Neighborhood Health Plan OF RHODE ISLAND™

Provider Manual 2025

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Section 1: Introduction to Neighborhood Health Plan of Rhode Island

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Welcome

Neighborhood Health Plan of Rhode Island (Neighborhood) is pleased you and your staff have chosen to be part of our provider network. We look forward to developing a strong relationship and partnering with you to provide high quality health care to our members.

This Provider Manual is designed to guide you in working with us and supplements your participating provider agreement with Neighborhood. This document includes valuable information specific to the benefits of our members, the services provided by Neighborhood, and the policies and procedures that have been put in place to ensure satisfaction for both our members and providers. The Provider Manual is updated annually, at minimum, but may be updated ad hoc.

As an organization, Neighborhood continually strives to embody the following Mission, Vision, and Values in our employee's day-to-day work and interactions with external customers:

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.

Vision

To advance its mission, Neighborhood is working to create a world where:

- Everyone in Rhode Island has comprehensive health care coverage and access to high-quality health care.
- Community Health Centers are models for the delivery of high-quality, cost-effective primary care and the building blocks of community health in their respective communities.
- Neighborhood helps transform health care delivery as an essential partner in the state's Medicaid program.
- Neighborhood members are actively engaged in their health and health care.

Values

Ardently Advocate for Members: Neighborhood treats members with dignity and respect and strives to create access to needed services and social supports.

Foster Partnerships: Only by working collaboratively at all levels of Neighborhood's internal organization and by strengthening our external partnerships can we accomplish our mission.

Innovate to Improve the Health Care System: Neighborhood is dedicated to innovating in order to improve the way we work and to transform the health care system.

Demonstrate Value: Neighborhood must use our health care financing position to improve health outcomes, lower costs and ensure access to care.

Passionately Promote Health Equity: Neighborhood cares about those who are disenfranchised from the health care system and works to ensure that access to care and improved health outcomes become more equitable.

Create an Exceptional Workplace: Neighborhood is an employer of choice and works to attract and advance a culturally competent and diverse workforce to better serve our members.

Company Profile

Neighborhood is a not-for-profit 501c3 health maintenance organization (HMO) insurance company accredited by the National Committee for Quality Assurance (NCQA). Founded in partnership with Rhode Island's Community Health Centers in December 1993, the organization is governed by a 17-person board.

We served our first 1,490 members in 1994, and by 2000, we grew to 50,000 members. Starting in November 2013 through the introduction of the Affordable Care Act and state leadership's decision to extend coverage to more Rhode Islanders, Neighborhood has significantly increased its membership, revenue, and staff.

Today, Neighborhood—with nearly 650 employees and $1.8 billion in revenue—serves one out of every five Rhode Islanders with more than 215,000 members.

Neighborhood Members

Neighborhood is a safety net health plan and insures about 60 percent of the vulnerable populations—with low income 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.

Approximately 78 percent of our membership is Medicaid eligible, and another 5 percent are enrolled in Neighborhood's INTEGRITY (MMP) (Medicare-Medicaid Plan). About 17 percent of our members are individuals, families and small businesses who select one of eleven Neighborhood Commercial plans. Of these members on our Commercial Individual and Family plans through Rhode Island's insurance exchange HealthSource RI, about 88 percent qualify for federal subsidies to cover a portion of their costs. Neighborhood's Commercial plans are consistently the most affordable, high-quality plans available through Rhode Island's health insurance exchange.

Rhode Island Medicaid

Medicaid is a program that offers free or low-cost health coverage for people with limited income and resources. If you qualify, you can enroll in Rhode Island (RI) Medicaid at any time. Neighborhood covers low-income adults, children, seniors, persons with disabilities, pregnant women, children in foster care and former foster youth up to age 26.

Coverage includes access to medical and behavioral health services, including hospitalization and specialists, as well as a broad array of services including primary and preventive care, emergency services, prescription drugs, and behavioral health among others.

Who Works at Neighborhood

Neighborhood employs staff who reside in the cities and neighborhoods we serve. Our diverse and talented employees are committed to the mission of providing everyone with access to high quality care. Accordingly, Neighborhood staff delivers excellent service to our members and providers alike, working daily to make care more equitable and cost-effective for all no matter the zip code, ancestry, educational or socio-economic background.

Confidentiality

Neighborhood and its employees are in possession of a broad range of confidential information. The improper use or disclosure of this information could be harmful to Neighborhood and its members, providers, employees, and business partners. Therefore, each Neighborhood employee has an obligation to protect and properly use all confidential information ethically and in accordance with the law and/or our contractual obligations. To that end, all employees, including temporary staff, consultants, students, and interns, receive Privacy Training and are required to read and sign Neighborhood's Confidentiality Policy.

Neighborhood requires that its subcontractors and business partners agree to protect the confidentiality of the information we disclose to them and sign a Business Associate Agreement that outlines their responsibilities relative to protected health information.

Neighborhood includes a clause on confidentiality in all its contractual agreements with its participating providers. To ensure appropriate oversight of all aspects of confidentiality, Neighborhood has an internal Security Review Team charged with the responsibility for ensuring that policies and processes are in place to safeguard confidential information and are implemented and followed throughout the organization, and with those entities with whom we have agreements.

Member/Patient Information

Neighborhood employees are required to protect and maintain the confidentiality of all member information in accordance with the law. Confidential information regarding Neighborhood members is not used or disclosed unless supported by a legitimate business purpose. Questions regarding the appropriateness of releasing confidential information are addressed by the Neighborhood Chief Privacy Officer at 1-401-427-6799 or the Compliance Hotline at 1-888-579-1551.

Proprietary Information

Provider information, as well as, information pertaining to Neighborhood's competitive position, business strategies, payment and reimbursement is considered proprietary and is shared only with staff that have a need to know such information to perform the functions of their job. Neighborhood employees are instructed to seek guidance from their supervisor or the Chief Privacy Officer regarding whether information is proprietary or whether proprietary information can be shared.

Publications

Neighborhood is committed to providing clear, accurate and timely communications to our provider network. Neighborhood publishes Neighborhood News, a quarterly provider e-newsletter, as well as posts timely notifications to our provider network via "News and Updates" on the **www.nhpri.org** website.

Website

Neighborhood's website, **www.nhpri.org,** offers the most current provider-focused information and resources including, but not limited to:

- Provider Resources
    - Provider training – Education and required training.
    - Forms – Provider forms for claims processes, prior authorization requests, and more.

    - Clinical Resources – Information on clinical programs and Clinical Practice Guidelines.
    - Pharmacy - Comprehensive information and resources for each product's formulary, preauthorization requirements, benefits, and the network.
    - Behavioral Health - Information about behavioral health benefits and resources.
    - Dental - Neighborhood partners with Delta Dental of Rhode Island to provide pediatric dental coverage to its members.
    - Compliance Program
    - Quick Reference Guide
- Claims and Eligibility Information - Neighborhood is contracted with NaviNet to provide online member benefit, eligibility, and claims status lookup.
- Policies and Guidelines
    - Clinical Medical Policies
    - Billing Guidelines and Payment Policies
    - Prior Authorization Reference Guide
    - Durable Medical Equipment (DME) Guide for Frequency, Quantity Limits, and Prior Authorization Requirements
    - InterQual Transparency Tool
    - External Criteria Sources
    - Medicare Distinction
    - Medicare Administrative Contractor
- Network Participation – Guidance on how to become a contracted provider.
- Provider Directory – Web-based search function to find a network provider.
- For INTEGRITY, our Medicare-Medicaid Plan, we have a dedicated web page: **www.nhpri.org/INTEGRITY**

Provider Quick Reference Guide

The Quick Reference Guide (QRG) helps Neighborhood providers with frequently asked questions. The QRG is categorized by business area and includes hyperlinks (in green) to the Neighborhood website. The QRG is also available on our website as a printable document. For more information on any of the topics below, please consult the entire Neighborhood Provider Manual or contact Neighborhood Provider Services by calling 1-800-963-1001. **Click here** to access all Neighborhood forms.

<table>
<tr><th colspan="3">Claims</th></tr>
<tr><td>Claim Forms

Questions on which form to use? Consult the Claim Form Finder for more information.</td><td colspan="2">For requesting Neighborhood review on a previously processed claim:
See the Claim Adjustments webpage for guidance by Neighborhood line of business (product) on requesting an adjustment to a previously processed singular claim or multiple claims for reasons such as, but not limited to, payment modifications, and/or timely filing denials.
Use the Corrected (Replacement)/Voided Claim Request Form to void or submit changes to a previously processed claim, such as, correcting a diagnosis or CPT code, date of service, or adding information such as a national drug code (NDC) number or modifier.
Submit a Claim Reconsideration Request E-Form with medical notes, to request reconsideration of a claims payment decision.
Submit a Provider Administrative Appeal E-Form for review of a denied claim, typically following the adverse outcome of a reconsideration request or an adverse adjustment request.
Submit a Provider Clinical Appeal E-Form for a denied or absent authorization benefit appeal on behalf of a member when the provider is asking for coverage of a service due to medical necessity or non-covered medication.</td></tr>
<tr><td>Claim Status</td><td colspan="2">Neighborhood is contracted with NaviNet to provide 24/7 claims status lookup including deductible, out of pocket information, and additional claim detail for 317 denials.</td></tr>
<tr><td rowspan="3">Claim Submission</td><td colspan="2">Neighborhood requires claims to be submitted electronically, with limited exceptions. The Payer ID associated with the member's product, as well as the physical address, are noted below.</td></tr>
<tr><td>For electronic claims submission:
Medicaid and Commercial Claims Payer ID is 05047
INTEGRITY (MMP) Claims Payer ID is 96240</td><td>For paper claims submission, mail to:
Neighborhood Health Plan of Rhode Island
P.O. Box 28259
Providence, RI 02908-3700</td></tr>
<tr><td colspan="2">Email EDISupport@nhpri.org to report clearinghouse issues with electronic claim submission.</td></tr>
<tr><td>Direct Deposit and EOP/RA Setup</td><td colspan="2">Email this form to eftproviders@nhpri.org to choose the delivery method of receiving explanation of payment/remittance advice (EOP/RA) statements and set up direct deposit.</td></tr>
<tr><td>Duplicate EOP/RA Requests</td><td colspan="2">Email this form to pecremittance@nhpri.org to initiate the process to retrieve duplicate EOP/RA as needed.</td></tr>
<tr><td>Payment Policies</td><td colspan="2">The Neighborhood website has a complete list of Billing Guidelines and Payment Policies.</td></tr>
<tr><th colspan="3">Provider Data Integrity</th></tr>
<tr><td>Provider Data Updates</td><td colspan="2">Providers are required to notify Neighborhood of any changes to their practice or profile set-up; including, but not limited to, changes in office hours, address updates, etc.
Use Update Your Information to notify Neighborhood of any important changes to your profile or practice, as well as, to add a new provider/location to an existing contracted group, terminate a provider and/or location, and submit a name change.
Email providerdata@nhpri.org with any questions regarding updating your information.</td></tr>
</table>

Medical Prior Authorization		
Out-of-Network Requests	Providers must complete an **Out of Network Prior Authorization E-Form** to receive approval to refer a member to a provider not contracted/participating with Neighborhood.	
Prior Authorization Search Tool	Make sure your request requires prior authorization, by consulting Neighborhood's **Prior Authorization Search Tool.** Simply enter the procedure/service code in question and select the member's line of business to determine if prior authorization from Neighborhood is required.	
Prior Authorization Request E-Forms	**Prior Authorization Request E-Forms** for each service requiring prior authorization are located on the Neighborhood website.	
Pharmacy Prior Authorization		
Pharmacy Prior Authorization Forms	CVS Caremark's **CoverMyMeds** is the fastest (and free) way to request prior authorization. Pharmacy's **Prior Authorization Forms webpage** hosts information on how to submit requests and what forms to use for specific drugs, medical authorization, and general requests. **Click here to request a Medicare Prescription Drug Coverage Determination**.	
Member Benefits & Eligibility		
Benefit and Eligibility Information	Membership eligibility and benefits are available via **NaviNet** 24/7. For Neighborhood's Commercial line of business, NaviNet displays benefit/cost-sharing information, such as co-pay, deductible, out-of-pocket and pharmacy spend.	
Interpreter Services	Complete the **Interpreter Request E-Form** to request language services, including American Sign Language, for a member.	
Network Participation		
Verify Participation	To verify/search in-network providers, Neighborhood's online **Find a Doctor** tool can be used to view and search providers, hospitals and facilities, pharmacies and more.	
Credentialing		
Application Status	Providers receive a status of their application at least once every 15 calendar days and informed within five (5) business days when the application is deemed complete.	
Re-credentialing	Neighborhood's Credentialing Department contacts a provider when it is time for re-credentialing. Any questions can be emailed to **credentialing@nhpri.org**.	
New Providers – Join the Network		
Neighborhood	Visit **Join Our Network** for more information.	
DME	Email Integra Provider Expansion, Neighborhood's Durable Medical Equipment (DME) provider network, at **network@accessintegra.com**.	
Pharmacy	Pharmacy providers will need to contract with **CVS Caremark**.	
Other Frequently Used Phone Numbers		
Evolent – Oncology and Radiation Oncology	Program for oncology-related drugs and/or treatment	Call (888) 999-7713 or log into the provider portal: **my.newcenturyhealth.com**
Integra Partners	DME provider network	Call (888)-729-8818
Evolent – High-End Radiology and Physical Medicine	Radiology/Physical Medicine	Call (800) 327-0641 or log into the Evolent portal

Section 2: Member Services and Benefits

Neighborhood Member Plans
Member Identification Card
Behavioral Health Services
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Interpreter Services
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Neighborhood Member Plans

Medicaid Plans - Plans for individuals and families who qualify for Medicaid.

Plan Name	Line of Business	Serves
ACCESS	**Rite Care** • Medicaid (MED)	**Children and Families** • Children up to age 19, income up to 261% FPL (regardless of immigration status); Parents up to 141% FPL (lawfully present >= 5 yr); Postpartum and pregnant women receive 12 months coverage regardless of immigration status
	• Extended Family Planning (EFP)	• Postpartum women up to 253% FPL, 12 months post-delivery or 12 months post loss of pregnancy
	• Substitute Care (SUB)	• Youth in DCYF care up to age 26 who were enrolled in DCYF at age 18
	• Children with Special Health Care Needs (CSN)	• Children with special health care needs (up to 21 yr)
	• Katie Beckett Care Mgt Only (KBW)	• Katie Beckett Care Mgmt. Only (KBW): Children up to age 19 with special needs receiving services at home that are usually provided in a facility.
TRUST	Rhody Health Partners (RHP) Rhody Health Partners Expansion (RHE)	**Adults** • 21 yr or older, receive SSI or income up to 100% FPL, not enrolled in Medicare, no long-term services and supports (LTSS) • 19-64 yrs, no dependents, not pregnant at time of enrollment, income up to 133% FPL, not eligible for Medicaid or Medicare Part A and Part B (RI resident, lawfully present >5 yr)

Medicare-Medicaid Plan - For individuals who are eligible for full benefit Medicare and Medicaid (dual eligibility).

Plan Name	Line of Business	Serves
INTEGRITY	Medicare-Medicaid Plan (MMP)	**Adults** • 21 yr or older, permanent Rhode Island resident; entitled to Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D; and are receiving full Medicaid benefits

Commercial Plans: Individual Market*

Plans with comprehensive coverage for individuals without access to employer-sponsored insurance or are ICHRA** eligible.

