# Neighborhood Provider Training

Revised June 2021

Neighborhood Health Plan of Rhode Island


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# Training Overview

To assure the quality and integration of services available to Neighborhood Health Plan of Rhode Island (Neighborhood) members and to facilitate communication regarding best practices, Neighborhood developed a comprehensive training program for its network providers.

- **This curriculum is designed for all network providers and includes a focused training on Neighborhood's Medicare-Medicaid Plan (MMP), INTEGRITY.**

Prior to treating members (or within 60-days of notification), and annually thereafter, Neighborhood providers must complete this provider training requirement.

- **An authorized representative from each provider organization must complete the training and attest to having done so (link to attestation at the end of this training). This authorized representative also attests that he/she will train his/her employees using Neighborhood's training.**

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# About Us

Neighborhood Health Plan of Rhode Island (Neighborhood) is very pleased you and your staff have chosen to be part of our provider network. As an organization, Neighborhood continually strives to embody our mission:

- Neighborhood Health Plan of Rhode Island, an innovative health plan in partnership with the Community Health Centers, secures access to high quality, cost-effective health care for Rhode Island's at-risk populations.

# Neighborhood Members

Neighborhood insures about 60 percent of the vulnerable populations—with low income, disabilities or other special needs—in Rhode Island. We are committed to a culture of caring and ensuring our members have access to the medical treatment and community services necessary within a culturally and linguistically appropriate setting to achieve health and wellbeing.

We also provide health coverage for about 25,000 individuals* through Rhode Island's health insurance exchange, HealthSourceRI.

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# Member Plans

**Medicaid**

- High-quality plans for children, families, pregnant women and adults who are eligible for Medicaid through the State of Rhode Island

**Commercial plans for individuals and families**

- Commercial plans for individuals and families cover all of the essential health benefits at an affordable price. Some members may qualify for tax-credits to help cover some of the cost of their premium.

**Commercial Plans for Small Businesses**

- Neighborhood offers a variety of plans for small businesses (2-50 employees)

**Neighborhood INTEGRITY (Medicare-Medicaid Plan)**

- A high-quality plan for individuals who are eligible for full benefit Medicare and Medicaid.

# Contract Oversight

**Medicaid**

- Contract with the State of Rhode Island Executive Offices of the State of Rhode Island (EOHHS)

**Commercial Plans for individuals and families and Small Businesses**

- Plan offered through HealthSourceRI, the state-run health insurance exchange, with oversight by the Department of Business Regulations/Office of the Health Insurance Commissioner.

**Neighborhood INTEGRITY (Medicare-Medicaid Plan)**

- Neighborhood's "three-way contract" with the Centers for Medicare and Medicaid Services (CMS) and the State of Rhode Island Executive Offices of the State of Rhode Island (EOHHS).

Visit cms.gov for the most recent version of the State Medicaid and Medicare Manuals.



 

# Provider Resources

Find all of the information you need to work with Neighborhood, including the provider manual, forms, trainings, pharmacy information and more, at https://www.nhpri.org/providers/providerresources/

**New! Quick Reference Guide for Providers**

Providers can refer to Neighborhood's Quick Reference Guide for help with common questions and answers, as well as, frequently used telephone numbers.

**Eligibility and Claims Information:** Neighborhood is contracted with NaviNet to provide online member benefit, eligibility, and claims status lookup. Access the NaviNet website here.

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# Provider Rights and Responsibilities

- Grievance and Appeals procedures and timelines
- Provider Complaints
- Clinical (Medical Necessity Appeals)

# Provider Complaints

- Neighborhood is committed to provider satisfaction and improving the provider experience. If, at any time, a provider's office or facility needs assistance, Neighborhood's Provider Services Department can assist and, if they are unable to resolve the issue for you on the telephone or via their internal escalation process, they may accept a provider-initiated complaint.

- Neighborhood Grievances and Appeals Unit logs each provider complaint and acknowledges the complaint either verbally or in writing. The complaint will be resolved via written notification within 30 calendar days from receipt unless additional time is needed.

# Member Complaints & Grievances –
## All Lines of Business

When a member is dissatisfied, they may file a complaint or a grievance verbally or in writing directly with Neighborhood or through an authorized representative, such as their provider, family member, or friend, as long as this person has been appointed in writing to speak for the member.

- A complaint or grievance is an oral or written expression of dissatisfaction from a member or his/her authorized representative. Neighborhood will review an actual or alleged circumstance that gives the member cause for protest, causes a disruption of care, creates a level of anxiety, or leads to dissatisfaction with the plan or treatment received from a contracted plan provider.


 

# INTEGRITY Member Grievances

Additional information pertaining to Members covered under Neighborhood INTEGRITY MMP:

- For members enrolled in the INTEGRITY (Medicare-Medicaid Plan), any expression of dissatisfaction with the manner in which health care services have been provided, regardless of whether remedial action can be taken by the plan, is considered a Grievance. Grievances could include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievances may also include complaints that a covered health care service procedure or item during the course of treatment did not meet accepted standards for delivery or health care. Grievances submitted by someone other than a member without written consent will be dismissed by Neighborhood until written consent is received from the member or his/her Legal Representative.

# The Provider Role with Member Grievances

When Neighborhood receives a complaint from a member against a contracted plan provider, the Grievance and Appeals Unit or Quality Assurance Committee will outreach to the office in question to allow the provider the opportunity to review the member's concerns and provide a response. Neighborhood appreciates your full cooperation in responding to these requests, as they are a beneficial way to provide additional member education and support.

- If a provider receives an inquiry from Neighborhood requesting information to aid in the investigation and resolution of a member complaint or grievance, the provider is required to comply with Neighborhood's request as soon as possible and within fourteen (14) calendar days.


 

# Clinical (Medical Necessity) Appeals

When to file the appeal:

- **Medicaid** appeals must be filed within 60 days of receiving the Initial Denial.
- **Commercial/Exchange** appeals must be filed within 180 days of receiving the Initial Denial.
- **INTEGRITY** appeals must be filed within 60 days of receiving the Initial Denial/Organization Determination.

Neighborhood's Grievance and Appeals Unit logs each appeal and sends a written acknowledgement to the appellant within five (5) calendar days of receipt of the appeal.

*Remember*:

- Appeals for high-end radiology services must be filed directly with eviCore, following the instructions on the initial denial notification.
- Appeals for Part D drugs must be filed directly with CVS Caremark, following the instructions on the adverse coverage determination notification.

# Clinical Appeals Description and Process

A clinical appeal is a request for reconsideration of an initial adverse clinical determination.

- Clinical appeals may be standard or expedited.

Appeals submitted by someone other than a member without written consent will be dismissed in writing by Neighborhood until written consent is received from the member or his/her Legal Representative.

- A licensed practitioner with the same licensure status as the ordering physician reviews clinical appeals. No reviewer involved in prior reviews/direct care may participate in subsequent reviews.

Consult Neighborhood's Provider Manual on timelines for appeals, as well as, guidance for members or their treating providers who are not satisfied with the outcome of a clinical appeal.

# Administrative (non-clinical "benefit") Appeals

An administrative appeal is a request by a member, a member's authorized representative, or a member's provider asking Neighborhood to reverse an administrative (non-clinical/non-utilization management) benefit limitation or adverse determination.

- Medicaid members who are not satisfied with the outcome of an administrative appeal may request a State Fair Hearing with the Executive Office of Health and Human Services (EOHHS) within 120 days of Neighborhood's internal appeal denial
- INTEGRITY administrative appeal denials for pre-service decisions or post-service member payment appeals for services that *may* be considered for coverage under Medicare, will automatically be forwarded to MAXIMUS for second level appeal review in accordance with CMS requirements by Neighborhood's Grievances and Appeals Unit.

Reference Neighborhood's Provider Manual for full details on administrative appeals.

# Provider Claim Disputes
## (formerly known as Provider Claim Payment Appeals)

Requests that Neighborhood review and reverse a claim denial, adverse Reconsideration Request decision, and/or Adjustment Request decision are known as Provider Claim Disputes.

- Dispute must be filed within 60 days from the date on the provider's Neighborhood Remittance Advice.

Neighborhood's Grievances and Appeals Unit does not acknowledge these requests in writing. Typically, these disputes are resolved within 60 calendar days from the date the appeal was received unless additional time is needed. Approvals may result in a claim adjustment and, in some cases, written notification. Denials will result in written notification.

# Appeal Resolution Timeframe

For all lines of business, the appeal will be resolved according to the following timeframes:

- Expedited appeals are resolved within 24-72 hours of the date and time of receipt unless an extension is needed, and then an additional 14 days will be added to the turnaround timeframe.
- Standard pre-service appeals are resolved within 30 calendar days of receipt unless an extension is needed, and then an additional 14 days will be added to the turnaround timeframe.
- Post-service or payment appeals are resolved within 30-60 calendar days of receipt and are not eligible for expedited appeal timeframe or extensions.

INTEGRITY-specific:

In addition to the timeframes above, effective January 1, 2020, INTEGRITY Part B Medication Appeals must be resolved within 72 hours (expedited) or seven (7) calendar days (standard) and are not eligible for extensions.

# Compliance at Neighborhood

Neighborhood requires compliance with all laws applicable to the organization's business including compliance with all applicable federal and state laws dealing with fraud, waste and abuse.

It is Neighborhood's policy aggressively to prevent, detect, and reduce fraud, waste and abuse in the delivery of covered healthcare services.

- **This is an obligation, a responsibility and a legal requirement for all Neighborhood employees, including contracted and non-contracted providers.**

Neighborhood employees, providers, contractors, consultants and agents may report issues of suspected fraud, waste and abuse to the Compliance Hotline at (888)-579-1551. Such reports may be made anonymously.

