). **Portuguese:** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-459-6019 (TTY: 711).

Chinese: 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 1-800-459-6019 (TTY : 711)。

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-459-6019 (TTY: 711).

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-459-6019 (TTY: 711)។

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-459-6019 (ATS : 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-459-6019 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮ່າງໃຫ້ທ່ານ. ໂທ 1-800-459-6019 (TTY: 711).

Arabic:

Árabe: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-459-6019 (رقم هاتف الصم والبكم: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-459-6019 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-459-6019 (TTY: 711).

Kru: Dè dè nìà ke dyédé gbo: ɔ̃ jù ké m̃ [Bàsòò-wùdù-po-nyò] jù ní, nìí, à wuḍu kà kò dọ po-po b̃éin m̃ gbo kpáá. Ɖá 1-800-459-6019 (TTY: 711)

Ibo: Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-459-6019 (TTY: 711).

Yoruba: AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-459-6019 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-459-6019 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-459-6019 (TTY: 711)번으로 전화해 주십시오.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-459-6019 (TTY: 711).