Plan Name	Line of Business	Deductible	Network
ECONOMY	Bronze HSA	$6,800	HMO – In Network
INNOVATION	Bronze	$7,050	HMO – In Network
COMMUNITY	Silver HSA – Base only	$3,600	HMO – In Network
PLUS	Gold	$1,375	HMO – In Network
ESSENTIAL	Gold	$2,650	HMO – In Network
VALUE	Silver	$4,750	HMO – In Network

Commercial Plans: Small Business Health Options Program (SHOP) *

Plans with comprehensive coverage for small businesses with up to 50 employees.

Plan Name	Line of Business	Deductible		Network
		In-network	Out-of-Network	
STANDARD	Bronze HSA	$6,450	*NA*	HMO – In Network
CHOICE	Silver	$3,900	*NA*	HMO – In Network
EDGE	Gold	$2,750	*NA*	HMO – In Network
PEAK	Gold HSA	$2,500	*NA*	HMO – In Network
PREMIER	Gold	$2,525	*NA*	HMO – In Network
PRIME	Platinum	$500	*NA*	HMO – In Network
PEAK Elite	Gold HSA	$2,500	$7,500	POS – Out of Network Option
PREMIER Elite	Gold	$2,525	$7,575	POS – Out of Network Option
PRIME Elite	Platinum	$500	$5000	POS – Out of Network Option

*Neighborhood Commercial Plans are also referred to as "Commercial/Exchange" or "Exchange" Plans.

**Individual Coverage Health Reimbursement Arrangements (ICHRA) are a type of health reimbursement account for employers to provide tax-free funds to their employees to purchase individual insurance plans, Medicare or qualified medical expenses.

Member Identification Card

Every Neighborhood member is issued a Neighborhood identification (ID) card upon enrollment. Members are advised and expected to carry their member ID card at all times and to call their primary care provider (PCP) before seeking services, except in cases of life-threatening emergencies.

Behavioral Health Services

Neighborhood has taken significant steps toward implementing a fully integrated care management model of care. The integrated care management approach aims to assess and address our members' medical and behavioral health needs through a single interdisciplinary team.

The Neighborhood Integrated Care Management Program (ICMP) is part of a comprehensive delivery program that offers a continuum of services including integrated care assessments and linkages, care coordination, and utilization management. Since many Neighborhood members have complex needs that require services from multiple providers and systems, fragmentation of services may occur in the healthcare delivery system, creating gaps in care. These gaps can create barriers to members receiving optimal care.

Neighborhood's ICMP helps reduce these barriers by identifying the unmet needs of members and assisting them in finding solutions to address those needs. The process involves member advocacy, coordination of care between multiple practitioners and providers, assisting members in accessing community-based resources, providing specific disease related education, addressing psycho-social needs, or any of a broad range of interventions designed to improve the quality of life and functionality of members while maintaining cost-effectiveness.

Neighborhood makes every effort to create a system of care which eliminates barriers for providers and members. Members can self-refer to a behavioral health provider. Primary care providers (PCPs) and specialists can also refer Neighborhood members to a behavioral health provider without obtaining prior authorization. Neighborhood's Member Services representatives can assist members, PCPs, and specialists in locating appropriate care providers and eliminating barriers to access. Members have access to urgent, inpatient, diversionary, and outpatient behavioral health care.

Neighborhood may also reimburse for some behavioral health services when rendered by a PCP if it is covered under the member's medical benefit plan.

Plan documents are available for each Neighborhood line of business and include information on covered behavioral health services. Please refer to **www.nhpri.org** for more information.

Medical Benefits Information

Plan documents are available for each Neighborhood line of business and include information on covered medical and behavioral health services. Please refer to **www.nhpri.org** for more information.

Interpreter Services

Neighborhood offers on-site interpreter services for Neighborhood members who speak languages other than English. To ensure that an interpreter is available, we request that our providers/practices or members contact Neighborhood Member Services at least two business days prior to the date of service

when interpreter services are required. Please contact us two (2) weeks prior to the date of service for sign language services.

Required information necessary when requesting interpreter services includes:

- Verify with the member that an interpreter is needed;
- Member ID number, member name, date of birth, home address and contact number;
- Name of the provider/ practice requesting services and the practice phone number;
- Place of service where interpreter services will be required, including provider name, phone number, and address (with suite, floor number, or special directions as necessary);
- Preferred gender of the interpreter;
- Requested language;
- Correct date and time of service.

To request interpreter services for a Neighborhood member, providers should submit an Interpreter Request electronic form (e-form) though the www.nhpri.org website.

Important Reminder: If a member or provider cancels an appointment after an interpreter has been scheduled to attend, Neighborhood requires that you contact us so that we may cancel and/or reschedule interpreter services as necessary.

Transportation Benefits

Bus Transportation

Bus transportation is a benefit available to eligible Neighborhood Medicaid and INTEGRITY members to assist them in getting to their provider if they do not have a car or anyone to take them. The following is a breakdown of the available bus passes by our eligible lines of business:

Medicaid

- Neighborhood ACCESS members (except Extended Family Planning members) can get a bus ticket through Medical Transportation Management, Inc. (MTM). Bus tickets are available for non-emergency medical appointments. Members can call MTM at 1-855-330-9131 (TTY 1-866-288-3133) to request a bus ticket for each medical appointment.
- Neighborhood TRUST / Rhody Health Partners (RHP) members may be eligible for a RIPTA bus pass. To get a RIPTA bus pass, visit the RIPTA Identification Office at One Kennedy Plaza, Providence, RI 02903. Call RIPTA at 1-401-781-9400 for more information.
- Neighborhood TRUST / Rhody Health Partners Expansion can get a bus ticket through Medical Transportation Management, Inc. (MTM) to get to their non-emergency medical appointments. They can call MTM at 1- 855-330-9131 (TTY 1-866-288-3133) to request a bus ticket.

INTEGRITY (Medicare-Medicaid Plan)

Neighborhood INTEGRITY members may be eligible for a RIPTA bus pass. To obtain a RIPTA bus pass, members can visit the RIPTA Identification Office at One Kennedy Plaza, Providence, RI 02903 or go to one of the Road Trip Community Outreach locations. Call RIPTA at 1-401-781-9400 for more information.

Other Transportation Options

Rhode Island Medical Assistance covers non-emergency transportation services through a vendor arrangement with Medical Transportation Management, Inc. (MTM). You can contact MTM by calling 1-855-330-9131 (TTY 1-866-288-3133). MTM is available 24 hours a day, seven days (24/7) a week.

Neighborhood TRUST, ACCESS and INTEGRITY members qualify for these services. Transportation requests must be scheduled at least two (2) business days before a member's scheduled appointment. The two days includes the day of the call, bus not the day of the appointment. For example, call Monday to request transportation on Wednesday. Urgent care transportation can be requested 24/7.

In order to qualify for these services, Neighborhood ACCESS members would need to meet one of the following criteria:

- They live more than a half mile from the nearest bus stop.
- Their provider's office is more than a half mile from the nearest bus stop.
- They or a covered child has a same day sick appointment.
- They have prior authorization for a medical condition.

Members can also arrange for transportation assistance by calling Neighborhood Member Services. Members should call at least two business days before their medical appointment to arrange for a ride. Neighborhood can also help members set up a ride to same-day urgent care appointments.

Member Eligibility

All providers should verify a member's eligibility when providing services to a member(s) who presents a Neighborhood ID card. Primary care providers (PCP) must also verify the member is assigned to the provider group and one of the group's participating PCPs to receive reimbursement for services rendered. Neighborhood encourages PCPs to verify member site assignment even if your practice is listed on the member's ID card. Please review medical coverage policies on **www.nhpri.org** for information on services that are only payable to the members' PCP or their covering provider.

NaviNet

Membership eligibility and benefits are available via **NaviNet** 24/7. NaviNet users can view complete eligibility and primary care provider (PCP) history and other insurance information for Neighborhood members. Claim status/payment information and cost-sharing (co-pay, deductible, and out of pocket) are also available 24/7. For Neighborhood's Commercial line of business, NaviNet displays benefit/cost-sharing information, such as co-pay, deductible, out-of-pocket and pharmacy spend. If you have questions regarding NaviNet, please call 1-888-482-8057 for Customer Support.

Requesting a PCP Change for a Member

All Neighborhood members are assigned a primary care provider (PCP) displayed on the member's Neighborhood identification card. A member may change the PCP assigned to them at any time by calling Neighborhood Member Services at the number listed on their ID card.

A provider's office can also request a PCP change on behalf of the Neighborhood member by completing the PCP Change E-Form (**www.nhpri.org/Providers > Provider Resources > Forms**).

The PCP Change e-form must be completed by the provider (or office representative) who the member has requested be their new PCP. The form requires a signature from the new PCP/office representative to attest the change is being submitted at the request of the member/authorized representative.

- The PCP Change e-form must be received by Neighborhood within five (5) business days from the date of service for services to be considered for payment (the date of service will be the effective date). Forms received after five (5) business days will be effective on the date the information was faxed;
- PCP changes for newborns will be accepted up to thirty (30) days from date of birth.

Providers will not receive confirmation from Neighborhood that the PCP Change Form was received or processed. All changes can be verified on NaviNet after one (1) business day.

Member Cost-share

In some plans, Neighborhood members may have limited benefit packages and/or may be required to pay a cost-share (co-payment or coinsurance) for certain services. When applicable, cost-share information is indicated on the front of the member's Neighborhood ID Card. *Co-payments should be collected from Neighborhood members at the time of service.

Types of cost-share information that may be shown on the Neighborhood ID card, include:

- PCP/Specialist/Pharmacy;
- Urgent Care/ ER.

Member Rights and Responsibilities

Members can find a copy of their rights and responsibilities in their Member Handbook.

Neighborhood promises to work with our primary care providers and other health care professionals to provide our members with the highest quality health care services.

Member Rights

Neighborhood members have the following rights:

- To receive information about Neighborhood, its services, providers, and members' rights and responsibilities;
- To be treated with respect and dignity and right to privacy;
- To participate with their providers in decision-making regarding personal health care;
- To privacy of all records and communications as required by law. Neighborhood employees follow a strict confidentiality policy regarding all member information;

- To be treated respectfully and receive personal attention without regard to race, national origin, gender, age, sexual orientation, religious affiliation, or preexisting conditions, medical conditions, claims, medical history, genetic information, or disability;
- To an open discussion of appropriate home and community services or medically necessary treatment options or the members conditions, regardless of cost or benefit coverage;
- To get a second medical opinion for medical and surgical concerns;
- To voice complaints or appeals about Neighborhood or the care provided by its providers and/or agencies;
- To make recommendations about Neighborhood's Member Rights and Responsibilities policies;
- To refuse treatment, and if so, it will not affect future treatment.
- To receive information on available treatment options and alternatives.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To request and receive a copy of their medical records, and request that they be amended or corrected.
- To be given health care services and reasonable accommodations.
- To receive health care services covered by Neighborhood with no balance billing by one of our providers or providers.
- To understand the requirements and benefits of the plan.
- To receive member materials in a manner that can easily be understood, including formats that take into consideration members with special needs.
- To include length of stay following childbirth for mothers and newborns.

Member Rights specific to the plan they are enrolled in with Neighborhood can be found within the Member Handbooks and/or Evidence of Coverage, specific to the line of business. This information is accessible through **www.nhpri.org** or by calling Member Services.

Member Responsibilities

As a Neighborhood member, members have the following responsibilities:

- To choose a Primary Care Provider (PCP) and primary care site. Their PCP will coordinate all of your medical care. They may change their PCP at any time by calling Neighborhood Member Services;
- To have all of their medical care provided by, or arranged by, a provider in the Neighborhood network;
- To carry their Neighborhood member ID and if applicable, their Rhode Island Medical Assistance card;
- To provide, to the extent possible, information that Neighborhood and its providers and providers need to care for them;
- To learn about their health problems and help coordinate treatment that they and you as the provider agree to;
- To follow the plans and instructions for care that they agreed upon with providers;
- To talk with their PCP about all specialty care. If they need a specialist, we encourage members to work with their PCP to make sure they get quality care;
- To call their PCP first for help if they have an urgent medical condition. If an emergency is life threatening, call 911 right away or go to the nearest emergency room;

- To let Neighborhood know about changes to their name, home address, telephone number, or if they have other insurance coverage;
- To call Neighborhood Member Services if they have any questions about their rights and responsibilities.

Member Education

Neighborhood's Member Services team is readily available to assist providers with Neighborhood members that may require additional education on benefits, polices, and procedures. Providers should request member outreach from Member Services by completing and submitting a **Member Education Request Form**, found on the Neighborhood website via the following path:

www.nhpri.org/Providers > Provider Resources > Forms

The **Member Education Request Form** can be used by providers for assistance with member outreach on matters including, but not limited to:

- Pattern of missed appointments;
- Non-compliance with vaccines and/or pediatric preventive care;
- Disruptive behavior;
- Appropriate use of the emergency room;
- Review of Neighborhood benefits;
- Intent to dismiss a member from a provider/practice.

Providers are expected to make every effort to preserve the patient relationship, including educational outreach from Neighborhood's Member Services department. However, in the event the issues cannot be addressed to the satisfaction of both parties, or the Neighborhood member has demonstrated an event/action/behavior considered to be serious and significant, the provider must follow the process outlined in Section 8 of this Manual ("Member Dismissals from a Provider's Care") in order to dismiss a Neighborhood member from their practice.

Section 3: Complaints and Appeals

Member Complaints and Appeals Processes
Clinical (Medical Necessity) Appeals and Behavioral Health Appeals
Member Administrative Appeals (Non-Clinical "Benefit")
Provider Complaints
Provider Administrative Appeals

Member Complaints and Appeals Processes

Neighborhood is committed to working with our members to provide quality health care services that meet their needs and are delivered in a timely and respectful manner. To better serve members, Neighborhood has a process to resolve member complaints, grievances and appeals about claims received, benefit coverage, medical services that were denied or determined not to be medically necessary, adverse medical services, access to medical care, quality issues or concerns, breaches of confidentiality, or other issues that cause member dissatisfaction, including allegations of discrimination.

Member Complaints and Grievances – All Lines of Business/Products

Member satisfaction is our number one priority at Neighborhood. 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. Complaints and 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. Written complaints and grievances should be mailed to:

Neighborhood Health Plan of Rhode Island
Attn: Grievance and Appeals Unit
910 Douglas Pike
Smithfield, RI 02917

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.

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.

Neighborhood's Grievance and Appeals Unit and Clinical Quality Assurance Specialist logs each complaint and/or grievance and contacts the member or their authorized representative with a resolution within thirty (30) or ninety (90) calendar days from the date the request was received in accordance with applicable regulations. If additional time is needed to obtain a sufficient response to a member grievance and it is in the best interest of the member to take additional time, Neighborhood may take an extension of up to 14 days.

If members are not satisfied with Neighborhood's complaint or grievance response, the Rhode Island Office of the Health Insurance Commissioner Rhode Island Insurance Resource, Education and Assistance Consumer Helpline (RIREACH) can also assist members with any complaints or concerns. They can be reached at 1-855-747-3224 (1-855-RIREACH) or rireach@ripin.org

Additional information pertaining to Members covered under Neighborhood INTEGRITY:

For members enrolled in the Neighborhood INTEGRITY Medicare-Medicaid Plan (MMP), 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.

INTEGRITY (MMP) grievances may be filed verbally with Neighborhood Member Services or in writing. Written grievances should be sent to:

Neighborhood Health Plan of Rhode Island
Attn: Grievance and Appeals Unit
910 Douglas Pike
Smithfield, RI 02917

When Neighborhood receives a complaint from a member against a contracted plan provider, the Grievance and Appeals Unit or Clinical Quality Assurance Specialist 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.

Neighborhood's Grievance and Appeals Unit and Clinical Quality Assurance Specialist logs each INTEGRITY grievance and contacts the member or their authorized representative with a resolution within thirty (30) calendar days from the date the request was received. If additional time is needed to obtain a sufficient response to a member grievance and it is in the best interest of the member to take the extra time, we may take an extension of up to 14 days.