# Fraud, Waste, and Abuse (FWA)

**Fraud** is a crime that involves knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. §1347.

**Waste** includes overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a government healthcare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Waste can result in fines and other penalties.

**Abuse** includes actions that may, directly or indirectly, result in unnecessary costs to a government healthcare program. Abuse involves payment for items or services when there is not a legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

# FWA – Examples

The following are common examples recognized as fraud and abuse by providers:

- Billing for services that were not rendered (e.g., billing for no-show appointments)
- Misrepresentation of a patient diagnosis to justify services
- Altering claims forms to receive a higher level of payment or circumvent a denial
- Soliciting, offering, or receiving a kickback for referral of patients in exchange for other services
- Concealing ownership of related companies (e.g.., the physician also owns the radiological service)
- Deliberate duplicate billing (to Neighborhood or another payer source)
- Unbundled or exploded charges in which the provider bills for components of a procedure instead of using a comprehensive code.
- Providing Certificates of Medical Necessity for members ineligible for services

- Falsifying plans of treatment or medical records
- Misrepresenting the services provided or the person receiving the services
- Billing for non-covered benefits by using a different procedure or diagnosis code
- Gang visit billing at a skilled nursing facility or other group domicile for members that did not receive care
- Excessive charges for services or supplies
- Claims for services that were not medically necessary
- Over-utilization of services
- Underutilization of services
- Solicitation for payment for covered services outside of co-payment, co-insurance, and/or deductible amount.

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# Implementing a Compliance Program to Deter FWA

Neighborhood strongly recommends that providers, their business associates and subcontractors develop their own compliance programs and regularly evaluate their effectiveness. Effective compliance programs can help create a work culture that prevents, detects, and resolves misconduct. Providers should take ongoing action to understand health insurance compliance requirements and meet them fully and consistently.

Neighborhood's Provider Manual includes references/links for compliance guidance documents prepared by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG).


 

# FWA Audits and Investigations

Neighborhood, or its designees, utilize various review methods to audit and verify provider billing compliance including but not limited to, industry standard coding, adequate medical note documentation, contractual provisions and authentication of billed charges. FWA audits and investigations may be performed pre- or post-payment.

FWA audits and investigation timeframes will not exceed six (6) years from the original date of service, except where potential overpayments have been determined to be related to fraud, in which, there is an indefinite lookback period. Results will be communicated, in writing, post review.

**Neighborhood's expectation is that all contractual obligations are fulfilled, as outlined in provider contracts.**


 

# Member Care

Providers will abide by critical incident (preventing abuse, neglect, and/or exploitation of members, information on reporting fraud, waste and abuse) guidelines.

**Abuse:** Intentional mental, emotional, physical or sexual injury to a child with disabilities, or failure to prevent such injury.

**Neglect:** Failure to provide a child with food, clothing, shelter and/or medical care, and/or leaving a child in a situation where the child is at risk of harm. Children with disabilities results in starvation, dehydration, over-or under-medication, unsanitary living conditions, and lack of heat, running water, electricity, medical care and personal hygiene.

**Exploitation:** Misuse of a child with disabilities for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

# Reporting Abuse

If you suspect abuse…

**Tell Someone.**

- Rhode Island law requires any person who has reasonable cause to suspect elder abuse to report it to the **Division of Elderly Affairs**. Call the DEA Protective Services Unit at (401) 462-0555.
- Suspected abuse of a person with a developmental disability must be reported to RI Department of **Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH).** Call the QA hotline (401)462-2629

Rape, Abuse and Incest National Network (RAINN)
National Sexual Assault Hotline 1-800-656-HOPE

Rhode Island Department of Health: https://health.ri.gov/

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# ADA Compliance

Providers must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees.

Persons with disabilities must have:

- ✓ Access to programs
- ✓ Opportunities for effective communication
- ✓ Physical accessibility

Neighborhood's approach to ADA compliance includes:

- Having a work plan for your practice to assess meaningful compliance with the ADA
- Conducting training and re-training with staff, as needed
- Working to understand members, their needs, and preferences



 

# Department of Justice - Civil Rights Division Understanding the Olmstead Act

1. In 2009, the Civil Rights Division launched an aggressive effort to enforce the Supreme Court's decision in *Olmstead v. L.C.*, a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

2. Former President Obama issued a proclamation launching the "Year of Community Living," and has directed the Administration to redouble enforcement efforts.

3. The Division has responded by working with state and local governments and officials, disability rights groups and attorneys around the country, and with representatives of the Department of Health and Human Services, to fashion an effective, nationwide program to enforce the integration mandate of the Department's regulation implementing title II of the ADA.


 

# Persons with Disabilities

The Americans with Disabilities Act (ADA) defines a person with a disability as:

- ***A person who has a physical or mental impairment that substantially limits one or more major life activities.***

This includes people who have a record of an impairment, even if they do not currently have a disability. It also includes individuals who do not have a disability, but are regarded as having a disability.

# Be Prepared–Know Your Patients!

- When scheduling the appointment, ask about accommodations - physical or otherwise - that may be required.
- Record pertinent information in patient charts or electronic health records.
- If making referrals to other providers that the patient may not have previously seen, communicate with the receiving provider regarding the necessary accommodations.


 

# Accommodating Persons with Disabilities

**Physical Accessibility Guidelines:**

1. Parking: Adequate, marked accessible parking.
2. Route: Access into the facility is stable, firm and slip resistant.
3. Entry: Zero steps into the building/office, entry doors at least 34” wide, entry door with easy assist system, elevators located on the accessible route with Braille symbols and also audible signals for up and down directions.
4. Restrooms: Large enough to accommodate a person with a wheelchair/scooter, entry doors at least 36” wide and easy to open, grab bars behind and to the wall side of the toilet, soap and towel dispenses 48” or less from the floor.
5. Exam Room: On the accessible route with an entry door at least a 32” clear opening.


 

# Accommodating Persons with Disabilities

**Effective Communication:**

1. Use of auxiliary aids and services such as qualified readers and/or interpreters, audio recordings, relay service, Braille, assistive listening devices, large print, captioning.

**Accessible Medical Equipment:**

1. Height-adjustable exam tables.
2. Hoyer-type lift available to transfer a patient onto an exam table.
3. Wheelchair accessible weight scales.
4. Moveable exam chairs.


 

# Accommodation Requirements

Providers need to make reasonable accommodations for members, including but are not limited to:

- Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments.
- Ensuring that all written materials are available in formats compatible with optical recognition software.
- Reading notices and other written materials to patients upon request.
- Assisting patients with filling out forms over the telephone.
- Ensuring effective communication to and from individuals with disabilities through email, telephone, personal assistance and other electronic means.
- Providing TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for persons who are Deaf.
- Providing individualized forms of assistance.

# Culturally Competent Member Care

**Culture -** The customary beliefs, social forms, and material traits of a racial, religious, or social group

**Competence –** The ability to do something successfully or efficiently

What is cultural competence?

Integrating cultural knowledge into standards, policies, and practices leads to better quality of services and outcomes.

Cultural Competence enables providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients.



 

# CLAS Standards

**CLAS** stands for Culturally and Linguistically Appropriate Services and is a set of national standards that aim to improve cultural and linguistic competency in the health care system. Ultimately, the goal of CLAS is to reduce racial and ethnic health care disparities.

- 2000: Standards established by Office of Minority Health
- 2013: Concepts broadened to include 15 standards that encompass physical, mental, social, and spiritual well-being.
  - Makes recommendations to address inequities in healthcare
  - Strives for "effective, equitable, understandable, and respectful quality care and services…"


 

# Becoming a Culturally Competent Provider

**Value Diversity and Acceptance of Differences**

- How does the member define health and family? Consider each person as an individual, as well as a product of their country, religion, ethnic background, language and family system.

**Self-Awareness**

- How does our own culture influence how we act and think?
- Do not place everyone in a particular ethnic group in the same category.

**Consciousness of the impact of culture when we interact**

- Respect cultural differences regarding physical distance and contact, eye contact, and rate and volume of voice.
- Misinterpretations or misjudgments may occur.


 

# Becoming a Culturally Competent Provider

**Knowledge of member's culture**

- Become familiar with aspects of culture.  Understand the linguistic, economic and social barriers that members from different cultures face which may prevent access to healthcare and social services.
- Make reasonable attempts to collect race-and language-specific member information.

**Adaptation of Skills**

- Provide services that reflect an understanding of diversity between and within cultures.
- Understand that members from different cultures consider and use alternatives to Western health care.
- Consider the member and their family's background in determining what services are appropriate.
- Consider the member and their family's perception of aging and caring for the elderly.
- Treatment plans are developed with consideration of the member's race, country or origin, native language, social class, religion, mental or physical abilities, age, gender and/or sexual orientation.

