MMP Addendum to Provider Manual

As of December 18, 2015

This document serves as a companion guide to the Provider Manual. Below you will find some of the key requirements for providers participating in Neighborhood Health Plan of Rhode Island's MMP line of business. This product is offered under a three way contract with the Center for Medicare and Medicaid Services, the Executive Office of Health and Human Services of the State of Rhode Island, and Neighborhood Health Plan of Rhode Island. For further detail please refer to the Provider Manual that will be available online as of January 4, 2016.

Education and Training

- Providers will ensure that a designated staff member has attested to taking the following web based module trainings as well as disseminating relevant information to other staff members. These training include:
    - Introduction to Integrity
    - Enrollee Rights and Protections
    - Cultural Competence, Disability Literacy, and the ADA
    - Model of Care, Assessment, and Care Planning
    - Putting Cultural and Disability Competence into Practice
    - Integration of Behavioral Health and Long Term Services and Supports
- Providers will abide by critical incident (preventing abuse/neglect/exploitation of members, information on reporting fraud, waste and abuse) guidelines.
- Network 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.

Contract and Regulations

- 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.
- As part of the contract providers must comply with all CMS regulations that govern the MMP product including all Medicare Part D requirements.
- Providers will comply with marketing guidelines outlined in the Medicare Marketing Guidelines including any limited English proficiency provisions.

- Under 42 CFR §422.504(g) (1) (iii), all MAOs --without exception-- must educate providers about balance billing protections applicable to dual eligible enrollees. Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program which exempts individuals from Medicare cost-sharing liability. (See Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997). Balance billing prohibitions may likewise apply to other dual eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing. See 42 CFR §422.504(g)(1)(iii).

Quality Standards and Care Requirements

- Providers will be responsible for ensuring compliance with quality improvements standards.
- Providers will meet Evidenced-based practices and specific levels of quality outcomes.
- As one of many efforts to improve transitions of care for members, facilities are required to fax (401459-6023 UM Fax) Neighborhood Health Plan of Rhode Island a copy of the transition of care document (Rhode Island Department of Health Continuity of Care Form) at member's discharge to another setting (hospital, SNF, etc.) (http://www.health.ri.gov/forms/continuityofcare/Form.pdf).
- During the transition period the contractor will advise enrollees and providers if and when they have received care that would not otherwise be covered in- network.
- Neighborhood seeks to minimize the disruption to members' continuity of care during the transition into the MMP product. For this reason members will be able to maintain current providers and service levels at the time of enrollment for at least six months after enrollment.
- One of the goals of the Medicare-Medicaid Program is to promote Alternative Payment Arrangements as a means to transform the delivery of high quality and cost-effective care within CMS requirements. Alternative Payment Arrangements are defined as methods of payment that are not solely based on fee-for-service reimbursements, and may include, but shall not be limited to, bundled payments, global payments, and shared savings arrangements. Alternative Payment Arrangements may include fee-for-service payments, which are settled or reconciled with a bundled or global payment. As part of the Duals Demonstration, Neighborhood is required to utilize Alternative Payment Arrangements to support this delivery system transformation. The details of these Alternative Payment Arrangements will be developed collaboratively with network providers, and will be implemented in Demonstration Year two and three (DY 2 and 3).