Expedited grievances are resolved verbally within 24 hours of the time the grievance was received. Sometimes the Grievance and Appeals Coordinator will need to contact the member or provider to get more information about the complaint or grievance.

Post-Service (Retrospective) Authorization Requests

For post-service (retrospective) authorizations to be processed, all clinical appeals must be submitted with clear rationale for why the authorization was not requested in accordance with Neighborhood preauthorization policy. Also, a copy of the medical record must be included and one of the following circumstances must be identified.
(Note: only the following circumstances will be considered as exceptions to this policy):

- Medicare/Medicaid retractions
- COB
- Retrospective eligibility as determined by EOHHS

Clinical (Medical Necessity) Appeals and Behavioral Health Appeals

When to file an appeal:

- Medicaid appeals must be filed within 60 days of receiving the initial denial.
- Commercial appeals must be filed within 180 days of receiving the initial denial.
- INTEGRITY appeals must be filed within 65 days of receiving the initial denial/organization determination.

To facilitate a clinical or behavioral health appeal, providers must submit a completed **Provider Clinical Appeal E-Form**.

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. The acknowledgment letter will note the anticipated date Neighborhood expects to complete review of the requested services or supplies. Due to the nature of expedited appeals, Neighborhood's Grievance and Appeals Unit may verbally acknowledge receipt of expedited appeals. When the appeal will be resolved:

- All Lines of Business/Products:
    - 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 time frame.
    - 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 time frame.
    - Post-service or payment appeals are resolved within 30-60 calendar days of receipt and are not eligible for expedited appeal time frame or extensions.
- INTEGRITY-specific:
    - In addition to the time frames 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.
    - Additional information related to INTEGRITY appeals is available in the INTEGRITY Section below.

Remember:

- Appeals for high-end radiology services, and physical, occupational, and speech therapy for the INTEGRITY line of business must be filed directly with Neighborhood's Grievance and Appeals Unit, following the instructions on the initial denial notification. Medicaid and Commercial appeals are still to be submitted to Evolent for processing.
- Appeals for Part D drugs must be filed directly with CVS Caremark, following the instructions on the adverse coverage determination notification.

Additional information pertaining to INTEGRITY appeals is available in the INTEGRITY Section of this Manual.

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 provider 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.

When applying the standard appeal resolution timeline could seriously jeopardize the member's life, health, or ability to regain and/or maintain maximum function, an expedited appeal can be requested by the member, their authorized representative, or the member's treating provider.

Neighborhood reserves the right to have any request for expedited appeal status reviewed by a plan Medical Director to ensure that the request meets criteria for expedited status. If approved for expedited review

status, expedited appeals are reviewed and determined no later than seventy-two (72) hours from time and date of receipt or as expeditiously as the member's condition dictates. If the request does not meet expedited status, it will be transferred to the standard appeal time frame.

Expedited appeals submitted by someone other than a member or a member's treating provider, without written consent, will be dismissed by Neighborhood until written consent is received from the member or his/her Legal Representative.

Next Steps after Neighborhood Issues a Clinical Appeal Denial

Medicaid members who are not satisfied with the outcome of a clinical 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. Members must exhaust Neighborhood's internal appeal process before requesting an EOHHS Fair Hearing. Members or their authorized representative must call EOHHS at 1-401-462-5300 or 1-401-462-3363 (TTY), (English or Spanish).

Medicaid and Commercial members or their treating providers who are not satisfied with the outcome of a clinical appeal may request an External Appeal in accordance with the Office of the Health Insurance Commissioner's (OHIC) requirements within four (4) months of Neighborhood's internal appeal denial. Please note that Commercial members may be responsible for paying $25 per external appeal, up to $75 in external appeal filing fees, per calendar year. No fee will be assessed for Medicaid members.

A member, a member's authorized representative, or a treating provider may ask for an External Appeal in writing, in person, or by calling Member Services at 1-800-459-6019 (TTY 711).

Provider appeal requests must be submitted via fax (401-709-7005) or e-form.

Additionally, OHIC can assist members with any complaints or concerns by contacting them at:

Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline
300 Jefferson Boulevard
Suite 300
Warwick, RI 02888

Telephone: (855) 747-3224 (855-RIREACH)
Web site: www.rireach.org
E-mail: rireach@ripin.org

INTEGRITY clinical appeal denials for pre-service medical necessity 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 the Centers for Medicare & Medicaid Services (CMS) requirements by Neighborhood's Grievances and Appeals Unit. If the service is not covered by Medicare or if the appeal is for a Provider Claim Payment Appeal, the appeal will not be forwarded to MAXIMUS for review as it does not qualify for MAXIMUS review. Any additional appeal rights, if applicable, will be communicated on the Neighborhood appeal denial notification letter (Additional information available in the INTEGRITY [MMP] Section).

Member Administrative Appeals (Non-Clinical "Benefit")

A member 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) benefit limitation or adverse determination. Appeals 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.

Next Steps after Neighborhood Issues a Member Administrative Appeal Denial

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. Members must exhaust Neighborhood's internal appeal process before requesting an EOHHS Fair Hearing. Members or their authorized representative must call EOHHS at 1-401-462-5300 or 1-401-462-3363 (TTY), (English or Spanish). The external review process is not applicable for administrative appeals.

Additionally, OHIC can assist members with any complaints or concerns by contacting them at:

Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline
300 Jefferson Boulevard
Suite 300
Warwick, RI 02888

Telephone: (855) 747-3224 (855-RIREACH)
Web site: www.rireach.org
E-mail: rireach@ripin.org

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. If the service is not covered by Medicare or if the appeal is for a Provider Claim Payment Appeal, the appeal will not be forwarded to MAXIMUS for review. Any additional appeal rights, if applicable, will be communicated on the Neighborhood appeal denial notification letter. (Additional information available in the INTEGRITY section below).

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 complaint initiated by the provider.

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.

Provider Administrative Appeals

A provider can submit a request for Neighborhood to review and reverse a claim denial due to an adverse reconsideration request decision or an adverse adjustment request decision. These requests must be filed to Neighborhood within 60 days from the:

- Reconsideration request denial date; and/or
- Adjustment request denial date.

Neighborhood strives to resolve administrative appeal requests within 60 calendar days from the date the appeal is received. Approvals may result in a claim adjustment.

Denials will always result in written notification. Duplicate and triplicate appeals will not be accepted or responded to as Neighborhood will use the first appeal submission as the official request in these instances.

To facilitate an administrative appeal, providers must submit a completed Provider Administrative Appeal E-Form to Neighborhood containing a detailed description of why they are appealing the decision, as well as specific supporting documentation to support their request to waive the denial.

Section 4: Billing and Reimbursement

Neighborhood Claim Submission Standards
Professional and Facility Industry Standard Coding Requirements
Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS) Provider Claims
Requirements for CMS-1500 Claim Submission (Paper)
Neighborhood Requirements for UB-04 Claim Submission
Claim Submission Timeframe Requirements

- Initial Claim Submission (Complete and Incomplete Claims)

Requests for Claim Review

A. Corrected (Replacement) and Voided Claims
B. Adjusted Claims
C. Claim Reconsideration Request

Coordination of Benefits
Lesser of Logic
Provider Administrative Appeals
Provider Payments
Billing Member and Hold Harmless Provisions
Explanation of Payment/Remittance Advice
EDI Response Reports
Billing Guidelines and Payment Policies

Neighborhood Claim Submission Standards

Claims that do not require an attachment must be filed electronically. All Commercial and Medicaid coordination of benefit (COB) claims, also known as secondary claims, must also be submitted electronically.

Claims with any type of attachment, including, but not limited to the following, must be submitted in paper form:

- Medical records
- Invoices
- Single case agreements

Professional

- Professional paper claim submissions, use 02/12 CMS-1500, Version 10.0 claim form. Please visit the National Uniform Committee website for 02/12 CMS-1500, Version 10.0 Instruction Manual.
- Professional electronic claim submissions, use ANSI 837P, Version 005010

Institutional

- Institutional paper claim submissions, uses UB-04 form
- Institutional electronic claim submissions, use ANSI 837I, Version 00510

Electronic Claims

Neighborhood can accept direct 837(X), Version 005010 submission of files via FTP, or Secure FTP from one of several clearinghouses (Change Healthcare, Inovalon [formerly known as ABILITY], Waystar, Healthcare Revenue Cycle Solutions [SSI] and Claim.MD.)

All claims submission files and any response files transmitted using legacy FTP protocol will require encryption. The selected clearinghouse may find it necessary to purchase encryption software compatible with the one that Neighborhood is currently using. This will ensure the proper level of security and confidentiality of the data being transmitted.

The use of Secure FTP protocol, which natively has an encryption algorithm included, will not require the use of an additional third-party encryption methodology. This decision was made between the clearinghouse and Neighborhood's EDI Support Team.

To submit claims electronically to Neighborhood through a clearinghouse:

1. Select a clearinghouse and follow the clearinghouse onboarding process.
2. Once EDI files have been submitted through the clearinghouse, if there is a technical problem the clearinghouse is unable to determine or resolve, the submitter can contact the Neighborhood EDI team for support: EDISupport@NHPRI.org.

Paper Claims

When filing on paper, submissions must be on original red forms. Claim submissions that are carbon copies, photocopies, difficult to interpret, faint in image, misaligned, or missing information, will be returned for resubmission.

Paper claims must be mailed to:

Neighborhood Health Plan of Rhode Island
Attention: Claims Department
P.O. Box 28259
Providence, RI 02908-3700

Professional and Facility Industry Standard Coding Requirements

Neighborhood uses coding criteria and protocols established by industry standard sources including, but not limited to:

- The Centers for Medicare and Medicaid Services (CMS);
- National Correct Coding Initiative (NCCI);
- The Current Procedural Terminology (CPT) Manual, published by the American Medical Association.
- Healthcare Common Procedure Coding System (HCPCS);
- International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System:
    - ICD-10-CM for diagnosis coding
    - ICD-10 PCS for procedure coding
- Other specialty society guidelines.

Failure to furnish valid coding may result in claim processing delays or claim rejection. Valid procedural coding is required to process professional and facility services. Codes must be in effect for the date of service. Claims with missing or invalid coding are not considered complete claims.

Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS) Provider Claims

Electronic claims for DMEPOS must be submitted to our DMEPOS vendor, Integra, through the Que system: https://accessintegra.com/resources/.

Paper DMEPOS provider claims must be submitted to this address:

Integra Partners, LLC
PO Box 80727
Rochester, MI 48308-0727

Requirements for CMS-1500 Claim Submission (Paper)

The following is a listing of the claims information that is required by Neighborhood in order for claims to be reviewed for potential payment. If any of the required information is omitted or invalid, claims will be returned for correction and resubmission. The "Instruction" column indicates whether a particular field is "required" or "optional":

All professional claims must be filed on a CMS-1500 form version (02/12). The original red and white printed version must be used.

Item	Heading	Instruction
1	Carrier Type	Optional
1a	Insured's ID Number	Required
2	Patient's Name	Required
3	Patient's Date of Birth (MM/DD/CCYY) and Sex	Required
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient's Relationship to Insured	Required
7	Insured's Address	Required
8	Reserved for NUCC Use	N/A
9	Other Insured's Name	Required if Field 11d = yes
9a	Other Insured's Policy or Group Number	Required if Field 11d = yes
9b	Reserved for NUCC Use	N/A
9c	Reserved for NUCC Use	N/A
9d	Insurance Plan Name or Program Name, if Applicable	Required if Field 11d = yes
10	Is Patient's Condition Related to:	
10a	Employment	Required, if applicable
10b	Auto Accident/Place (state)	Required, if applicable
10c	Other Accident	Required, if applicable
10d	Claim Codes (designated by NUCC)	Required, if applicable
11	Insured's Policy Group or FECA Number	Required, if applicable* **Required in instances of COB*
11a	Insured's Date of Birth (MM/DD/CCYY) and Sex	Required, if applicable
11b	Other Claim ID (designated by NUCC)	N/A
11c	Insurance Plan Name or Program Name	Required, if applicable
11d	Is There Another Health Benefit Plan?	Required
12	Patient's or Authorized Person's Signature/computer-generated signature and Date (MM/DD/YY, MM/DD/CCYY, or alpha-numeric) OR Signature on file/authorized signature on file/SOF are acceptable without a date	Required
Item	**Heading**	**Instruction**
13	Insured's or Authorized Person's Signature (Payment of Benefits)	Required
14	Date of Current Illness, Injury, Pregnancy (LMP) (MM/DD/YY) and Qualifier	Required, if applicable
15	Other Date and Qual. (MM/DD/YY)	Required, if applicable
16	Dates Patient Unable to Work in Current Occupation	Optional
17	Name of Referring Provider or Other Source	Required for Medicaid and Medicare/Medicaid (MMP)

		Required for Commercial DME, PT/OT/ST, and laboratory services
17a	Referring Provider ID	Required for instances noted in box 17 Optional for all others
17b	Referring Provider NPI#	Required if there is data in Field 17
18	Hospitalization Dates Related to Current Services	Optional
19	Additional Claim Information (designated by NUCC)	N/A
20	Outside Lab?	Optional
21	Diagnosis or Nature of Illness or Injury; *and* ICD Ind.	Required
22	Resubmission Code/Original Ref. No.	Both Resubmission Code/Original Ref No. are required for a corrected/replacement or voided claim
23	Prior Authorization Number or CLIA Number	Required, if applicable
24a	Date(s) of Service, From and To (MM/DD/YY)	Required
24b	Place of Service	Required
24c	Emergency Service (EMG)	Optional
24d	Procedures, Services or Supplies (CPT/HCPCS, Modifiers or National Drug Code [NDC] numbers)	Required
24e	Diagnosis Pointer	Required
24f	Charges	Required
24g	Days or Units	Required
24h	EPSDT Family Plan	Optional
24i	ID Qualifier	Optional
24j	Rendering Provider ID #	Required, if NPI is different from data recorded in items 33a and 33b.

24	Supplemental Information (entered in the shaded areas of Item 24)	Beginning in 24A Supplemental information for NDC is to be added in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity, one space
25	Federal Tax ID Number and SSN/EIN	Required
26	Patient's Account Number	Optional
27	Accept Assignment	Required
28	Total Charge	Required *Continued claims only require a total on the last page
29	Amount Paid	Required, if applicable
30	Reserved for NUCC Use	N/A
31	Signature of Physician or Supplier and Date	Required
32	Service Facility Location Information	Required, if applicable
32a	Service Facility NPI	Required, if applicable
32b	Other ID	Optional
33	Billing Provider' Info and Phone Number	Required
33a	Billing Provider NPI #	Required
33b	Non-NPI ID/Neighborhood provider or vendor number assigned by Neighborhood	Optional

Neighborhood Requirements for UB-04 Claim Submission

The following is a listing of the claims information that is required by Neighborhood in order to process claims for potential payment. If any of the required information is omitted or invalid, claims may be returned for correction and resubmission. The "Instruction" column indicates whether a particular field is required or optional. All Institutional claims must be filed on a UB-04 form (latest version). The original red and white printed version must be used.