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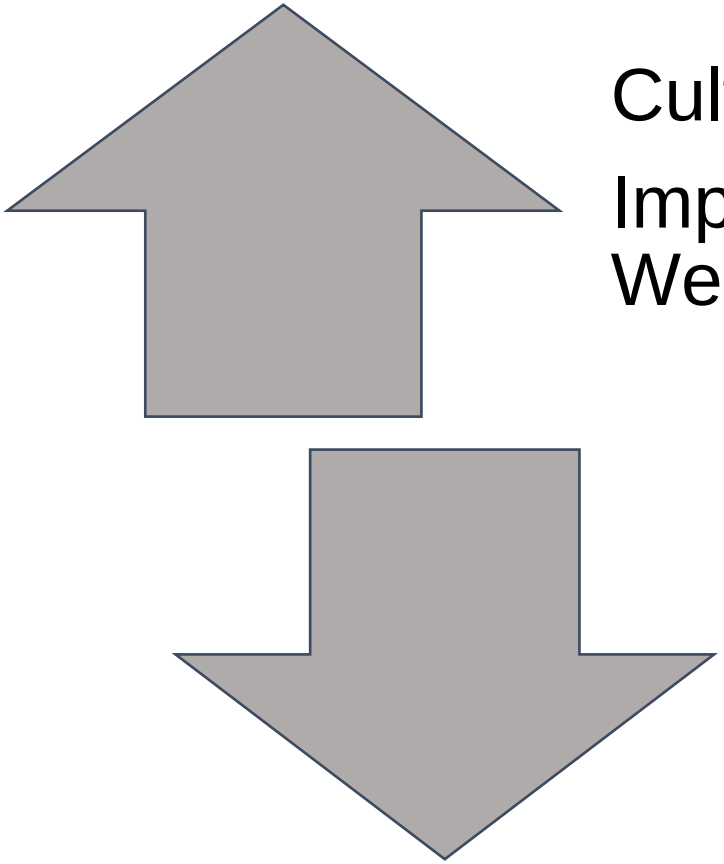
# Tips for Successful Cross-Cultural Communication

- Let the person see your lips as you speak.
- Be careful with your pronunciation.
- Project a friendly demeanor/attitude.
- Stick to the main point.
- Be aware of your assumptions.
- Emphasize or repeat key words.
- Don’t rush the person.
- Control your vocabulary; avoid jargon, slang, and difficult words.
- Listen carefully.
- Make your statement in a variety of ways to increase the chance of getting the thought across.
- Speak clearly but not more loudly.
- Write down key information for him or her to refer to later.

# Cultural Competency and Quality



Cultural Competency:

Improves Health and Well Being

Cultural Competency:

Lowers Health Disparities

# INTEGRITY Overview

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# What is INTEGRITY?

- INTEGRITY provides “one-stop shopping” to serve the Whole Person
- Provides all acute and long term services for enrollees
- Seniors and adults with disabilities with both Medicare and Medicaid coverage
- Individuals eligible for INTEGRITY are considered “dual eligible” or “duals”
- Provides members with a better care experience with better coordination of benefits and services
- Individual care plans provide customized service delivery
- Person-centered care
- Single health plan meeting unique needs of each member as a Whole

**Neighborhood is the *only* health plan in Rhode Island to participate in the Duals Demonstration Program**

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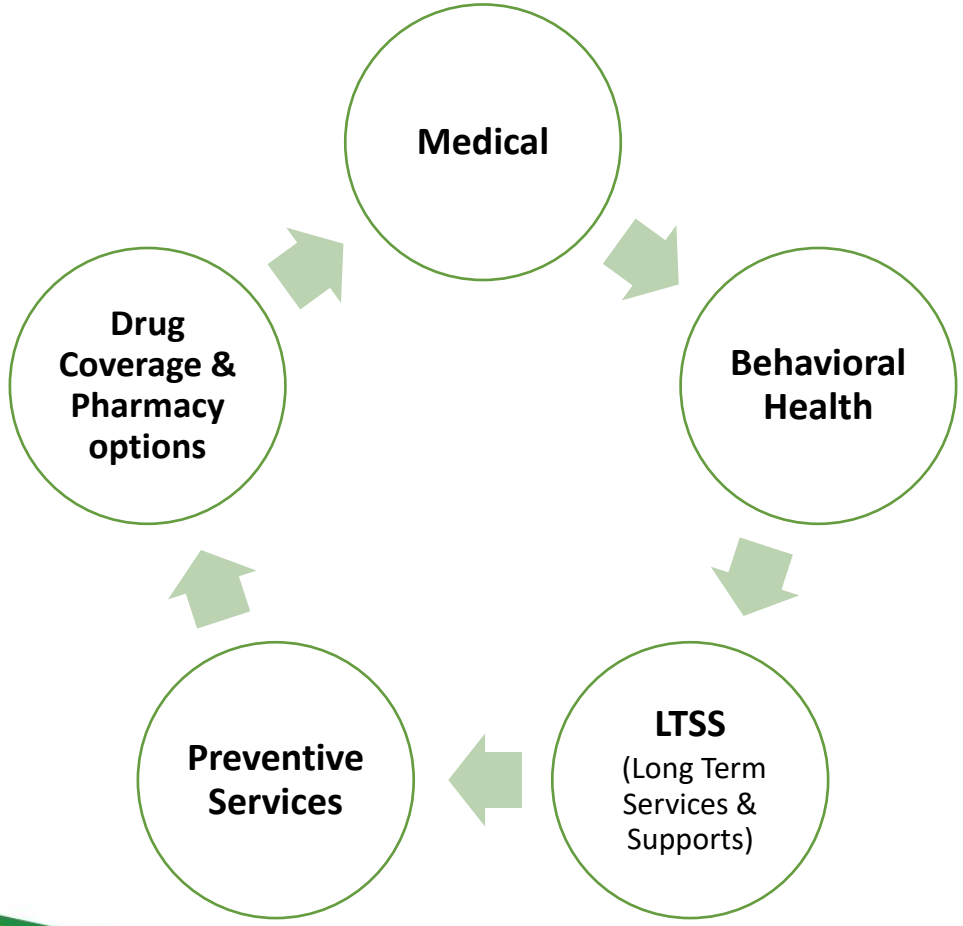
# Goals of INTEGRITY

1. Offer quality primary and preventive care, integrated across the full continuum of care that builds and enhances the role of the Patient-Centered Medical Home (PCMH) and primary care practices;
2. Integrate the full continuum of Medicare and Medicaid benefits through collaborative relationships among Neighborhood's care management staff and with medical, behavioral and other community-based partners;
3. Facilitate informed member- and family-centric decision-making that meets the self-defined and varied needs of members, in collaboration with the informal supports and Neighborhood;
4. Improve members' health outcomes by coordinating care efficiently across the plan and with medical, behavioral and non-medical social supports and providers; and
5. Develop effective, efficient operations that leverage strong interpersonal and technical communications to deliver high-quality clinical and non-clinical care.

# Comprehensive Coverage

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# INTEGRITY Enrollee Benefits

**Medical, Behavioral Health and Long Term Services and Supports**

- INTEGRITY MMP benefits include comprehensive medical, behavioral health and long term services and supports. In addition, Neighborhood will provide Medicare Part D and over-the-counter drug benefits, through the INTEGRITY formulary.


 

# Medical Benefits*

- Inpatient Hospitalization
- Skilled Nursing Facility - 3 day stay not required
- PCP & specialty care
- Emergent & urgent care
- MRI, CT Scans, Labs
- Durable Medical Equipment (DME)
- Hearing aids
- Eyeglasses
- Routine podiatry

** Authorization rules may apply.*

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# Preventive Services

- Annual Wellness Visit
- Flu Shot & Pneumococcal Vaccine
- Bone Mass Measurements
- Medicare Diabetes Prevention Program
- Counseling to prevent tobacco use
- Screenings e.g. diabetes, depression, glaucoma, mammography, prostate cancer, Hepatitis B

** Authorization rules may apply.*

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# Behavioral Health & Substance Use Treatment Services*

- Inpatient & Partial Hospitalization
- Intensive outpatient services
- Substance abuse residential treatment
- Integrated health homes (IHH)
- Assertive community treatment (ACT)
- Opioid Treatment Program (OTP)

** Authorization rules may apply.*

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# LTSS (Long Term Services & Supports)*

- Homemaker
- Meals on Wheels (home delivered meals)
- Skilled nursing services
- Assisted Living Facility
- RIte@Home shared living
- Nursing Home Care
- Personal Choice Program (self directed care)

** Authorization rules may apply.*

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# INTEGRITY – Pharmacy Benefits

**MMP Pharmacy Program**

- As part of the contract providers must comply with all CMS regulations that govern the MMP product including all Medicare Part D requirements. This section outlines INTEGRITY MMP pharmacy program, including general information on our formulary and utilization management programs. Also included is a description of Neighborhood's Step Therapy program and Medication Therapy Management program (MTM).
- Neighborhood contracted with CVS/Caremark, a national pharmacy benefits management company, to administer the Medicare Part D pharmacy benefit provided to INTEGRITY members. In addition to many smaller independent pharmacies, Neighborhood's pharmacy network includes CVS, Rite Aid, Walgreens, Walmart and many others. A complete list of contracted pharmacies is available on our web site, www.nhpri.org


 

# Drug Coverage & Pharmacy Options

## Drug coverage**

- Medicare Part **D** drugs
- Medicaid-covered drugs, i.e. the State-approved list that includes Over the Counter (OTC) drugs
- Medicare Part **B** drugs (e.g. nebulizer drugs, injectable and infused drugs)

## Pharmacy Options

- Network of retail pharmacies, access to mail-order and coverage at physician offices
- Extended day supplies are available

***Authorization rules, quantity limits, step therapy may apply.**

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# Benefits Covered Outside of INTEGRITY

**Medicare**

- **Hospice Care**

**Medicaid**

- **Non Emergency Transportation**
  (Members use State's transportation vendor)
- **Routine Dental**
- **Residential Services for I/DD Enrollees**
- **Home Stabilization Services**


 

# Non-Covered Services for INTEGRITY

Experimental Procedures

Cosmetic Surgery

(except if needed because of accidental injury or reconstruction of a breast after a mastectomy)

Private rooms in hospitals

(unless medically necessary)

Medications for sexual or erectile dysfunction

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# Transition Policy

Neighborhood will provide an appropriate transition process applicable to  with regard to:

- The transition of new enrollees into prescription drug plans at the beginning of a contract year;
- The transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year;
- The transition of individuals who switch from one plan to another after the start of the contract year;
- Enrollees residing in long term care facilities;
- Enrollees who change treatment setting due to changes in level of care;
- In some cases, current enrollees affected by formulary changes from one contract year to the next, consistent with the requirements set forth in CMS guidance for participation in the Medicare Part D Drug Program. CVS/Caremark also provides an appropriate transition process that meets the criteria above and any other criteria established by the state and CMS.

This transition process is applicable to medications that require Prior Authorization (PA) edits (except edits required for safety); Step Therapy (ST) edit; Quantity Limit (QL) edit;  or not on the formulary.

# Continuity of Care Policies

## Access to Providers & Services

- Enrollees are allowed to maintain their current providers and service levels at the time of enrollment until the later of:
  - Six months after enrollment; or
  - For enrollees determined to be low or moderate risk, when an Initial Health Screen (IHS) has been completed by the MMP; or
  - For enrollees determined to be high risk, when a Comprehensive Functional Needs Assessment (CFNA) and an ICP have been completed by the MMP.
  - applies to all items & services other than nursing facility services and non-Part D prescription drugs.
  - Includes non-preferred diabetic testing supplies.
- Members residing in a nursing home during the enrollment period may remain there as long as EOHHS criteria is met.

## Change in Provider

During the transition period, Neighborhood may change a member's provider when:

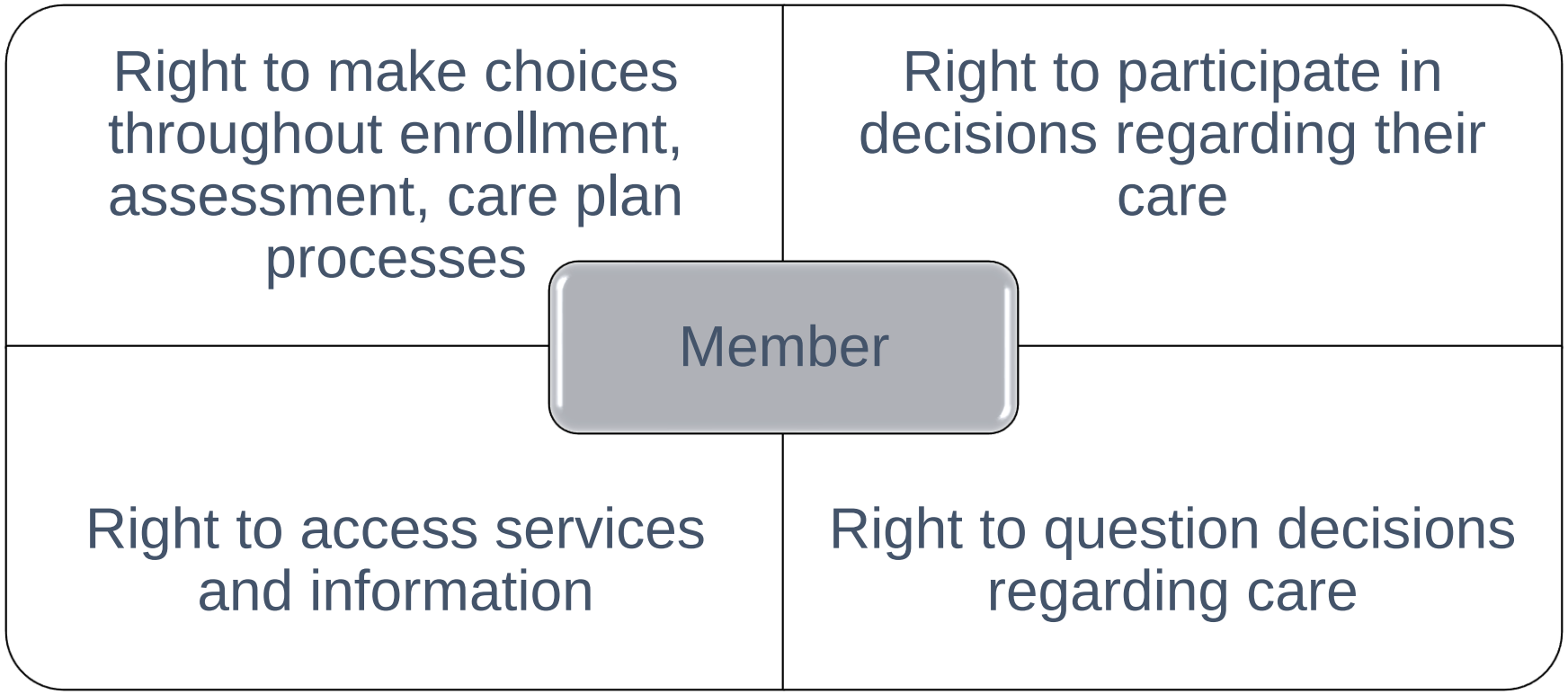
- Member requests a change in provider, or
- The IHS and CFNA are complete and the member agrees to a change in provider, or
- The provider discontinues treating the member, or
- Identified performance issues with the provider that affect a member's health and well being.

# The MMP Enrollment Process

- Individuals eligible for Medicaid and Medicare may enroll into INTEGRITY at any time
- The State of Rhode Island has continuous open enrollment for most dual eligible individuals
- Most individuals may opt out of INTEGRITY at any time.


Right to make choices throughout enrollment, assessment, care plan processes
Right to participate in decisions regarding their care
Member
Right to access services and information
Right to question decisions regarding care

# Access to Relevant Information

- Health and functional status information
- Medical records upon request
- Request corrections or amendments to medical records
- Information on available treatment options, alternatives
- Full explanation of plan options, rules, benefits

# Choice and Participation in Assessment Process

## Continuity of Care Period

- Initial Health Screening
- Be involved
- Continue existing services
- Keep current providers

## **After** the assessment

- Care Plan agreed upon
- Care Coordination
- Periodic reassessments
- File an internal appeal



# Balance Billing

Neighborhood prohibits providers from “balance billing” INTEGRITY members

# INTEGRITY Member Appeals

INTEGRITY members have the right to file a grievance if they have concerns or problems related to their coverage or care as discussed in the general provider training. Below focuses on member appeals following an Adverse Organization Determination.

INTEGRITY members have five (5) types of appeals available, each with variable additional levels of appeal available to the member:

- A Part C appeal is defined as: Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), as defined in 42 CFR 422.566(b).
- A Part D appeal is defined as: Any of the procedures that deal with the review of adverse coverage determinations made by Neighborhood relative to benefits covered under a Part D plan the enrollee believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee) as defined in §423.566(b).

# INTEGRITY Member Appeals, cont.

In addition to a Part C appeal and a Part D appeal, INTEGRITY members have the following available to them:

- A Fast Track Appeal is a type of appeal when the member disagrees with the coverage termination decision from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), or upon notification of discharge for an inpatient hospital stay. CMS contracts with Quality Improvement Organizations (QIOs) to conduct fast-track appeals.
- A clinical appeal is a request for reconsideration of an initial adverse clinical organization determination.
- An administrative appeal is a request to reverse an administrative (non-clinical/non utilization management) determination such as payment of claims or coverage of services relative to a member's available benefits.

Applicable appeal rights are determined by whether the services are covered by Medicare, Medicaid or by both Medicare and Medicaid. For services covered by both Medicare and Medicaid, members are entitled to all appeal rights available to services covered by Medicare and Medicaid.

# Standard Member Appeals

**Procedure for Services Covered by Medicare**

1. The member, member's authorized representative, or treating provider initiates a request for reconsideration to the Neighborhood Grievances and Appeals Unit either verbally, in writing or in person.
2. The Grievances and Appeals Unit consults with other Neighborhood departments when appropriate, and completes the investigation and notifies the member as expeditiously as the member's health condition requires.

**Procedure for Services Covered by Part D**

1. The member, member's authorized representative, or treating provider initiates a request for redetermination to the CVS Caremark Coverage Determination and Appeals Department either verbally, in writing or in person.
2. The CVS Caremark Coverage Determination and Appeals Department receives and reviews the written appeal and, if needed, will request additional documentation.

**For information on timelines and additional level of appeals available, please consult Neighborhood's Provider Manual.**



# Fast-Track Appeals

To initiate a fast-track review for services covered by Medicare, the member or his/her authorized representative must submit a fast track appeal request within the required time frame to:

KEPRO, BFCC-QIO Program
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131

Toll-free Phone: 888-319-8452
TTY: 855-843-4776
Toll-free Fax: 833-868-4055

Once an appeal is filed, members remain entitled to continuation of coverage for their inpatient hospital stay, skilled nursing services, home health services, or comprehensive outpatient rehab services until KEPRO renders a decision.

- When the member contacts KEPRO for a fast-track appeal, Neighborhood requires the provider to make the medical record and a copy of the Important Message (IM) and/or the Notice of Medicare Non-Coverage (NOMNC) issued to the member readily available upon request.

# Fast-Track Appeal Resources

Please refer to the CMS notification form IM/OMB number 0938-0692 or OMB number 00938 – 0953 for the requirements to prepare and deliver a valid IM or NOMNC.

Refer to the "KEPRO Fax Cover Sheet for Fast Track Appeals" for the required medical record documentation list located on the KEPRO web page www.keproqio.com website.

- All sections of the medical record are to be faxed to Neighborhood's Grievance and Appeal Unit at (401) 709-7005.