R	Required
RA	Required, if applicable
O	Optional
NR	Not Required

Item	Heading	IP Instruction	OP
1	Provider Name, Address and Phone	R	R
2	Pay-to Name, Address and Secondary Identification Fields	NR	NR
3a	Patient Control #	O	O
3b	Medical/Health Record #	NR	NR
4	Type of Bill	R	R
5	Federal Tax Number	R	R
6	Statement Covers Period (From – Through)	R	R
7	Not Used	N/A	
8a	Patient ID Number	R	R
8b	Patient's Name	R	R
9a-e	Patient's Address	R	R
10	Patient's Birth Date	R	R
11	Patient's Sex	R	R
12	Admission Date	R	RA
13	Admission Hour	R	RA
14	Type of Admission/Visit	R	R
15	Source of Admission	R	R,
16	Discharge Hour	R	NR
17	Patient Discharge Status	R	R
18-28	Condition Codes	RA	RA
29	Accident State	RA	RA
30	Not Used	N/A	
31-34	Occurrence Codes and Dates	RA	RA
35-36	Occurrence Span Codes and Dates	RA	RA
37	Not Used	N/A	

38	Responsible Party Name and Address	RA	RA
39-41	Value Codes and Amounts	RA	RA
42	Revenue Code	R	R
43	Revenue Code Description	R	R
	NDC Code	RA	RA
44	HCPCS/Rate/HIPPS Code	RA	RA
45	Service Date	NR	R
46	Units of Service	R	
47	Total Charges	R	
48	Non-Covered Charges	RA	RA
n/a	Totals	R ***Continued claims only require a total on the last page*	R
49	Not Used	N/A	N/A
50	Payer Name	R	
51	Health Plan ID	R	R
52	Release of Information Certification Indicator	R	R
53	Assignment of Benefits Certification Indicator	R	R
54	Prior Payments	RA	RA
55	Estimated Amount Due	O	O
56	National Provider ID (NPI)	R	R
57	Other Provider ID	O	O
58	Insured's Name	R	R
59	Patient's Relationship to Insured	R	R
60	Insured's Unique ID	R	R
61	Insurance Group Name	O	O
62	Insurance Group Number	O	O
63 A-C	Treatment Authorization Code	RA	RA
64 A-C	Document Control Number (DCN)	O	O
65	Employer Name	O	O
66 A-Q	Diagnosis and Procedure Code Qualifier (DX)	R	R
67	Principal Diagnosis Code & POA Indicator	R	R
68	Not Used	N/A	N/A
69	Admitting Diagnosis	R	R
70A-C	Patient Reason for Visit	RA	RA
71	Prospective Payment System (PPS) Code	RA	RA
72 A-C	External Cause of Injury (ECI) Code	RA	RA

73	Not Used	N/A	
74 A-B	Principle Procedure Code and Date	R	R
74 A-E	Other Procedure Codes and Dates	R	R
75	Not used	N/A	N/A
76	Attending Provider Name and Identifiers (including NPI)	R	RA
77	Operating Provider Name and Identifiers (including NPI)	RA	RA
78-79	Other Provider Name and Identifiers (including NPI)	RA	RA
80	Remarks	O	O
81a-d	Code-Code Field	O	O

Claim Submission Timeframe Requirements

Unless a provider's contract with Neighborhood states otherwise, the claim submission and processing timelines detailed in this section apply to all participating providers for all lines of business.

Initial Claim Submission

Each claim submission must meet the definition of a complete claim as detailed below. Only complete ("clean") claims are eligible for timely filing reconsideration.

Complete Claims

Neighborhood defines a complete (clean) claim as a claim for payment of health care services rendered. Clean claims are submitted via approved CMS claim forms or electronic formats with all required fields completed with accurate and complete information in accordance with the insurer's requirements.

- Complete claims must be received by Neighborhood within one hundred eighty (180) days from the date of service.
    - For date range claim submissions, (i.e., claims that require "from"/ "to" and/or "through" dates) 180 days begins at the "to"/"through" date.

A claim is considered "complete" if ALL of the following conditions are met:

1) The service is a covered benefit, provided by an eligible provider, and provided to a person covered by Neighborhood;
2) The claim has no material defect or impropriety, including, but not limited to, incorrect coding or any lack of required substantiating documentation;
3) There is no dispute regarding the amount claimed;
4) The payer has no reason to believe that the claim was submitted fraudulently or there is no material misrepresentation;
5) The claim does not require special treatment or review (submission outside of the corporation for external review or requiring additional documentation to be reviewed for consideration) that would prevent the timely payment of the claim;
6) The claim does not require COB, subrogation or other third-party liability;
7) Services must be incurred during a time where the premium is not delinquent (this does not apply to MMP or Medicaid Members);
8) Only one billing provider submitted on each claim;

9) Participating providers are required to bill claims via an electronic 837 file;
10) For electronic submissions, the proper payer ID for the applicable line of business has been utilized.
    a. Medicaid and Commercial products - Use Payer ID 05047
    b. INTEGRITY MMP - Use Payer ID 96240

All of the following information is required for a claim to be accepted for processing:

- Valid and properly formatted member identification number (do not cut off or truncate the member identification number)
- Patient's full name
- Patient's date of birth
- Date of Service
- Industry standard diagnosis codes
- Place of service
- Industry standard procedure codes
- Charge information and units
- Rendering provider valid NPI number
- Provider federal tax identification number
- Accept assignment
- Billing provider's name, address and valid NPI number
- Proper formatting of all the claim components
- All other required elements

Note: Please validate this information prior to submitting the claim.

Incomplete Claims

Incomplete claims are standard claim forms that do not meet the criteria above and/or may require further investigation beyond the information contained on the claim. Neighborhood may require additional information to process and/or adjudicate the claim including, but not limited to, medical necessity review, pricing review, an invoice, complete billing details or operative notes to substantiate payment.
Submissions that are sent back to the provider by Neighborhood are not considered clean.
The notice of rejection does not serve as proof of timely filing. This applies to all methods of claims submission, including paper and electronic submissions. Claims must be resubmitted with all appropriate information within 180 days or the contractually determined timely filing requirement.

Requests for Claim Review

If a provider believes that changes should be made to a claim, or to a payment decision rendered on a claim, please consult the scenarios below for more information on the procedure. All referenced forms can be found on the Neighborhood website via the following path: **www.nhpri.org/Providers > Provider Resources > Forms**

A. Corrected (Replacement) and Voided Claims

Neighborhood accepts corrected (replacement) and voided claims for reprocessing via paper or electronic submission. A change made to an original submitted claim that was previously processed and posted on a Remittance Advice (RA).

Examples include, but are not limited to:

a. Correcting
    i. ICD-10 diagnosis code(s)
    ii. CPT-4 or HCPCS procedure code(s)
    iii. Modifier(s)
    iv. Date(s) of Service
b. Amending the original charge(s)
c. Adding additional information (i.e. NDC number)
d. Adding coordination of benefit information
e. Voiding a claim

Claims must be resubmitted with all appropriate information within 365 days from the date of service. For date range claim submissions, (i.e., claims that require "from"/ "to" and/or "through" dates) 365 days begins at the "to"/ "through" date.

In the event Neighborhood retracts payment, providers have 365 days from the date on the RA regarding the retraction to submit a corrected claim, if necessary.

Paper Corrected Claims

Corrected claims are accepted on paper for participating providers when additional documentation is required to adjudicate the claim. Providers must use a **Corrected (Replacement)/Voided Claim Request Form** to assist with accurate processing of corrected (replacement) and voided paper claims. This form should be used to void or to submit changes, such as correcting a diagnosis code, CPT or HCPCS code, or date of service, or adding additional information such as an NDC number or modifiers, to a previously processed claim.

Corrected (Replacement)/Voided Claim Request Form Guidelines

- Claim submission must be an original red form, CMS1500 or UB04.
- Claim submission must not be copied or in any other form of replication.
- No handwriting, stamps, correction fluid, or staples should be present.
- Failure to provide the request form could cause the claim to be delayed, improperly paid, or denied.
- A corrected or voided claim replaces the previously submitted version of that claim.

Please be sure to use a corrected or voided bill type when resubmitting a UB-04 claim and populate the applicable resubmission code on a CMS-1500 claim or the type of bill on the UB-04 form. Corrected claims submitted without replacement or voided bill types/resubmission codes will be rejected or denied. You may also refer to the form requirements that begin on page 26.

Electronic Corrected Claims

For electronic claims, submit a claim via EDI, in the applicable loop and segment location:

- Loop 2300 (Claim Information)

- Segment: CLM
- Element: CLM05-3 (Claim Frequency Type Code)

For UB-04 Claims
Enter the four-digit code, the first of which is a zero, and use a 7 (the "Replace" billing code) in the fourth position to identify it as a corrected or replacement claim
Enter the four-digit code, the first of which is a zero, and use an 8 (the "Void" billing code) in the fourth position to identify it as a voided claim
For 1500 claims
Use a 7 (the "Replace" billing code) to identify it as a corrected or replacement claim
Use an 8 (the "Void" billing code) to identify it as a voided claim

Please refer to the CMS Companion Guides for additional information.

B. Adjusted Claims

Providers may request to have an adjustment made to a previously processed claim for reasons such as, but not limited to payment modifications or timely filing. Adjustment requests require the submission of a completed applicable **Claim Adjustment Request E-Form**, applicable claim number, and supporting documentation.

Neighborhood's Claim Adjustment webpage and accompanying **Claim Adjustment Request E-Forms** can be accessed via the following path:

www.nhpri.org/Providers > Provider Resources > Forms > Claim Adjustments

Adjustment requests for previously adjudicated claim must be submitted within 60 days from the date on the initial EOP/RA statement or from the date of retraction on the EOP/RA.

Providers may also request an adjustment to a claim that has denied for timely filing if:

1. They have proof that the provider billed another health insurer or the patient within at least 90 days of the date of service and the date of the proof is within 60 days of the adjustment request.
2. The provider billed another health insurer, an EOP/RA, EOB, or other communication from the plan confirming the claim was denied and not paid, or inappropriate payment was returned. If you do not have this type of proof, please file an administrative appeal as described in the section below entitled "Provider Claim Appeals."

Requests for Timely Filing Adjustments must include*:*

1. A copy of timely filing denial or documentation that clearly lists the claim(s) in question;
2. Written documentation that the provider billed another Health Insurer or the patient within ninety (90) days of the date of service;
3. If the provider billed another health insurer, an EOP/RA, EOB, or other communication from the plan confirming the claim was denied and not paid, or inappropriate payment was returned;
4. If the provider billed the patient, acceptable documentation may include:
   - Benefit determination documents from another carrier;
   - A copy from the provider's billing system documenting proof of an original carrier claim submission;
   - A patient billing statement that includes initial claim send date and the date of service; or

5. Documentation as to the exact date the provider was notified of member's correct coverage, who notified the provider, how the provider was notified and a brief, reasonable statement as to why the provider did not initially know the patient was not covered by the carrier. Practice management and billing system information can be used as supportive documentation for these purposes.

Note: Providers requesting retraction or recoupment of overpayment, do not have a timely filing limit.

C. Claim Reconsideration Request

A reconsideration is a review, with medical notes, of a claims payment decision.

- **Claims reconsideration requests must be submitted within sixty (60) days from the date on the initial EOP/RA or within 60 days of an adverse determination of an adjustment request.**

Requests for Claim Reconsiderations must adhere to the following guidelines:

1. A completed Reconsideration Request Form must accompany submitted documentation;
2. Multiple claims for the same member must still be submitted separately;
3. For each claim, submit all medical notes in one document;
4. Providers will be notified in writing of any upheld denial;
5. If a reconsidered claim denial is upheld, the provider may pursue the matter through Neighborhood's Provider Administrative Appeal process. These requests must be filed within sixty (60) days from the date on the Claims Reconsideration Denial Letter;
6. Neighborhood is not responsible for administrative fees related to records submitted as part of a claim reconsideration request;
7. Duplicate and triplicate Reconsideration Requests will not be accepted or responded to, as Neighborhood will use the first submission as the official request in these instances.

A Claim Reconsideration Request E-Form and accompanying documentation must be submitted for a reconsideration request to be processed.

Note: The electronic reconsideration request process is not intended for corrected or adjusted claim submission, nor is it to obtain status updates on prior submissions.

Coordination of Benefits

Coordination of benefits (COB) occurs when a member is covered by more than one health insurance carrier (including medical, dental and vision coverage). For Medicaid, Neighborhood is the payer of last resort. If a member is known to have other primary insurance coverage, all claims must be filed to the primary insurer first. Benefit and reimbursement consideration can be made upon timely submission of the claim with the primary insurance payment information.

All Commercial and Medicaid Coordination of Benefits (COB) claim information **must be submitted electronically**. Providers are required to enter detailed COB data into the electronic claim submission.

This includes, but is not limited to, the following:

- **Primary carrier name**
- **Subscriber Information**

- **Primary carrier ID number**
- **Amount charged to the primary carrier**
- **Amount allowed by the primary carrier**
- **Amount paid by the primary carrier**
- **Member responsibility details**, including:
    - Copayment
    - Deductible
    - Coinsurance
    - Out-of-pocket amounts
- **Denial information**, if applicable:
    - CARCs (Claim Adjustment Reason Codes)
    - RARCs (Remittance Advice Remark Codes)
- **Date of the Explanation of Benefits (EOB)**

Note: Neighborhood does **not** accept paper submissions of the primary carrier's EOB. All relevant information from the primary EOB must be present on the electronic claim submission.

When submitting to Neighborhood for secondary payments, please be aware of the following:

- Contracted providers have 180 days from the date on the primary carrier's EOB to submit for any secondary balances, unless otherwise dictated by provider contract;
- Neighborhood will only pay as secondary for services that are covered benefits under the plan;
- Where there is indication that the primary payer's guidelines were not followed the claim will be considered invalid and will be denied.

Lesser of Logic

Neighborhood will apply "lesser of logic" as follows:

1. **Fee schedule-based claim payments**
   When the member's primary coverage is with Neighborhood, Neighborhood will apply "lesser of logic," meaning if a claim is billed with a rate that is lower than the contracted rate, the claim will pay the provider's billed charge.

2. **COB**
   When coordinating benefits for members who have primary coverage with another health plan, Neighborhood will pay the allowable amount minus the primary carrier payment, or the member's responsibility, whichever is less.
    - If the primary carrier paid more than Neighborhood's Fee Schedule allowed amount, payment is zero;
    - If Neighborhood's Fee Schedule allowed amount is greater than the primary carrier's payment, the "lesser of logic" is applied.

Provider Payments

Neighborhood abides by the prompt processing requirements established by R.I. Gen. Laws §§ 27-18-61, 27-19-52, 27-20-47 and 27-41-64 and processes electronic claims submitted by Rhode Island health care

providers and policyholders within thirty (30) calendar days from receipt of said claims and to process written claims submitted by Rhode Island health care providers and policyholders within forty (40) calendar days from receipt of said claims.

Neighborhood supports paying providers electronically via electronic funds transfer (EFT). This process ensures timely payment directly into your bank account.

We will issue the corresponding EOP/RA to you electronically or via standard mail, as well. If you are not currently set up for EFT please go to the "Provider Resources – Forms" section of **www.nhpri.org** to complete the Electronic Payment and Remittance Advice Application.

Billing Member and Hold Harmless Provisions

Providers accept the lesser of the Neighborhood fee schedule or the provider's billed charges as payment in full. Therefore, providers cannot bill or balance bill members for covered services. Other than allowable co-payments or deductibles for certain lines of business, in no event can the provider bill, charge, or have any recourse against Neighborhood members for services provided by the provider under their agreement with Neighborhood. Providers may not bill members for missed appointments.

Billing Member for Non-Covered Services

A member may request services which are not covered by Neighborhood. A provider may bill the member for these services. For Medicaid and Commercial members, a financial liability form will need to be provided to the member to review and sign prior to the services being rendered to ensure they are aware of their potential financial responsibility.

For INTEGRITY (MMP) members, a provider is allowed to bill the member if the service is non-covered and listed as an exclusion within the member handbook. If an authorization request is denied for a service that may be considered covered based on medical necessity, the provider may bill the member for the service upon receipt of denial notification from Neighborhood. Participating providers are required to follow the prior authorization process for any services requiring authorization. The provider is not allowed to bill the member for a service in which the provider failed to request authorization.