**Review to Neighborhood's Provider Manual for more information.**

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# Enrollment Services

**Enrollee Ombudsman Services**

Rhode Island's Executive Office of Health and Human Services (EOHHS) has a contract with Rhode Island Parent Information Network (RIPIN) to provide Ombudsman services for the Medicare-Medicaid eligible population in Rhode Island.

**Role of the Enrollment Counselor**

The State contracts with an independent entity, which will be responsible for processing all enrollment and disenrollment transactions. The enrollment counselor will provide unbiased education to enrollees on MMPs and other potential enrollment choices, and ensure ongoing customer service related to outreach, education and support for individuals eligible for the Demonstration. The enrollment counselor incorporates the option of PACE enrollment into its scripts and protocols.

# Enrollee Resources

**RIPIN Healthcare Advocates** (http://ripin.org/healthcareadvocate/)
1-855-747-3224
Email: HealthcareAdvocate@ripin.org

**The POINT/State Health Insurance Assistance Program (SHIP) Counselors**
1-401-462-4444 (TTY 711)

# Role of the Provider

Neighborhood's INTEGRITY plan is based on a signed three-way contract with CMS and EOHHS. Collaboration with Neighborhood's contracted providers is critical to the program. Contracted providers actively assist with the data collection, reporting and performance review components of the plan as defined in the three-way contract. Additionally, Neighborhood collaborates with contracted providers to identify opportunities for improvement.

**Marketing Guidelines**

Neighborhood's contract with CMS and EOHHS defines how we and our providers can market and advertise INTEGRITY. Providers will comply with marketing guidelines outlined in the Medicare Marketing Guidelines including any limited English proficiency provisions. Providers may not include any references to their affiliation with INTEGRITY MMP in their marketing or advertising without prior approval. Neighborhood will submit all designated marketing materials and scripts to CMS and EOHHS to obtain approval prior to distribution or display. Please contact Neighborhood prior to beginning any communications or marketing initiatives.

# Primary Care Providers

The Primary Care Provider (PCP) serves as the “medical home” for the member. The “medical home” concept should assist in establishing a patient-provider relationship and ultimately better health outcomes.
Responsibilities include but are not limited to:

- Supervision, coordination, and provision of care to each assigned member
- Initiation of referrals for medically-necessary specialty care.
- Maintaining continuity of care for each assigned member.
- Maintaining the member’s medical record, including documentation for all services provided to the member by the PCP, as well as any specialists, behavioral health or other referral services.
- Screening for behavioral health needs at each visit and when appropriate, initiate a behavioral health referral.
- Identification of and coordination of LTSS and behavioral health services

# Referrals and Specialty Care

**Neighborhood does not require members to have a referral to see specialists.**

Out-of-network care requires prior authorization from Neighborhood.

- Neighborhood providers must complete an **Out of Network Prior Authorization Form** or **eForm** to receive approval to refer a member out-of-network.

Certain benefits for INTEGRITY members require prior authorization. These benefits include both skilled and unskilled services. Please refer to the Prior Authorization Reference Guide and Prior Authorization Request Forms found on Neighborhood's website (www.nhpri.org) to determine which services require prior authorization:

- https://www.nhpri.org/Providers/ResourcesFAQs/PriorAuthorizationReferenceGuide.aspx

# Behavioral Health Providers

Behavioral health services are available to all Neighborhood INTEGRITY members without a referral. Optum™ is the behavioral health benefits and network manager for Neighborhood Health Plan of Rhode Island.

Behavioral health providers are required to provide covered health services to members within the scope of their Neighborhood agreement and specialty license.

# LTSS Providers

Neighborhood INTEGRITY members will receive an initial health screen to help determine their long-term services and supports (LTSS) needs.

If a member requires LTSS services, they will be included in the member's care plan, which will be shared with the member's PCP

INTEGRITY members eligible for LTSS may have to pay part of the cost of the services. The amount is determined by Rhode Island Medicaid.

# Interdisciplinary Care Management

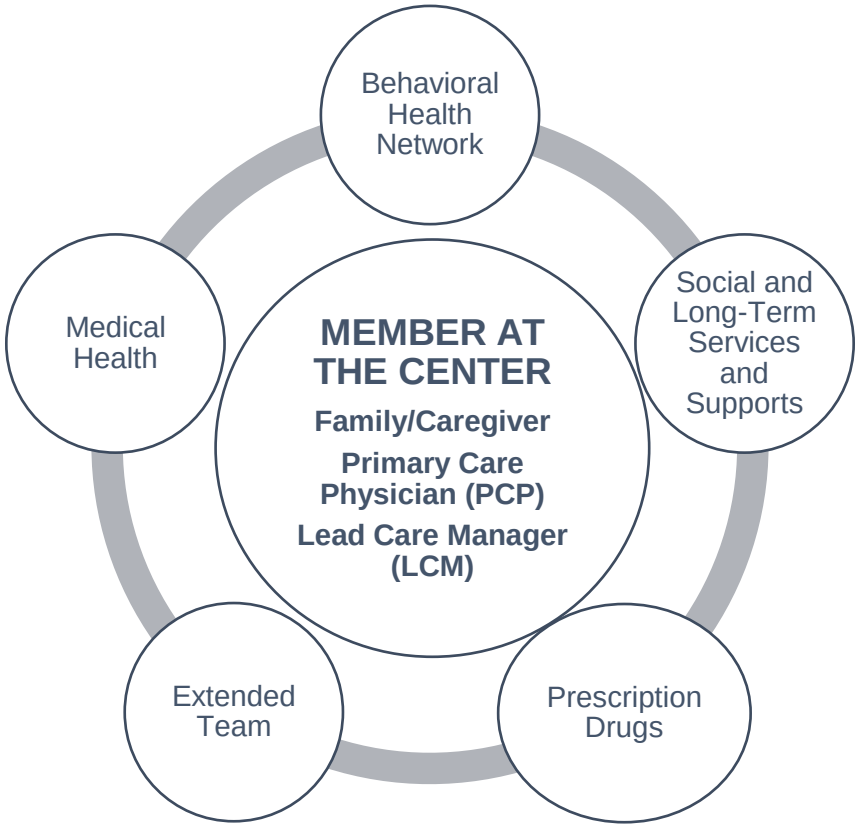
Conflict-free case management must be provided. Individuals performing evaluations, assessments, and plans of care cannot be related by blood or marriage to the individual or any of the individual's paid caregivers, financially responsible for the individual or empowered to make financial decisions or health-related decisions on behalf of the individual.

**The Interdisciplinary Care Team works together to develop the member's Interdisciplinary Care Plan (ICP).**

# Interdisciplinary Care Plan

**The membership of the team is based on member's goals, priorities and needs: medical, behavioral health, social supports and long-term services and supports.**




**Member is at the center of the team.**



# Initial Health Screen

| | |
|---|---|
| Who receives one? | **Community Non LTSS** newly-eligible members who reside in the community and who are not eligible for long term services and supports (LTSS) **This could also include INTEGRITY members who have SPMI, I/DD.** |
| Goal | To determine if the member is low, moderate, or high risk.<br>To maximize independence, focus on preventative health, wellness and self management. |
| Tool | Standardized tool that identifies a member's need for case management services. This holistic tool screens for: medical and physical needs, behavioral health needs, substance abuse, and functional, social and financial issues. |
| Timeline | Within 45 calendar days of enrollment in the health plan.<br>Within 15 calendar days of request from member or caregiver. |
| Telephonic or In Person | Telephonic outreach |

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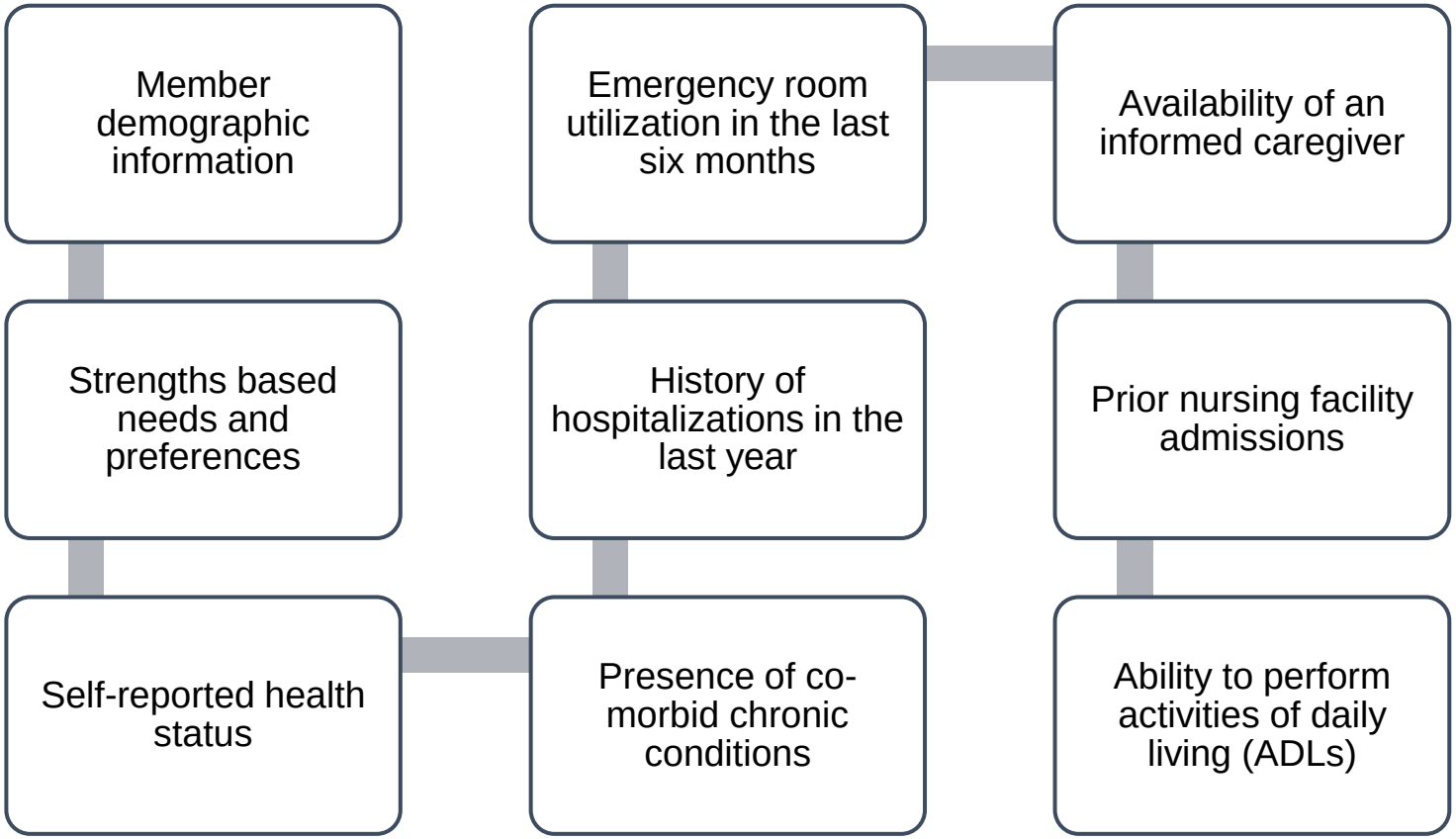
# Risk Stratification Based on IHS Results
## Groups and Definitions