Explanation of Payment/Remittance Advice

Providers receive the Neighborhood explanation of payment, also known as a remittance advice, as notification of claims adjudication completion. The EOP/RA details all claims adjudicated for that period along with a bulk payment, if applicable. Payments are made via Electronic Funds Transfer and an EOP/RA is sent to providers via secure e-mail address or standard mail.

The EOP/RA details the following information for each claim:

- Member ID
- Patient Name
- Provider Name
- Provider Address
- Claim ID
- Patient Account Number
- Servicing Provider
- Line Number
- NPI Number
- Date of Service

- Payment Date
- Claim Number
- Procedure Code
- Modifier (s)
- Units
- Billed/Charged Amount
- Allowed Amount
- Denied Amount
- Deducted Amount
- Payment Issued
- Capitated Payments
- Co-pay/Coinsurance/Patient Share
- Other Insurance Allowed
- Other Insurance Paid
- Explanation/Reason Code
- Previous Negative Balance
- Claims Payment This Run
- Negative Balance This Run
- Check/EFT Number
- Payment Methodology
- Line of Business
- Interest Paid
- Claim Totals

Requests for duplicate EOP/RA statements can be initiated by completing the Application for Duplicate Remittance Advice (RA) Statement, found in the "Forms" section of **www.nhpri.org** (**www.nhpri.org/Providers** > **Provider Resources** > **Forms)**

EDI Response Reports

In addition to the Neighborhood EOP/RA, providers who submit claims electronically also receive the following reports to confirm receipt and verify information received via the EDI process.

999 – Functional Acknowledgement File

- The 999 file is used to confirm that an electronic file was received. Receipt of a transaction, such as a health care claim (837), does not necessarily mean that the transaction can be processed. Every trading partner must review the 999 for all electronic claim files submitted and confirm if the file was accepted, rejected or partially accepted. For partially accepted files, you must correct and submit a corrected file. The trading partner will then receive a 999 for the corrected file if it passes pre-compliance and compliance file checking.

277CA – Health Care Claim Acknowledgment

- The 277CA is an acknowledged receipt of the claim submission file. It provides claim-level acknowledgment of claims before sending to adjudication. You may send this transaction after receiving the 999 for claims on the 837 file submitted. This document acknowledges the validity and acceptability of the claims at the pre-processing stage. Claims that are incorrectly formatted or missing mandatory information may not be introduced into Neighborhood's adjudication system

and will be considered rejected claims. If a claim is rejected, providers can update their claims, and resubmit them for processing.

Billing Guidelines and Payment Policies

Neighborhood publishes payment polices on **www.nhpri.org**. The guidelines and policies are updated regularly and are subject to change as State, Federal, CMS, AMA, Neighborhood, and other industry standards change.

The guidelines and policies are not intended to certify coverage availability.

Section 5: Authorization Process and Medical Management

Medical Management at Neighborhood
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How to Reach Medical Management
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Retrospective Authorization Requests

- Extenuating Circumstances
- Expedited Requests

Provider Notification of Decisions
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Adverse Determination (Denials)

- Peer-to-Peer Review

Medical Management at Neighborhood

The goal of Neighborhood's Medical Management Department is to ensure positive patient outcomes by addressing and supporting member's medical needs, social needs, and behavioral health in the most cost-effective and efficient way. The department is designed into three functional areas including, Utilization Management, Case Management and Clinical Programs.

The Utilization Management (UM) department ensures timely, accessible, and coordinated care for our members. UM confirms that medically necessary utilization occurs in the most appropriate care setting within the benefit plan through the use of approved clinical protocols and guidelines.

- Neighborhood's utilization management decisions are based only on appropriateness of care and service and existence of coverage.
- Neighborhood does not reward staff or providers conducting utilization review for denying coverage or service.
- Neighborhood does not offer financial incentives to encourage decisions that result in under-utilization.

UM physicians, nurses, coordinators, and other clinical staff work in collaboration with the member's provider(s) to ensure that the services requested are medically necessary and also not over- or under-utilized. On an annual basis, the physicians and nurses evaluate clinical criteria used for decision making, and through training and consultation with external clinical specialists, ensure the clinical criteria available is appropriate and specific for our membership. The Neighborhood team also works with the member's providers to facilitate coordination of services and identifies members that may benefit from case management. The team members are not compensated for denying covered services.

The Case Management area offers programs that focus on the assessment and coordination of member's care along the health care continuum to maximize positive outcomes and to provide quality, member focused, cost effective care. The case management program is a comprehensive, collaborative design that supports the unique needs of our members by encouraging self-management by working with providers, community resources, and collaborating with other members of the clinical team, such as behavioral health and pharmacy.

The Clinical Programs area drives Neighborhood's Disease Management program (see Section 6 of this Manual) to empower members with chronic conditions to live active, healthy lives, confident in their abilities to manage their condition(s). These programs apply a multi-disciplinary, continuum-based approach to health care delivery that focus on the identification of populations with established medical conditions. Built on evidence-based practice guidelines, Neighborhood's Disease Management programs are designed to reinforce and support providers' care treatment plans through member outreach and education focused on self-management, ongoing monitoring, and continuous evaluation and management.

Prior Authorization Process

For services requiring authorization, Neighborhood will issue authorization tracking numbers to the requesting provider/provider. This may be the referring provider or the treating provider. Payment is contingent upon the member's eligibility and benefits in Neighborhood at the time services are rendered, and, if applicable, medical review determinations regarding level of care.

The following information is required from the referring or treating provider to initiate a prior authorization and for Neighborhood to issue an authorization for services:

- Member's identification number, and/or other identifiers;
- Ordering provider;
- Provider, hospital clinic, or ancillary provider who is to provide the service;
- Billing provider name and NPI number;
- Dates of Services;
- Principle diagnosis;
- Principle procedure codes;
- Services or level of care requested;
- All clinical information that supports medical necessity of the planned procedure, level of care, and place of service requested;
- Verification of a third party liability to COB (e.g., other insurance, workers compensation, MVA).

Neighborhood prefers requests for authorization be made electronically using prior authorization e-forms.

Authorization requests can also be faxed to Utilization Management (UM) at 1-401-459-6023 (direct line) or can be mailed to the address below:

Neighborhood Health Plan of Rhode Island
Attn: Utilization Management
910 Douglas Pike
Smithfield, RI 02917

For Authorization Requests pertaining to Oncology and Radiation Oncology, please submit requests via the provider portal at: https://my.newcenturyhealth.com or call (888) 999-7713.

For Authorization Requests pertaining to High End Radiology or Physical Medicine (Physical Therapy, Speech Therapy, Occupational Therapy), please submit requests via the provider portal at: https://radmd.com or call (800) 327-0641.

Decision Time Frames

Neighborhood makes decisions and communicates them as expeditiously as the enrollee's health condition requires and within the following time frames:

- Prior authorization decisions (non-urgent requests) are made within 14 calendar days from the receipt of the request.
- Prior authorization decisions (qualifying expedited requests) are made within 72 hours of receipt of the request.
- Concurrent (hospital inpatient and post-acute care) requests are made within:
    - 24 hours of receipt of notification and supporting clinical information for Commercial members
    - 72 hours of receipt of notification and supporting clinical information for Medicaid and INTEGRITY (MMP) members

- Post-service decisions for Medicaid and Commercial requests are made within thirty (30) calendar days from receipt of the request.

    - Please note: INTEGRITY (MMP) members post-service authorization requests will be dismissed. A dismissal letter will be sent to the member and provider explaining next steps regarding claim payment consideration. **INTEGRITY (MMP) Members in need of urgent or acute inpatient medical care will not be impacted**

How to Reach Medical Management

A fax line is available to providers both during and outside of normal business hours for inbound communications and access to Neighborhood's Medical Management Department twenty-four (24) hours a day, seven (7) days a week.

Department staff is physically available from 8:30 a.m. – 5:00 p.m., Monday through Friday, to receive inbound communication and conduct outbound communication.

A phone messaging system is in place for requests/inquiries both during and outside of business hours. Providers can call 1-800-963-1001 for assistance.

Medical Management staff communicates with providers about the following utilization topics:

- Inquiries about utilization management policies and procedures;
- Requests for prior authorization;
- Inquiries about the status of an existing authorization;
- Requests for additional information needed for medical review decision making;
- Requests for copies of the clinical criteria used to make a decision;
- Notification of inpatient admissions or other services requiring prior authorization;
- Other utilization management inquiries or requests.

Prior Authorization Requirements

Additional information unique to authorizations for Neighborhood INTEGRITY (MMP) members may be found in the respective section of this manual.

Neighborhood's prior authorization search tool is available to determine which Neighborhood which services require prior authorization.

Planned inpatient stays associated with services or procedures requiring prior authorization must have a prior authorization request initiated for the service or procedure prior to the inpatient admission and in accordance with all other prior authorization guidance. For a procedure that does not require a prior authorization for outpatient, but the provider is now requesting inpatient hospitalization, pertinent clinical information would need to be submitted for an inpatient level of care determination, at the time of inpatient admission.

Authorizations are to be obtained prior to the date of service or elective admission. To allow sufficient time for a thorough medical review of the request, the expectation is that authorization requests for scheduled services will be received as soon as scheduling is contemplated and will include required medical necessity documentation. Please note there are no restrictions on submitting a request well in advance of the

scheduled date of service.

Post-Service (Retrospective) Authorization Requests

Neighborhood requires that providers request authorization for services prior to providing services to our members.

INTEGRITY(MMP) members post-service authorization requests will be dismissed, except in the scenarios defined below. The provider will receive either a dismissal letter issued by Utilization Management with **clinical appeal** rights, or a claim remittance advice indicating claim denial due to missing/no authorization with **clinical appeal** rights.

The following scenarios are exemptions from the INTEGRITY (MMP) prior authorization requirement:

- INTEGRITY (MMP) members who have been retroactively enrolled after receiving services;
- INTEGRITY (MMP) members within their continuity of care period.
- INTEGRITY (MMP) members in need of urgent or acute inpatient medical care.

For Medicaid and Commercial members, exceptions to this policy are made only under extenuating circumstances as defined below. Neighborhood will accept a request for post-service authorization if the request meets either of the following guidelines:

- The request precedes a bill for services (no claim received by Neighborhood) and is within seven (7) calendar days of the service, **or**
- The request precedes a bill for services (no claim received by Neighborhood) and one of the extenuating circumstances detailed below applies.

The request for a post-service authorization only guarantees consideration of the request against medical necessity criteria and is not a guarantee of authorization.

Extenuating Circumstances

If Neighborhood receives a request for post-service authorization that qualifies under the guidelines above, the request may be submitted to Utilization Management for review. If the request is more than seven (7) calendar days and less than 14 calendar days after the date of service, the provider must indicate which of the extenuating circumstances apply.

Extenuating circumstances fall into three categories:

1. Unable to Know Situation – The provider and/or facility is unable to identify from which health plan to request an authorization. The patient was not able to tell the provider about their insurance coverage, or the provider verified different insurance coverage prior to rendering services. Provider to submit with authorization request the verification that was done.
2. Not Enough Time Situation – The patient requires immediate medical services and the provider is unable to anticipate the need for a pre-authorization immediately before or while performing a service.
3. An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

In each case (extenuating circumstances), the provider is unable to request prior authorization for services as required by the provider's contract and the member's coverage agreement.

The extenuating circumstances must be detailed within the retrospective authorization request and providers are required to request the authorization as soon as they are able and retrospective requests outside of the above will not be considered by Neighborhood.

For requests beyond 14 calendar days from the date of service:

1. Providers should file their claim and, if the claim denies, file a clinical appeal (please see "Clinical (Medical Necessity) Appeals" in Section 3 of this Manual). Neighborhood's Grievances and Appeals Unit is responsible for determining if the retrospective review request meets one of the limited extenuating circumstances or exceptions for review.
2. Please note that our oncology, radiology, and physical medicine vendor, Evolent, and our DME vendor, Integra Partners, will also follow the seven (7) calendar day retro policy.

Expedited Requests

Neighborhood recognizes the need for expedited requests under certain circumstances. In accordance with applicable regulation, Neighborhood will provide an expedited determination if it is determined that applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Clinical staff, including the medical director, associate medical director, or physician reviewer will determine if requests to expedite the Neighborhood decision meet this established criteria. If it is determined that a request does not meet expedited criteria, the requesting provider and member will receive a prompt verbal notice with subsequent letter mailed in three days notifying member of appeals rights and the request will be processed under standard time frames.

Provider Notification of Decisions

Neighborhood complies with all regulatory turnaround times for prior authorization and concurrent decisions and communication of authorization status. Any adverse decisions will be communicated via phone, fax, or email. A letter regarding next steps will follow and may include other information including members' appeal rights.

Emergency and Urgent Care Services

Neighborhood does not require prior authorization for emergency services rendered to eligible members. Emergency services means covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services under this title, and necessary to evaluate or stabilize an emergency medical condition.

An emergency medical or behavioral health condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Imminent harm to the individual or to others by the individual;
- Serious impairment to bodily functions; or

- Serious dysfunction of any bodily organ or part.

Urgent care services are covered in-network. Out of network services for urgent medical conditions are covered when the services are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition:

- A member is temporarily out of the plan's service area; or
- The plan's provider network is temporarily unavailable or inaccessible; or
- It was not reasonable given the circumstances to obtain the services through the members' primary physician.

An urgent medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Post-Stabilization Care Services means services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

Referrals

Neighborhood does not require referrals for services rendered by in-network providers.

Requesting Services from a Non-Participating Provider

When determined to be medically necessary, Neighborhood authorizes covered services provided by a non-participating provider. In order for the member to receive these services, prior authorization from Neighborhood's Utilization Management Department must be obtained by visiting our website and completing the Out of Network Prior Authorization E-Form or faxing the PDF version of the form to 1-401-459-6023.

Prior authorization from Neighborhood is also required for consultations, second opinions and follow-up services provided by a non-participating provider.

Authorizations to a non-participating provider may be issued by the Utilization Management Department for reasons including, but not limited to:

- Services not available within the participating provider network including a second opinion;
- Services that cannot be delayed for member temporarily outside the service area who cannot reach a network provider;
- Services to preserve continuity of care (CoC) for members including, but not limited to, those receiving treatment for an acute medical condition or an acute episode of a chronic illness, or members in their second or third trimester of pregnancy;

- Ongoing treatment for an acute medical condition, or if member undergoing active treatment for a chronic condition at the time the member's provider terminates his/her contract with the health plan;
- Follow up care from emergency services;
- Ancillary services required during a transition period for new members, until such provider/provider becomes contracted or member can be redirected to an in-network provider/provider.

Members who see a specialist who is not in Neighborhood's provider network could be responsible for a co-pay or pay for the services provided by that specialist if prior authorization is not obtained. Please also refer to Neighborhood's Out-of-Area and Out-of-Network Clinical Medical Policy.

Continuity of Care

Neighborhood recognizes the importance of our members' established relationships with both participating and non-participating providers. Neighborhood will, on a base-by-case basis, authorize services to preserve an on-going clinical relationship with a non-participating provider or recently terminated provider to preserve CoC for reasons including, but not limited to:

- Neighborhood members currently receiving active treatment for an acute medical condition or an acute episode of a chronic illness,
- Neighborhood members currently in their second or third trimester of pregnancy, and
- Children with special health care needs that are unable to be transitioned to a provider with comparable or greater expertise.

CoC periods are designed to continue services and/or items that the member was receiving prior to enrolling with Neighborhood. It also provides a reasonable timeframe to transition the member (i.e., connecting them to an in-network provider, adjusting home care hours to a medically necessary level, etc.). Adhering to a member's CoC period ensures that the member will continue to receive appropriate care without any gaps in coverage.

Neighborhood is committed to allowing newly enrolled members to continue pre-existing courses of treatment from their time of enrollment. CoC periods for new members are based on their line of business and are as follows:

- **INTEGRITY (MMP)**: Six months from date of enrollment
- **Medicaid**: 90 days from date of enrollment
- **Commercial**: 90 days from date of enrollment

Also, the member hold harmless provisions of the Neighborhood contract shall continue in effect during the active treatment period.

Medical Review Process

Medical review is conducted to confirm the medical necessity of benefits, items, treatments, or services rendered, as well as the appropriateness of the care setting to ensure equitable access to care. This process includes the prospective, concurrent, or retrospective assessment of the medical necessity request.

Medical review requires evaluation of specific clinical information on-site, over the telephone, or via written communication.

Clinical management nurses compile all pertinent clinical information gathered from the treating providers/staff, review against the Neighborhood medical necessity decision criteria and consider individual patient needs. Once complete, the clinical management nurse confirms medical necessity, the appropriateness of the care setting and authorizes the requested service.

When a review is required for medical necessity determination, the following elements, are applicable, are requested by the clinical management nurse and/or associate medical director, or Neighborhood physician reviewer:

- Medical records
- Progress notes describing history of the current problem, status, and current treatment plan;
- Diagnostic testing results pertinent to the requested service;
- Patient psychosocial history as appropriate and related to the current problem;
- Consultant's summaries/notes;
- Copy of the written order from the Ordering Provider (NP, MD, DO);
- Operative and pathological reports;
- Rehabilitation evaluations, progress, attendance, and adherence.

In addition, the following information is requested and considered in order to determine if there are other factors which may impact the plan of care and attribute to the medical necessity of the request:

- Age;
- Knowledge and skills for self-care;
- Support system deficits, barriers;
- Co-morbidities;
- Other complications;
- Available resources within the local delivery system;
- Psychosocial situation;
- Home environment, when applicable;
- Benefit coverage and potential alternatives available.

When the utilization management nurse is not able to confirm the medical necessity and appropriateness of the care setting, the case is referred to a Neighborhood physician reviewer for final decision.

Medical Necessity Review

The Medical Management program includes utilization review for medical necessity for inpatient services and some specialty services (i.e., inpatient acute hospital, post-acute, and outpatient services). Neighborhood's Pharmacy Department and staff work in collaboration with CVS, our Pharmacy Benefits Manager, and are responsible for pharmacy benefit coverage and medical necessity decisions.

Below is a brief description of each of the different types of reviews:

- A review before service is provided is a prospective or prior authorization review. An example is custom equipment requested for the member or a request for a planned inpatient or outpatient procedure.
- Review during the same time as the service is given is concurrent review. An example is an inpatient stay in a facility or skilled nursing facility.
- When the request for authorization occurs after the services have been given, a post-service review is required.
- The Neighborhood team works with our providers to determine medical necessity and coverage of services. Services will be provided in the most cost-effective manner. (Refer to Medical Review Process and Adverse Determination and Appeals.)

Neighborhood's Utilization Management Department uses objective, evidenced-based medical necessity criteria with consideration of individual needs to ensure delivery of high-quality, cost-efficient, and effective care to ensure member have:

- Access to services that address prevention, diagnosis, and treatment of diseases, conditions, or disorders that result in health impairments or disabilities;
- Access to care to allow them to achieve age-appropriate growth and development; and
- Access to services needed to attain, maintain, or regain functional capacity.

Neighborhood has established criteria based on the line of business used to evaluate medical necessity to ensure equitable access to care and decision are made in a fair, impartial, consistent manner.

Clinical Medical Policies

Neighborhood's Clinical Medical Policies (CMPs) are developed and/or revised following thorough review of current medical literature and standards of practice.

To the extent possible, Neighborhood's CMPs are developed according to evidence-based outcomes and are presented to UMC annually for further review and recommendations. Neighborhood's Medical Director gives final approval. Current CMPs can be obtained by contacting Medical Management or can be viewed on Neighborhood's website via the following path:

www.nhpri.org/Providers > Policies and Guidelines > Clinical Medical Policies

Neighborhood uses the above-established criteria as a guideline when reviewing medical service necessity, but clinical judgment is always used when determining the appropriate level of care. Neighborhood considers its ultimate goal to be the provision of clinically necessary services at the appropriate level of care for the appropriate duration. Medical Review criteria may not be appropriately applicable to all members in all circumstances. Neighborhood's clinical staff ensures that individual consideration is given when necessary.

Adverse Determinations (Denials)

Medical necessity denials are decisions not to certify or authorize a covered medical benefit. Decisions regarding level of care or services are not medically necessary are made only by one of Neighborhood's Associate Medical Directors or physician reviewers who is a similarly licensed provider as the ordering

provider. In order to accommodate the clinical urgency of each medical situation, medical review decisions are determined in a timely manner once all medical information is collected.

- Verbal and/or written notification of the adverse decision is communicated to the provider by the clinical management nurse.
- Written notification of the adverse decision is communicated to the provider and the member and includes the total number of days or services denied, the denial reason, the medical necessity decision criteria utilized, the availability of physician reviewers to further discuss the decision with the ordering provider, and the availability of the criteria used. The notification may include a description of the appeal rights, if applicable.

Decisions are made according to the following regulatory timelines:

- Prior authorization decisions (non-urgent requests) are made within 14 calendar days from the receipt of the request;
- Prior authorization decisions (qualifying expedited requests) are made within 72 hours of receipt of the request;
- Concurrent (hospital inpatient) requests are made within:
    - 24 hours of receipt of notification and supporting clinical information for Commercial members;
    - 72 hours of receipt of notification and supporting clinical information for Medicaid and Medicare members.
- Post-service requests are made within thirty (30) calendar days from receipt of the request.
    - Please note: INTEGRITY (MMP) members' post-service authorization requests will be dismissed. A dismissal letter will be sent to the member and provider explaining next steps regarding claim payment consideration.

Peer-to-Peer Review

To facilitate medically necessary care for Neighborhood members, Neighborhood will afford the provider of record a reasonable opportunity to discuss a denied member request with a physician during a peer-to-peer discussion. his opportunity to discuss denial decisions is not considered to be an initiation and/or part of an appeal.

Providers should follow the procedure below and note that peer-to-peer review is available for Neighborhood Medicaid and Commercial (Exchange) members. The INTEGRITY(MMP) line of business peer-to-peer review is available prior to an organization determination.

1. The requesting provider has five (5) business days from receipt of the denial notification (verbal, fax, or letter notification) to schedule a peer-to-peer review by calling 1-401-459-6608. Peer-to-peer reviews can also be initiated by Neighborhood Associate Medical Director (AMD) staff to the requesting provider.
    - If the peer-to-peer request is made more than five (5) business days after the denial notification, or the member has been discharged from inpatient hospitalization, then the requesting provider will be instructed to file an appeal on behalf of the member.
    - The appealing provider should specify the area of appeal. For example, if the issue is a specific date of service, the date of service should be specified in the appeal. Once an appeal is formally requested and filed, any notes from the peer-to-peer discussion will be reviewed during the appeal process.

2. The AMD will respond to requests for peer-to-peer reviews with the requesting provider within one (1) business day of the request to obtain clarification, additional clinical information, and/or other pertinent information to render a final medical determination.
3. If the AMD requests additional information during a peer-to-peer discussion, the additional information must be submitted within two (2) business days of the discussion in order to be considered during the peer-to-peer discussion process. If the information is received after this time frame, the initial decision will be upheld.
4. The peer-to-peer review will include, at a minimum, the clinical basis for the Neighborhood decision and a review of documentation or supporting clinical information, if any, that can be submitted that may lead to a different utilization review decision.
5. A peer-to-peer review will not be scheduled if a formal member appeal has already been filed. Peer-to-peer review discussions are for medical necessity denials rather than administrative denials. Administrative denials must be appealed through the appeal process.
6. Once a final decision is rendered, it will be recorded in the Neighborhood clinical system and notification of the determination (if changed), will be communicational to the member and provider per regulatory guidelines.

Providers and members continue to have appeals rights based on any final adverse determination after the peer-to-peer process. In the event of a denial under peer-to-peer review, the medical director, associate medical director, or physician reviewer will discuss with the provider the reason for the denial, and an explanation of the appeals process.

To address clinical concerns in a timely fashion, Neighborhood asks that providers restrict use of peer-to-peer line for review requests only. Neighborhood's Provider Services department can assist with all other inquiries or issues and can be reached by calling 1-800-963-1001. Call center staff is available Monday through Friday, from 8:00 a.m. to 6:00 p.m.

Section 6: Case and Disease Management

- Case Management
- Disease Management
- Breathe Easy Asthma Program
- Control for Life Diabetes Program
- Take a Breath Program for Members with COPD
- Bright Start Program
- Healthy Heart Program for Members with Heart Failure
- Keep the Beat Program for Members with Coronary Artery Disease

Case Management

Neighborhood's Case Management Program design focuses on evaluation and assistance in the coordination of member's care along the health care continuum. Members are identified and referred in a variety of ways including member self-referral, referrals from family members, providers, medical review nurses, member service staff, disease management staff, pharmacy staff, and external agencies. Individualized care coordination programs focus on wellness education, the removal of barriers that have been identified as preventing access to medically necessary health care services and the delivery of continuous and coordinated medically appropriate care. The Medical Management Department has multiple care coordination programs.

Individualized care management programs focus on assisting members at risk or with complex needs in achieving and maintaining wellness, providing educational support, and improving quality of life including the coordination of service and supports. Each case management program has established policies and procedures, outcome measures, and program admission criteria that identify those members who may benefit form case management intervention in order to maximize positive outcomes and to provide quality, member-focused, cost-effective care.

Neighborhood care managers utilize the Case Management Society of America (CMSA) standards or practice along with the nursing process of assessment, planning, intervention, and evaluation in conducting activities.

The Medical Management Department has the following care management programs: Prenatal and Postpartum Care Management; Neonatal Care Management; Pediatric Care Management; Integrated Care Management; Transitions of Care; and Complex Case Management. Each program has defined practices and standards for member care planning and documentation as well as case closure criteria. To determine whether a member is eligible for one of Neighborhood's care management programs, providers are encouraged to contact Provider Services 1-800-963-1001, Monday through Friday 8:00 a.m. – 6:00 p.m.

The care managers at Neighborhood are nurses, licensed independent social workers, community outreach specialists and other health care professionals with experience and skills in related clinical areas.

Neighborhood's care managers will work with our providers to:

- Support and reinforce members in their efforts to adhere to treatment interventions recommended by their health care providers.
- Advocate for members to obtain the most appropriate health care services available, through education, referral, and negotiation.
- Act as a liaison between all providers to enhance communication and coordination of care.
- Educate members, families and health care providers regarding benefits, availability of services, community resources, entitlement programs, and health care alternatives.
- Reduce barriers relating to transportation, language, pharmacy and keeping follow-up appointments.

Disease Management

Disease Management is a multi-disciplinary, continuum-based approach to health care delivery that focuses on the identification of populations with established medical conditions. Neighborhood recognizes the importance of Disease Management Programs to:

- Support the relationship between providers and their patients and reinforce the established plan of care.
- Emphasize the prevention of exacerbations and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management.
- Continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health.

Disease management resides within the Medical Management Department at Neighborhood. Disease management programs currently offered at Neighborhood include programs that address Asthma, Chronic Obstructive Pulmonary Disease, Diabetes, Heart Failure, and Coronary Artery Disease. Please contact Neighborhood Member Services for further information or questions about Neighborhood's Disease Management Programs.

Breathe Easy Asthma Program

The goal of Neighborhood's Breathe Easy Asthma Program is to enable and empower members with persistent asthma to live normal, healthy lives, confident in their abilities to manage asthma. Built on evidence-based clinical practice guidelines, the Breathe Easy program is designed to reinforce the provider's care and treatment plan through member outreach, education, monitoring and self-management.

Evidence Based Clinical Practice Guidelines

Neighborhood develops and/or adopts clinical practice guidelines for asthma based on the recommendations of the National Asthma Education and Prevention Program (NAEPP). The interventions and member education offered by the Breathe Easy Asthma Program have been developed to align with the recommendations detailed in the guidelines. Copies of the guidelines are available upon request or may be obtained by visiting our website via the following path:

www.nhpri.org/Providers > Provider Resources > Clinical Resources > Clinical Practice Guidelines (*listed in alphabetical order*)

Population Identification

A member is considered to have persistent asthma if he/she is two years of age to 64 years of age and has one or more of the following (using CPT and national drug codes (NDC) provided by Healthcare Effectiveness Data and Information Set [HEDIS]/NCQA and updated annually) during the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least four asthma medication dispensing events (excluding leukotriene receptor antagonists if that is the only asthma dispensed);
- At least one emergency department visit with primary diagnosis of asthma;
- At least one acute inpatient stay with primary diagnosis of asthma;

- At least four outpatient visits with any diagnosis of asthma and at least two asthma medication dispensing events.

Program Participation

Neighborhood members identified as having asthma do not need to enroll in the Breath Easy Program; they are automatically enrolled upon identification. Participation and membership in the program are voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a welcome letter introducing the Breathe Easy Program and informing them of the services, benefits, and educational materials they can expect to receive. Participation in the program can also result in referrals made by Neighborhood's Member Services, Medical Management or other internal departments, our network providers or member self-referral.

Patient Education and Outreach

Members in the Breathe Easy Program can access the Be Well, Stay Well (BWSW) educational newsletter. BWSW is an educational newsletter that promotes health prevention and healthy lifestyle, and provides simple healthy living tips to self-manage chronic conditions. This newsletter is published electronically on an annual basis and can be readily accessible to everyone on Neighborhood's website: www.nhpri.org/your-health/programs/.

Most letters sent to members are accompanied by educational materials, brochures, or guides that have been adopted for use by Neighborhood. To request a copy of those materials or mailings, please call Member Services.

Additionally, if a member is identified as being at the highest risk, the member will receive telephonic outreach from our care management staff who will conduct an assessment to determine problems, identify interventions and develop a treatment plan that will assist the member in regaining control of their asthma condition, discuss self- management strategies, evaluate their status, and monitor their condition and adherence to treatment goals.

Coordination of Care – Working with Our Providers

Neighborhood provides our physicians with actionable information derived from health plan claims and pharmacy data to support improved patient outcomes. Quarterly reports are sent to selected primary care sites to inform them of the asthma care milestones that Neighborhood monitors, and whether or not each was achieved by the member. Report detail includes members receiving three (3) or more prescriptions for a short-acting beta agonist and not on a controller medication OR members with two (2) or more oral corticosteroid prescriptions without evidence of a PCP visit for asthma during a 6 month period. If you would like to see a sample copy of the report that you might receive, call us at 1-401-459-6019. Members who have opted out of the Breathe Easy Program, but do have asthma, will still be included in the quarterly asthma report sent to providers.

Outcome Measurement and Effectiveness of the Breathe Easy Programs

We want to make sure that our Breathe Easy Program is effective in achieving improved health outcomes for our members with asthma and its delivery of services to our members and providers. Some of the key measures that Neighborhood uses to assess the program include:

- HEDIS Measure: Use of Appropriate Asthma Medications;
- Evidence of at least two or more outpatient visits each year for asthma management;
- Utilization metrics (ER visits/inpatient utilization);
- Member satisfaction with Neighborhood's Care Management Services (annual survey/complaints data).

For More Information

Please call Member Services if you have questions about Neighborhood's Breathe Easy Program for members with asthma, how we work with your patients, or about the services available to your members with asthma.