| | |
|---|---|
| High Risk | **Members identified as high risk based on, but not limited to the following criteria.** Evidence of hospitalizations and readmissions, multiple emergency room visits, impairment with activities of daily living (ADLs), cognitive impairment, loss of informal caregiver in the prior six month period before enrollment, potential loss of housing, has complex medical or behavioral health conditions, and/or social supports needs that may lead to the need for high-cost services, deterioration in health status, or institutionalized after completing health risk assessment. |
| Moderate Risk | **Members identified as moderate risk based on evidence of needs related to housing, communication, cognitive and/or functional status or access to health care.** |
| Low Risk | **Members identified as low risk based on the responses to the Initial Health Screen (IHS).** |

# What does the IHS Tool Assess?





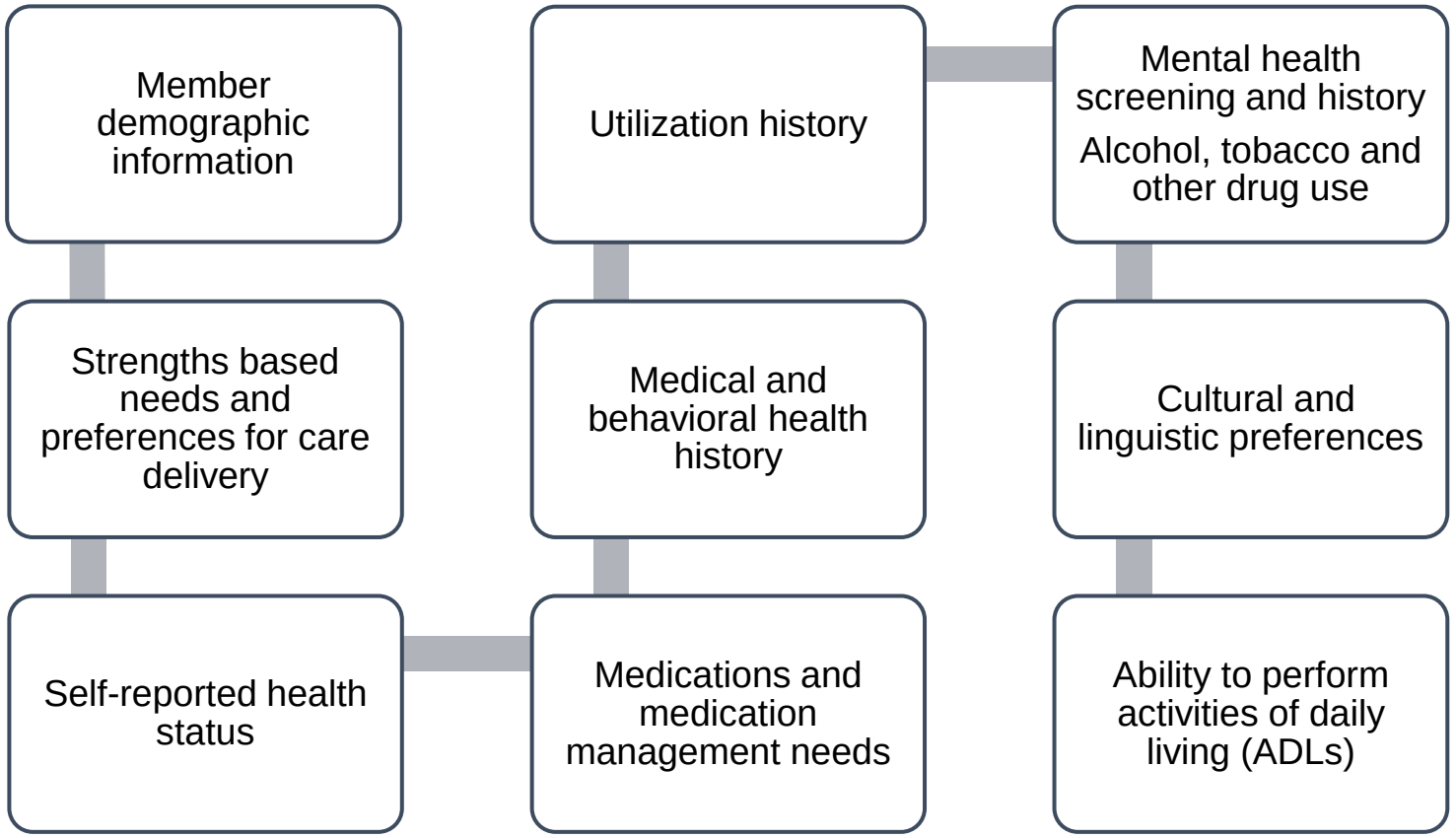
# Comprehensive Functional Needs Assessment

| | |
|---|---|
| Who receives one? | **INTEGRITY MEMBERS DETERMINED AS HIGH RISK AND COMMUNITY LTSS MEMBERS**<br>Members living in the community: (1) receiving long-term services and supports (LTSS); (2) determined to be "high risk" based on the results of the Initial Health Screen (IHS); and (3) as needs are identified for those determined to be "moderate risk." |
| Goal | To identify the multi-disciplinary conditions and needs of the member including but not limited to: medical, behavioral health, functional condition, long-term care, social services, informal support system, housing conditions, other conditions and needs to assure that members maximize their health and functional capabilities, well being and independence. |
| Tool | Approved CFNA, user-friendly, culturally and linguistically appropriate. |
| Timeline | For Community Non-LTSS members identified as high risk based on IHS results: No later than 15 days of completing the IHS. |
| Telephonic or In Person | In person in the member's home (with the member's consent). |

# What does the CFNA Tool Assess?

## Key Information: Member Preferences and Strengths

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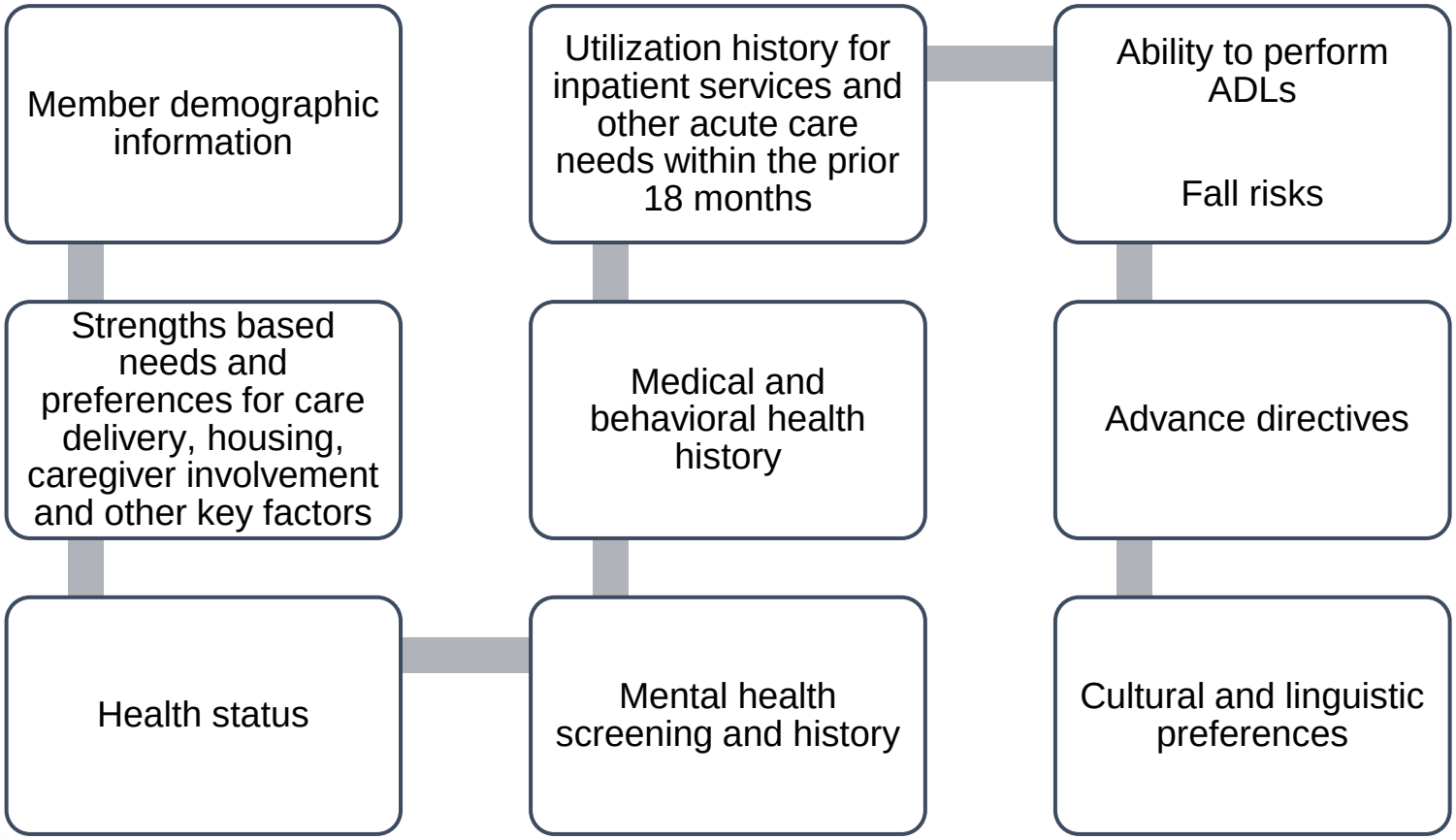
# Wellness Assessment (Plan)

| | |
|---|---|
| Who receives one? | • **COMMUNITY NON-LTSS WHO ARE LOW RISK**<br>• **NURSING FACILITY** members who reside in a nursing facility at the time of enrollment and do not have the desire to return to the community. |
| Goal | To keep the member healthy. |
| Tool | The IHS is used to develop the Wellness Plan. |
| Timeline | Within 120 days of enrollment |
| Telephonic or In Person | Telephone |

# What Does the Wellness Tool Assess?
## Examples:

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# The Reassessment Process

## What happens when circumstances change for community members? The process is faster.

**RE-ASSESSMENT**

Members will receive a comprehensive re-assessment sooner than they otherwise would, when there is a change in circumstances.

**MEMBER IS HOSPITALIZED**

A face to face re-assessment must be conducted within 5 days of discharge from a hospitalization.

**MEMBER EXPERIENCES OTHER CHANGES**

A face to face re-assessment must be conducted within 15 calendar days of identifying one or more significant changes in the member's condition, needs or circumstances (see right)

**Change in circumstances includes:**

1. Significant change in medication
2. Change in, or loss of a caregiver
3. Medical, psychosocial or behavioral health crisis
4. Excessive emergency department utilization
5. Other major changes in the member's psychosocial, medical, or behavioral condition
6. A major change in housing

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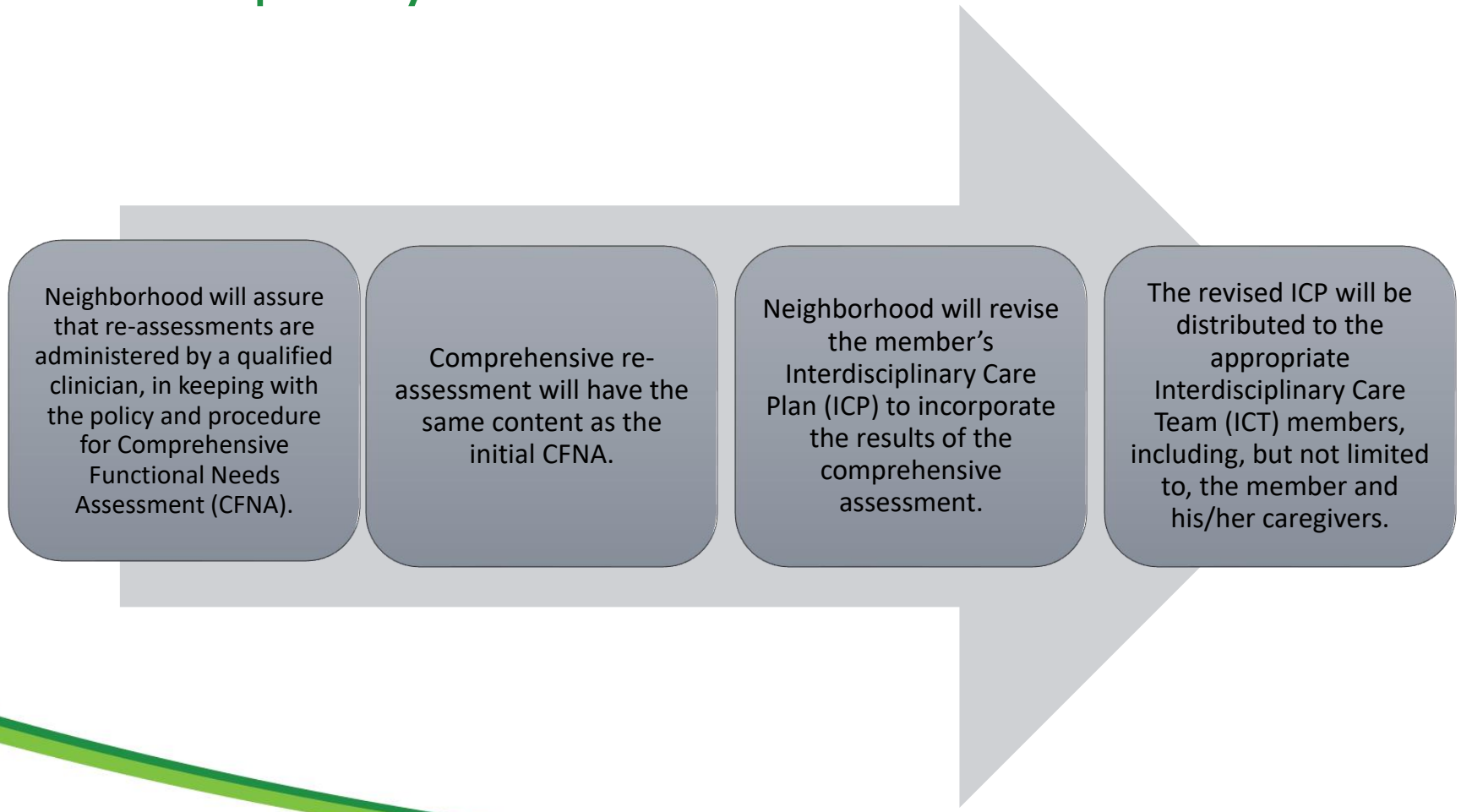
# Reassessments and their Effects on the Interdisciplinary Care Plan





# The Discharge Opportunity Assessment

| | |
|---|---|
| Who receives one? | **NURSING FACILITY** members |
| Goal | To identify nursing facility residents who may have a desire and/or opportunity to return to the community, based on, but not limited to, self or provider referral, Minimum Data Set (MDS) results and predictive modeling. |
| Timeline | Within 30 days of the member being identified or referred. |
| Telephonic or In Person | In person |
| Neighborhood Actions | For members residing in nursing home facilities identified as having a desire and/or opportunity to return to the community, Neighborhood will: (1) Develop a person-centered Community Transition Plan; and, (2) Assign the member a Transitions Care Manager (TCM). |

# Quality Improvement

Neighborhood's Quality Improvement (QI) Program strives to ensure that members have access to high quality health care services that are responsive to their needs and result in positive health outcomes.

- To meet this goal, Neighborhood's program targets clinical quality of care, member and provider satisfaction and internal operations. Annually the Quality Improvement Program Description is approved by Neighborhood's Board of Directors.

# Quality Management Structure

## Board of Directors

- Final authority and responsibility for the care and service delivered to Neighborhood's members
- Delegates oversight of the Quality Improvement Program to the Clinical Affairs Committee (CAC)
- Annually reviews and approves:
  - Quality Improvement Work Plan
  - Quality Improvement Program Description
  - Quality Improvement Program Evaluation

# Performance and Health Outcome Measurements

| | | | |
|---|---|---|---|
| Plan of Care completion rate | Member involvement in the development of their Plan of Care | Network adequacy: access, time, and distance standards | HEDIS Effectiveness and Access to Care measures |
| Ambulatory follow-up visit post discharge from an acute care facility | Ambulatory follow-up visit post discharge from a skilled nursing facility or group home | Monitoring of complaints, grievances, and appeals | CAHPS member experience measures |
| Hospital admission rate per 1,000 members per year | Hospital re-admissions rate per 100 discharges | Rate of emergency department visits per 1,000 members per year | |

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# Clinical Affairs Committee (CAC)

The INTEGRITY Quality Improvement Program is in compliance with CMS and EOHHS quality standards, expectations and priority initiatives.

- Providers are responsible for ensuring compliance with quality improvement standards.
- Providers must meet specific levels of quality outcomes using evidenced-based practices.

Findings and issues will be presented to the Clinical Affairs Committee for review and approval and be shared with the Chief Medical Officer and the Vice President of Medicare & Medicaid Integration.