Control for Life Diabetes Program

The goal of Neighborhood's Control for Life Diabetes Program is to enable and empower members with diabetes to live normal, healthy lives, confident in their abilities to manage diabetes. Built on evidence-based practice guidelines; the Control for Life Program is designed to reinforce the physician's care and treatment plan through member outreach/education, monitoring, and management.

Evidence Based Practice Guidelines

Neighborhood has adopted as a primary source, the clinical practice guideline based on nationally recognized clinical guidelines such as those of the American Diabetes Association. The interventions and member education offered by the Control for Life Diabetes Program have been developed to align with the recommendations detailed in the guidelines. Copies of the guidelines are available upon request or may be obtained by visiting our website via the following path:

www.nhpri.org/Providers > Provider Resources > **Clinical Resources** > Clinical Practice Guidelines (*listed in alphabetical order*)

Population Identification

Neighborhood identifies members 18 years to 75 years of age for participation in the Control for Life Program. Members are considered to have diabetes if claims data meets one or more of the following criteria (using CPT and NDC codes provided by HEDIS/NCQA and updated annually):

- The member was dispensed insulin and/or oral hypoglycemic and/or anti-hyperglycemic agents (excluding Glucophage/metformin) during the past two years on an ambulatory basis; and/or
- The member had two face-to-face encounters in an ambulatory or non-acute inpatient setting with a diagnosis of diabetes; and/or
- The member had one face-to-face encounter in an acute inpatient or emergency room setting during the past two years with a diagnosis of diabetes.

Note: Members with diagnosis of gestational diabetes, polycystic ovary syndrome, and steroid-induced diabetes are excluded from the population.

Program Participation

Neighborhood members identified as having diabetes do not need to enroll in the Control for Life Program; they are automatically enrolled upon identification. Participation and membership in this program are voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a welcome letter introducing the Control for Life Program and informing them of the services, benefits, and educational materials they can expect to receive.

Participation in the program can also result from referrals made by Neighborhood's Member Services, Medical Management or other internal departments, our network providers, or member self-referral.

Patient Education and Outreach

Member of the Control for Life Program can access the Be Well, Stay Well (BWSW) educational newsletter. BWSW is an educational newsletter that promotes health prevention and healthy lifestyle, and provides simple healthy living tips to self-manage chronic conditions. This newsletter is published electronically on an annual basis and can be readily accessible to everyone on Neighborhood's website: www.nhpri.org/your-health/programs/.

Education materials, brochures, or guides that have been adopted for use by Neighborhood accompany most of the letters sent to members. To request a copy of those materials or mailings, please call Member Services.

Additionally, if a member is identified as being a high risk they will receive telephonic outreach from our care management staff. An assessment will be conducted to determine problems, identify interventions, and develop a treatment plan that will assist the member in regaining control of their diabetes condition. The care manager will discuss lifestyle issues with may exacerbate their condition, discuss self-management strategies, evaluate their status and in general, monitor their condition and adherence to treatment goals.

Coordination of Care-Working with our Providers

Neighborhood provides our physicians with actionable information derived from health plan claims and pharmacy data to support improved patient outcomes. A quarterly report is sent in conjunction with HEDIS to selected primary care sites to inform them of diabetes care milestones that Neighborhood monitors, and whether or not each was achieved by the member. The report details include whether the practice's members with diabetes have received specific lab tests, such as HbA1C and/or LDL. If you would like to see a sample copy of the report that you might receive, call us at 1-401-459-6750. Members who have opted out of the Control for Life Program, but do have diabetes, will still be included in the quarterly diabetes reports sent to providers.

Take a Breath Program for Members with COPD

The goal of the Neighborhood's Take a Breath Program for Members with COPD is to enable and empower members with COPD to live normal, healthy lives, confident in their abilities to manage their condition. Built on evidence-based practice guidelines, the Take a Breath COPD Program is designed to reinforce the physician's care and treatment plan through member outreach/education, monitoring, and management.

Evidence Based Practice Guidelines

Neighborhood has adopted the COPD guidelines developed through the Global initiative for the Diagnosis Management and Prevention of Chronic Obstructive Lunch Disease, World Health Organization, National Heart, Lung and Blood Institute; 2006. The interventions and member education offered by the Take a Breath Program have been developed to align with the recommendations detailed in the guidelines.

Copies of the guidelines are available upon request or may be obtained by visiting our website via the following path:

www.nhpri.org/Providers > Provider Resources > **Clinical Resources** > Clinical Practice Guidelines (*listed in alphabetical order*)

Population Identification

Neighborhood identifies members ages 40 years and older for participation in the Take a Breath Program. Members are considered to have COPD if claims data meet one or more of the following criteria (using CPT and NDC codes provided by HEDIS/NCQA and updated annually):

- Claims evidence of at least one inpatient or one emergency room visit with a primary diagnosis of COPD in the last 24 months, or
- Claims evidence of at least one physician or specialist office visit with primary diagnosis of COPD within the last 24 months.

Please note the HEDIS now includes ICD-9 Code 493.2 Chronic Obstructive Asthma as a code for COPD.

Program Participation

Neighborhood members identified as having COPD do not need to enroll in the Take a Breath Program; they are automatically enrolled upon identification. Participation and membership in the program are voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a welcome letter introducing the Take a Breath Program informing them of services, benefits, and educational materials they can expect to receive. Participation in the program can also result from referrals made by Neighborhood Member Services, Medical Management or other internal departments, our network providers, or member self- referrals.

Patient Education and Outreach

Members in the Take a Breath Program can access the Be Well, Stay Well (BWSW) educational newsletter. BWSW is an educational newsletter that promotes health prevention and healthy lifestyle, and provides simple healthy living tips to self-manage chronic conditions. This newsletter is published electronically on an annual basis and can be readily accessible to everyone on Neighborhood's website: www.nhpri.org/your-health/programs/.

Educational materials, brochures, or guidelines that have been adopted for use by Neighborhood accompany most of the letters sent to members. To request a copy of those materials or mailings, please call us at 1-401-459-6019.

Additionally, if a member is identified as being at high risk they will receive telephonic outreach from our care management staff. An assessment will be conducted to determine problems, identify interventions, and develop a treatment plan that will assist the member in regaining control of their COPD condition. The care manager will discuss lifestyle issues which may exacerbate their condition, discuss self-management strategies, evaluate their status and in general, monitor their condition and adherence to treatment goals.

Outcome Measurement and Effectiveness of the Take a Breath Program

We want to make sure that our Take a Breath Program is effective in achieving improved health outcomes for our members with COPD and in its delivery of services to our members and providers. Some of the key measures that Neighborhood pays attention to assess the program include:

- HEDIS measure: Use of Spirometry in Diagnosis and Assessment of COPD
- Utilization metrics (ER visits/inpatient utilization)
- Member satisfaction in Neighborhood's care management services (annual survey/complaints data).

For more information, please call us at 1-401-459-6019 if you have any questions about Neighborhood's Take a Breath Program for members with COPD or how we work with your patients with COPD.

Bright Start Program

The goal of Neighborhood's Bright Start Program is to improve birth outcomes for the children born to Neighborhood members. Build on evidence-based guidelines, the Bright Start Program is designed to reinforce the provider's care and treatment plan through member's outreach/education, monitoring, and management.

Neighborhood works with members and providers participating in the Bright Start Program to facilitate:

- Appropriate prenatal care;
- Adequate prenatal nutrition;
- Access to needed services for behavioral health problems and substance abuse (tobacco, alcohol, and/or drugs in the prenatal period);
- Case management services and community support referrals as needed;
- Education about breastfeeding for optimal infant/child development;
- Education about optimal birth spacing;
- Education about birth control;
- Adequate postpartum care.

Evidence Based Practice Guidelines

Neighborhood has established clinical guidelines for prenatal care based on national clinical guidelines such as those of the American College of Obstetricians and Gynecologists. The interventions and member education offered by the Bright Start Program have been developed to align with the recommendations detailed in the guidelines. Copies of the guidelines are available upon request or may be obtained by visiting our website via the following path:

www.nhpri.org/Providers > Provider Resources > **Clinical Resources** > Clinical Practice Guidelines (*listed in alphabetical order*)

Population Identification

Neighborhood identifies pregnant women for participation in the Bright Start Program based on the providers' submission of a **Prenatal Risk Assessment (PRA) form**, member health survey, through hospital admissions, and member self-report of pregnancy.

Program Participation

Neighborhood members identified as being pregnant do not need to enroll in the Bright Start Program; they are automatically enrolled upon identification. Participation in the program is voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a Welcome Kit introducing the Bright Start Program and information them of the services, benefits, and education materials they can expect to receive. Participation can also result from the referrals made by Neighborhood's Member Services or Care Management Department, our network providers or member self-referral.

Patient Education and Outreach

Once notified of the pregnancy, Neighborhood mails educational information about topics such as the importance of prenatal care, nutrition, avoiding substance abuse, breastfeeding, doula services, the need for a postpartum visit, the importance of choosing a provider for your baby, birth control, and postpartum depression.

Care Management

Members with a moderate or high-risk pregnancy, as determined by a health risk assessment or due to a recent hospital admission, may be eligible to receive case management services, (depending on the risk factor identified) throughout their prenatal and postpartum period. Behavioral health, doula, and smoking cessation services are available, and members are referred to the appropriate community resources as needed.

Coordination of Care-Working with our Providers

Individual care management encounter reports are sent to the pregnant member's provider that include the education provided, referrals, plan of care and other services provided by the care manager. Please call us at 1-401-459-6019 if you have questions about Neighborhood's Bright Start Program for pregnant members, how we work with your patients, or about the services available to your pregnant Neighborhood members. If you would like to refer someone to the Neighborhood Bright Start Program, please call 1-401-459- 6019.

Healthy Heart Program for Members with Heart Failure

The goal of the Neighborhood's Healthy Heart Program for members with heart failure, is to enable and empower members with heart failure to live normal, healthy lives, confident in their abilities to manage their heart condition. Built on evidence-based practice guidelines, the Healthy Heart Program is designed to reinforce the physician's care and treatment plan through member outreach/education, monitoring, and management.

Evidence Based Practice Guidelines

Neighborhood has adopted as primary sources, the clinical practice guideline based on nationally recognized clinical guidelines such as those of the American College of Cardiology and the American Heart Association (ACC/AHA). The interventions and member education offered by the Healthy Heart Program have been developed to align with the recommendations detailed in the guidelines. Copies of the guidelines are available upon request or may be obtained by visiting our website via the following path:

www.nhpri.org/Providers > Provider Resources > **Clinical Resources** > Clinical Practice Guidelines (*listed in alphabetical order*)

Population Identification – Healthy Heart Program

Neighborhood identifies members 18 years to 75 years of age for participation in the Healthy Heart Program.

Members are considered to have heart failure if claims data meets one or more of the following criteria (using CPT and NDC codes provided by HEDIS/NCQA and updated annually):

- Claims evidence of at least two (2) face-to-face encounters in an ambulatory, non-acute inpatient settings, or emergency room setting with a diagnosis of heart failure within the previous 12 months; and/or
- Claims evidence of at least one (1) face-to-face encounter in an acute inpatient setting, with a diagnosis of heart failure within the previous 12 months.

Program Participation

Neighborhood members identified as having heart failure do not need to enroll in the Healthy Heart Program; they are automatically enrolled upon identification. Participation and membership in the program are voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a welcome letter introducing the Healthy Heart Program informing them of the services, benefits, and educational materials they can expect to receive. Participation in the program can also result from referrals made by Neighborhood Member Services, Medical Management or other internal departments, network providers, or member self-referrals.

Patient Education and Outreach

Members in the Healthy Heart Program can access the Be Well, Stay Well (BWSW) educational newsletter. BWSW is an educational newsletter that promotes health prevention and healthy lifestyle, and provides simple healthy living tips to self-manage chronic conditions. This newsletter is published electronically on an annual basis and can be readily accessible to everyone on Neighborhood's website: www.nhpri.org/your-health/programs/.

Educational materials, brochures, or guides that have been adopted for use by Neighborhood accompany most of the letter sent to members. To request a copy of those materials or mailings, please call Member Services.

Outcome Measurement and Effectiveness of the Health Heart Program

We want to make sure that our Healthy Heart Program is affective in achieving improved health outcomes for our members with heart failure and in its delivery of services to our members and providers. Some of the key measures that Neighborhood pays attention to assess the programs include:

- Utilization metrics (ER visits/inpatient utilization)
- Member satisfaction with Neighborhood's care management services (complaints data)

Please call Member Services if you have any questions about Neighborhood's Healthy Heart Program for members with heart failure or how we work with your patients with heart failure.

Keep the Beat Program for Members with Coronary Artery

The goal of the Neighborhood's Keep the Beat Program for members with Coronary Artery Disease is to enable and empower members with coronary artery disease live normal, healthy lives, confident in their abilities to manage their heart condition. Built on evidence-based practice guidelines, the Keep the Beat Program is designed to reinforce the physician's care and treatment plan through member outreach/education, monitoring, and management.

Evidence Based Practice Guidelines

Neighborhood has adopted as primary sources, the clinical practice guideline based on nationally recognized clinical guidelines such as those of the American College of Cardiology and the American Heart Association (ACC/AHA). The interventions and member education offered by the Keep the Beat Program have been developed to align with the recommendations detailed in the guidelines. Copies of the guidelines are available upon request or may be obtained by visiting our website via the following path:

www.nhpri.org/Providers > Provider Resources > **Clinical Resources** > Clinical Practice Guidelines (*listed in alphabetical order*)

Population Identification – Keep the Beat Program

Neighborhood identifies members by searching their claims for Coronary Artery Disease for participation in the Keep the Beat Program.

Members are considered to have coronary artery disease if claims data meets criteria (using CPT and NDC codes provided by HEDIS/NCQA and updated annually):

Program Participation

Neighborhood members identified as having coronary artery disease do not need to enroll in the Keep the Beat Program; they are automatically enrolled upon identification. Participation and membership in the program are voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a welcome letter introducing the Keep the Beat Program informing them of the services, benefits, and educational materials they can expect to receive. Participation in the program can also result from referrals made by Neighborhood Member Service, Medical Management or other Internal Department, network providers, or member self-referrals.

Patient Education and Outreach

Members in the Keep the Beat Program can access the Be Well, Stay Well (BWSW) educational newsletter. BWSW is an educational newsletter that promotes health prevention and healthy lifestyle, and provides simple healthy living tips to self-manage chronic conditions. This newsletter is published electronically on an annual basis and can be readily accessible to everyone on Neighborhood's website: www.nhpri.org/your-health/programs/.

Educational materials, brochures, or guides that have been adopted for use by Neighborhood accompany most of the letter sent to members. To request a copy of those materials or mailings, please call Member Services.

Outcome Measurement and Effectiveness of the Keep the Beat Program

We want to make sure that our Keep the Beat Program is affective in achieving improved health outcomes for our members with coronary artery disease and in its delivery of services to our members and providers. Some of the key measures that Neighborhood pays attention to assess the programs include:

- Utilization metrics (ER visits/inpatient utilization)
- Member satisfaction with Neighborhood's care management services (complaints data)

Please call Member Services if you have any questions about Neighborhood's Keep the Beat Program for members with coronary artery disease or how we work with your patients with coronary artery disease.

Section 7: Pharmacy

Pharmacy Benefit Overview
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Pharmacy Benefit Overview

The following information applies to all lines of business (Medicaid, Commercial, and INTEGRITY). For more information on INTEGRITY and supplemental drug coverage, refer to the INTEGRITY section of this manual.

Formulary

A Formulary is a list of medications covered under a specific pharmacy benefit. Below is the rationale and process used in defining the Neighborhood Formulary, other details of the pharmacy benefit, and avenues for discussion and appeal when Non-Formulary and restricted medications are requested.