 

# INTEGRITY Population

- Seniors 65 and older
- Adults with disabilities 21-64
- High health care needs and costs
- Range of complex conditions and disabilities
  - Many have significant behavioral health conditions
  - Physical disabilities, multiple chronic conditions
  - Functional and cognitive limitations, and more
- Comorbidities, more than one condition
- Among the nation's poorest, with significant disabilities


 

# Rhode Island's 35,000 Full Benefit Duals:
## Where do they live?

### ADULTS

- Between 21-64 years of age
- Adults with disabilities, living in the community or in an institution.
- 95% live in the community.
  - 30% receive home and community-based services (HCBS)
- 5% live in LTC institutions

### SENIORS

- 65 years of age and older
- Seniors, living in the community or in an institution.
- 65% live in the community
  - 6% receive home and community-based services (HCBS).
- 35% live in long term care institutions

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# A Sketch of the Population

**Most persons have 2 or more chronic conditions**

**DIVERSE:** Age, Race, Ethnicity, Language, Sexual Orientation, Religion and Disability.

Significant, **complex** disabilities.

50% Behavioral health diagnosis

**Top 3 conditions:** Diabetes, Psychiatric Disorders and Heart Disease.

Most need help with daily living activities

**RI Duals**

- ✓ 44% under the age of 65.
- ✓ 66% female.
- ✓ Many live in Providence.



 

# INTEGRITY & Cultural Competence

"*The concept of cultural competency has a* ***positive effect*** *on patient care delivery by enabling providers to deliver services that are* ***respectful of and responsive to*** *the health beliefs, practices and cultural and linguistic needs of diverse patients.*"

- National Institutes of Health (NIH)

Seniors aged 65 and older

Adults with disabilities aged 21-64

Range of complex conditions and disabilities

Comorbidity conditions

(Multiple conditions)

High health care needs and costs

Among the most economically disadvantaged with significant disabilities

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# INTEGRITY Members and Health Disparities

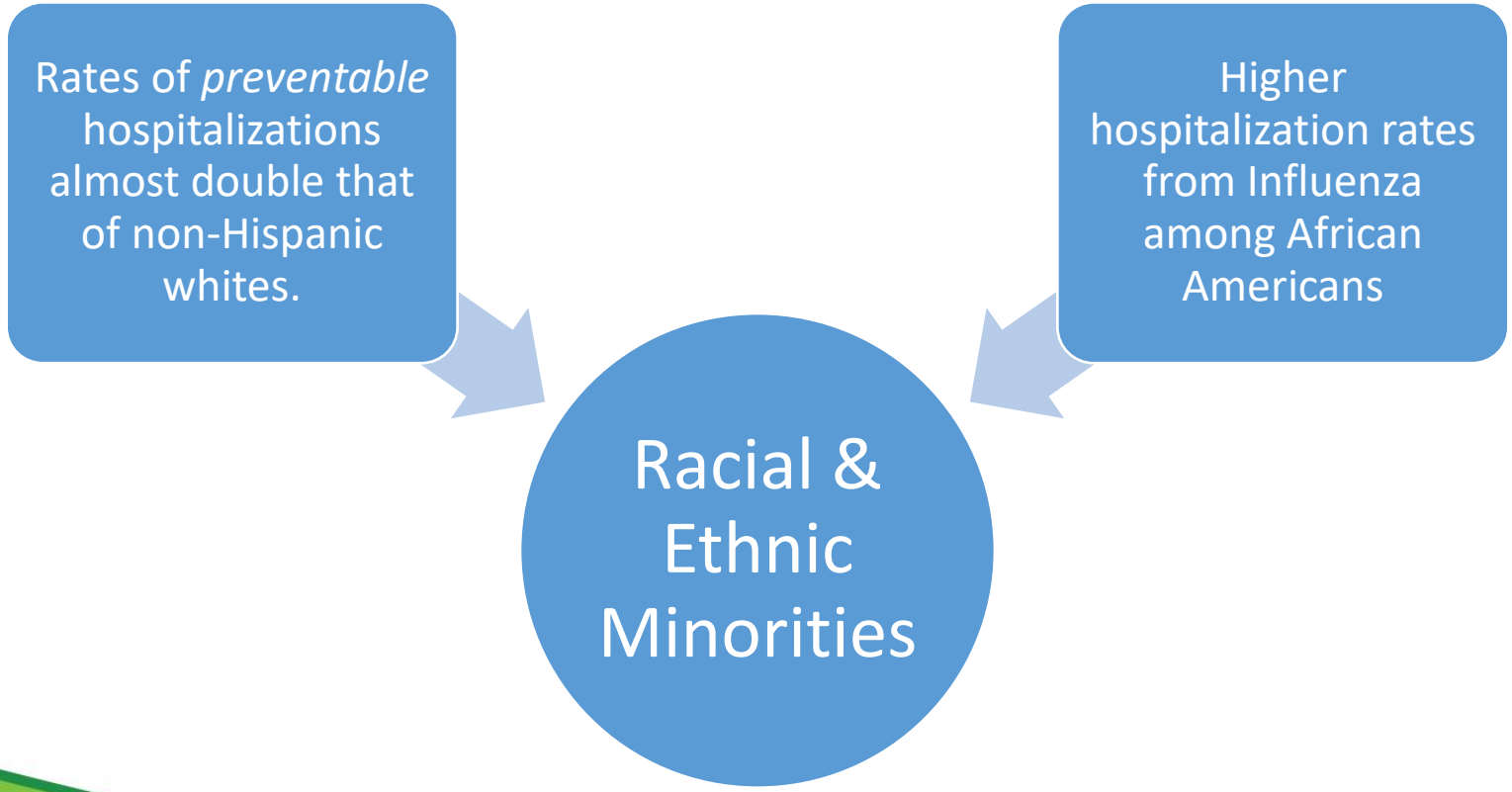
Healthy People 2020 definition:

***A health disparity*** **is "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage."**



# Racial, Ethnic, Linguistic Minorities



# LGBTQ Individuals

## Health disparities resulting in negative health outcomes:

- Structural and legal factors
- Social discrimination
- Lack of culturally competent health care
  - Lesbians and bisexual women up to 10 times less likely to receive regular cervical cancer screening.

- 1 in 4 transgender women are HIV positive
- Gay and bisexual men account for 66% of new HIV infections.

- LGBT Individuals experience higher prevalence of HIV, mental illness, substance abuse, smoking and other conditions

# Aging Demographic

By 2050:

- 20% of Americans will be elderly.
- 35% over age 65 will be racial or ethnic minority.



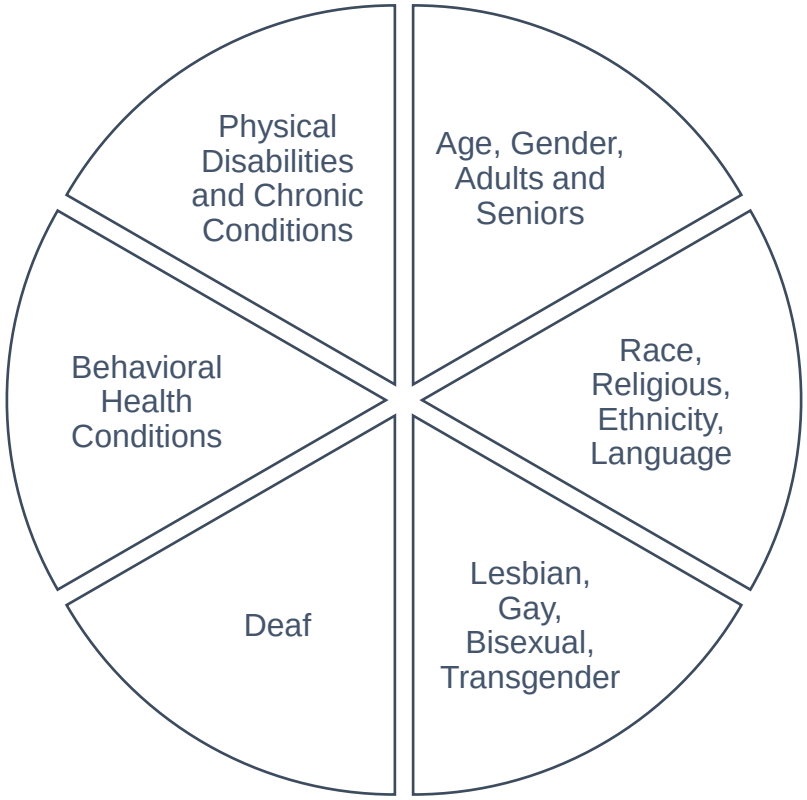
# Barriers to Culturally Competent Care

| |
|---|
| Structural racism |
| Oppression |
| Discrimination |
| Language – Lack of interpreters |
| Attitudes |
| Communication:  Interpreters for the Deaf |
| Physical space and equipment – Lack of ADA compliance |

# Equal Access For All Cultures and Communities

INTEGRITY will serve a diverse population representing many cultures and identities.

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# Educational Resources

RI EOHHS Integrated Care Initiative: https://eohhs.ri.gov/initiatives/integrated-care-initiative

Training Culturally Competent Direct Care Workers: Key Considerations for Long-Term Services and Supports Providers

Health Resources & Services Administration: Health Literacy
https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/index.html

**Email ProviderTraining@nhpri.org for assistance in finding other resources**

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**Thank you for your time, collaboration, and commitment to Neighborhood members.**

# At the end of this training, please click this link to attest to your understanding and completion.

**An authorized representative from each provider organization must complete the training and attest to having done so. This authorized representative also attests that he/she will train his/her employees using Neighborhood's training.**

Together with our provider partners, Neighborhood is dedicated to providing high quality, cost-effective health care for Rhode Island's at-risk populations.

**If you have any questions regarding this training, please contact Provider Relations or email: providertraining@nhpri.org**

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