The Neighborhood Formulary (Formulary) is a list of covered and preferred drug agents for Neighborhood members. There are separate formularies for each line of business that include Medicaid, Commercial, and INTEGRITY. The Formulary is available as a PDF document or as a searchable formulary on Neighborhood's website via the following path:

www.nhpri.org/Providers > **Provider Resources** > **Pharmacy**

Drugs are listed by their drug class and alphabetically. Certain drugs on the Formulary have restrictions which are identified as PA (Prior Authorization), PA** (Prior Authorization applies if Step Therapy is not met), QL (Quantity Limits), ST (Step Therapy), B/D (Medicare B vs D; INTEGRITY only), NDS (Non-Extended Days' Supply; 30-day supply max), OTC (Over the counter), and DP (Not a Medicare Part D drug, but covered under the Medicaid benefit; INTEGRITY only). Drug tier information is also available on the Formulary. A key for these restrictions can be found at the bottom of each formulary.

For drugs that require prior authorization (both medical and pharmacy benefit), criteria may be found on Neighborhood's website via the following path:

www.nhpri.org/Providers > **Provider Resources** > **Pharmacy**

In addition, there is a Searchable Medical Pharmacy Benefit HCPCS Code Listing which includes Neighborhood medical benefit drug coverage by HCPCS code, by product, and prior authorization requirements (if applicable). This tool is also available via the website path outlined above.

Coverage Limitations

The Formulary does not provide information regarding all coverage and limitations associated with an individual member's prescription drug plan. Drugs that are not covered or are considered Benefit Exclusions are not listed on the Formulary.

The Pharmacy Benefit Formulary applies only to outpatient drugs provided to members and does not apply to those used in inpatient settings. If a member has any specific questions regarding their coverage, they should contact Neighborhood Member Services at 1-800-459-6019 for Medicaid; 1-855-321-9244 for Commercial; or 1-844-812-6896 for INTEGRITY.

The following general provisions pertain to covered individuals:

- Some over-the-counter products are covered for members if they have a written prescription from an in-network provider;
- Drugs used for cosmetic purposes are not covered;
- Experimental drugs, or any drug used in an experimental manner, such as in a clinical trial, are not covered (except as required by law or regulation);
- Replacement coverage of lost or stolen medications is evaluated on a case-by-case basis. If the drug is a controlled substance, verbal authorization from the provider is required;
- Infertility treatment is not a covered benefit for Medicaid members;
- Drugs used to treat erectile and sexual dysfunction are not a covered benefit;
- Any drugs that do not meet industry-standard patient safety screens will not be dispensed at the pharmacy without further information from the prescriber;
- In accordance with the 21st Century Cures Act (Cures Act), 114 P.L. 255, prescription drugs for Medicaid members will only be covered when dispensed at a pharmacy that is enrolled with the Rhode Island State Medicaid program;
- Medicaid members may only be dispensed medications (on the Pharmacy Benefit) or administered medications (on the Medical Benefit) from manufacturers who have signed a drug rebate agreement with the United States Department of Health and Human Services (HHS);
- Providers must submit the national drug code (NDC) of the product administered to a Medicaid member on the claim sent to Neighborhood if the provider is billing Neighborhood's Medical Benefit for a product;
- Medicaid and Commercial members utilizing Specialty Pharmacy products will be restricted to a Specialty Pharmacy Limited Network.

Please refer to **www.nhpri.org** for information on formularies available by each plan.

Billing 340B Claims

If you are billing the **pharmacy benefit** for a 340B claim, please follow the stated guidance to properly submit the claim:

- NCPDP Data Element 420-DK: Submission Clarification Code = 20

If you are billing the **medical benefit** for a 340B claim, please follow the stated guidance to properly submit the claim:

- Modifier: JG, TB, or UD
- Description: Medicaid level of care 13, as defined by each state

Pharmacy Providers Dispense Medicaid Rebate-able Drugs Only

It is required that outpatient Medicaid pharmacy providers (both pharmacy benefit and medical benefit) dispense and administer only rebate-able drugs (as determined by the Medicaid Drug Rebate Program). For medical pharmacy benefit claims, all claims must be submitted with both the appropriate HCPCS code and NDC. Only claims with valid NDCs that are included in the Medicaid Prescription Drug Rebate program are eligible for payment consideration. More information can be referenced in Neighborhood's Pharmaceuticals NDC Billing Requirements Policy found via the following path:

www.nhpri.org/Providers > Policies and Guidelines > Billing Guidelines and Payment Policies

Medical and pharmacy benefit claims submitted with NDCs that are not rebate-able are not covered.

Pharmacy and Therapeutics Committee*

The development and maintenance of the Neighborhood formulary is dynamic and requires constant attention. Expert advice is provided to Neighborhood by its Pharmacy and Therapeutics (P&T) Committee. The P&T Committee meets regularly to consider addition of new pharmaceuticals, and to review the adequacy of the current Formulary. Providers are encouraged to review the Formulary and provide input and comments to the Neighborhood P&T Committee.

Drugs considered for inclusion on the Neighborhood Formulary are evaluated relative to available alternate therapies (both pharmaceutical and non-pharmaceutical) used to treat specific disease states and/or physical conditions. The Neighborhood P&T Committee uses the criteria listed below in the evaluation of drugs considered for inclusion on the Neighborhood Formulary:

- Safety: the potential for adverse reactions, side effects and drug interactions.
- Efficacy: the potential effects of treatment under optimal conditions.
- Effectiveness: the actual effects of treatment under real-life conditions.
- Relevant benefits of current formulary agents of similar use.
- Cost and outcome modeling: potential health outcomes and resulting total cost of drug and medical care. The context of plan demographics, alternate agents, and cost-effectiveness are pieces of the decision-making process.
- Condition of potential duplication of similar drugs currently on the formulary.
- Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.
- Access: ensuring the right medication is available for the right patient with consideration of our members' ability to effectively utilize the health care delivery system.
- Requirements and restrictions set forth in the Medicaid Managed Care Services Pharmacy Benefit Plan. Protocols established (and amended) by the RI Executive Office of Health and Human Services or for the Office of the Health Insurance Commissioner.

Generic First/Biosimilar First Strategy

When available, FDA approved generic drugs are preferred. Greater economy is realized through the use of generic equivalents or biosimilar products. This policy is consistent with Rhode Island law and is not meant to preclude or supplant any state statutes that may exist. All drugs, which are or become available generically or as a biosimilar, are subject to review by Neighborhood's Pharmacy and Therapeutics Committee.

- As permitted by Rhode Island pharmacy statutes, substitution using all forms of A-rated generics or biosimilars is allowed, pursuant to pharmacist's judgment, there is sufficient evidence that the generic product will produce the same therapeutic effect as the brand comparator.
- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy, or where blood level maintenance is crucial will be considered for an exception.
- If there is inadequate access to a recently released generic product, the brand product may remain on formulary until generic product market saturation occurs. This process occurs on a case-by-case basis.

Experimental Drugs

The P&T Committee, using current medical literature, will determine the appropriate experimental nature or use of drug products. Drugs used experimentally without supporting clinical documentation or literature, or provided to members as part of a clinical trial, will be excluded from coverage.

Non-formulary Exception Process

To request coverage of a non-formulary drug, providers can submit a Formulary Exception for review by the Neighborhood Pharmacy department. Formulary Exception forms can be found on our website.

The provider must include the following information:

1. Rationale for use of the non-formulary drug;
2. Previous medications tried and failed;
3. Diagnosis being treated;
4. Supporting statement from the provider;
5. Relevant medical chart notes and other applicable clinical support.

Application of the above information will reflect patient safety screens and P&T Committee protocols. All non-formulary exception requests must be submitted by the provider's office and not by a third party. To minimize administrative burden, please submit pertinent clinical records at the time of prior authorization submission.

Prior Authorization

Drugs listed on the formulary with PA restriction require prior authorization. Prior authorization criteria and forms can be found on the Neighborhood website via the following path:

www.nhpri.org/Providers > **Provider Resources** > **Pharmacy** > **Criteria and Clinical Medical Policies**

To submit a coverage request, a prescriber may:

- Submit an electronic prior authorization request via Cover My Meds (link available at nhpri.org); **or**
- Fax a completed Pharmacy Benefit Prior Authorization Request to Neighborhood at 1-866-423-0945 for Medicaid and Commercial members **or** 1-855-829-2875 for INTEGRITY members; **or**
- Contact Provider Services to submit the request verbally: Medicaid 1-800-459-6019; Commercial 1-855-321-9244; or INTEGRITY 1-844-812-6896; **or**
- For Outpatient Provider-Administered Medications ("Buy and Bill"):
    - Email securely to RxMedicalBenefits@nhpri.org
    - Fax the request to 1-844-639-7906, or
    - Submit online via the Pharmacy General Medical Authorization E-Form https://www.nhpri.org/pharmacy-general-medical-authorization-eform/

Prior Authorization Requests for Specialty Medications require submission of the member's chart or medical record documenting medical necessity based on the criteria corresponding to the indication. To minimize administrative burden, please submit pertinent clinical records at the time of prior authorization submission.

All prior authorization requests must be submitted by the provider's office and not by a third party.

Each request will be reviewed on individual patient need and according to criteria approved by the Neighborhood P&T Committee. For information on the process for denials, see the section on Adverse Determination below.

Adverse Determination

For requests that do not meet the criteria for a Formulary exception, denial rationale and Formulary alternatives will be provided to the provider. The member will also receive written notification of the denial.

If the requesting provider does not agree with the denial, the Medical Director upon request can conduct a peer-to-peer review. To request a peer-to-peer review, call 401-459-6069. A peer-to-peer review request needs to occur within 60 days of the denial for Medicaid and 180 days of the denial for Commercial. Peer-to-peer reviews are not available for INTEGRITY members.

In the event of a denial under peer-to-peer review, the Medical Director will discuss with the provider the reason for the denial, and an explanation of the appeals process as outlined in Policy and Procedure for Clinical Appeals.

Pharmacist and Provider Communications

The Formulary is a tool to promote high-quality, cost-effective prescription drug use. The Neighborhood Pharmacy and Therapeutics Committee has made every attempt to create a document that meets all therapeutic needs; however, the art of medicine makes this a formidable task. Neighborhood welcomes the participation of prescribers, pharmacists, and ancillary medical providers in this dynamic process. Prescribers and pharmacists are strongly encouraged to direct any suggestions or comments regarding the Formulary to Neighborhood at the following address:

Neighborhood Health Plan of Rhode Island
Attn: Chair, Pharmacy and Therapeutics
Committee 910 Douglas Pike
Smithfield, RI 02917

Continuity of Care

Medicaid

For a period of at least ninety (90) days following a member's effective date of enrollment with Neighborhood, when that member, the member's appointed representative, or their provider can demonstrate that the member was covered by another qualified health plan (QHP) during the ninety (90) days preceding enrollment with Neighborhood, Neighborhood must:

i. Accept any prior authorizations approved by the member's previous QHP for the duration of that authorization for which the provider shows evidence of the prior authorization approval.

ii. Allow the member to receive a medically administered drug at an out-of-network provider's office or facility on an in-network basis if that provider was part of the member's previous QHP network for a period of at least 6 months from enrollment with Neighborhood.

iii. Make a formulary exception for the remainder of the continuity of care (CoC) period to allow the member to refill or renew any drug which the member had received through their previous QHP as part of its formulary.

Exceptions:

1) Requests where the member has not yet started the medication will be denied for appropriate formulary alternatives;
2) Requests where the member has only received the medication via samples will be denied for appropriate formulary alternatives;
3) Benefit exclusions will be denied.

Commercial

For a period of at least ninety (90) days following a member's effective date of enrollment with Neighborhood, when that member, the member's appointed representative, or their provider can demonstrate that the member was covered by another QHP for at least one day during the ninety (90) days preceding enrollment with Neighborhood, Neighborhood must:

i. Accept any prior authorizations approved by the member's previous QHP for the duration of that authorization for which the provider shows evidence of the prior authorization approval
ii. Allow the member to receive a medically administered drug at an out-of-network provider's office or facility on an in-network basis if that provider was part of the member's previous QHP network for a period of at least 6 months from enrollment with Neighborhood.

All requests for behavioral health medications, inclusive of prior authorization, quantity limit, step therapy, or nonformulary requirements, will be assessed for Continuity of Care regardless of enrollment date with Neighborhood. Neighborhood will approve these behavioral health medication requests for Continuity of Care if the prescriber attests that the patient is stable on the current regimen, either when continuing on the regimen from another health plan or continuing on the regimen with samples from the provider.

Exceptions are as follows: i. A request can be denied if the clinical reviewer speaks with the provider and he or she confirms that the member can be safely switched to a formulary alternative. The details of the conversation must be documented thoroughly in the case. ii. Benefit exclusions will be denied c. Neighborhood will make formulary exceptions to allow the member to refill or renew any prescription for which the member had received through the member's previous managed care organization as part of its formulary and which is not on the Neighborhood formulary. The formulary exception shall provide the member the prescription at the appropriate copay tier. Exceptions:

1. Requests where the member has not yet started the medication will be denied for appropriate formulary alternatives.
2. Requests where the member has only received the medication via samples will be denied for appropriate formulary alternatives.
3. Benefit exclusions will be denied.

Prior Authorization and Non-Formulary Exception Turnaround Times

Standard Retail Pharmacy Request

i. Medicaid: 24 hours
ii. Commercial: 72 hours
iii. MMP: 72 hours

Urgent Retail Pharmacy Request

i. Medicaid: 24 hours
ii. Commercial: 24 hours * Also constitutes a Non Formulary medication that is to be taken by a member who is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function, with deference given to any such determination by the ordering provider, or when a member is undergoing a current course of treatment.
iii. MMP: 24 hours

Standard Pharmacy Medical Benefit Request

i. Medicaid: 14 days
ii. Commercial: 14 days *Pre-service claims may be extended for up to fifteen additional calendar days when substantiated as being required by special circumstances OR when the claimant is noticed within the first fifteen calendar day period of the need for such extension.
iii. MMP: 72 hours

Urgent Pharmacy Medical Benefit Request

i. Medicaid: 72 hours
ii. Commercial: 72 hours
iii. MMP: 24 hours

Requests from Non-Participating Providers

Neighborhood will evaluate medical benefit drug requests from non-participating providers in the time frames established above and for CoC. However, Neighborhood will not approve a medical benefit drug to be administered out of network if it is available from an in-network provider.

Oncology Reviews

Neighborhood collaborates with Evolent (previously New Century Health), an oncology quality management company, to simplify the administrative process for providers and to support the effective delivery of quality patient care.

The following require a prior authorization from Evolent before administration of the drug or treatment in the provider's office, outpatient hospital, ambulatory setting, or infusion center:

- Oncology-related chemotherapeutic drugs and supportive agents,
- Hematology-related drugs and supportive agents,
- Radiation oncology treatment, and
- Genomic/genetic testing for oncology-related chemotherapy treatment

The scope for review will be based on the Oncology and Hematology diagnosis and HCPCS code/CPT code and not on the requesting provider's specialty. Evolent will review all provider specialties that meet the Oncology and Hematology diagnosis and HCPCS code/CPT code requirements.

This prior authorization requirement applies to all Neighborhood members in all lines of business (Medicaid, Commercial, and INTEGRITY MMP for Pharmacy Medical Benefit HCPCS codes and all medications on the Pharmacy Benefit for Medicaid members).

Prior Authorization Process

The requesting physician must complete an authorization request using one of the following methods:

- Log into the Evolent provider portal: https://my.newcenturyhealth.com
- Efax: 1-213-596-3783
- Secured emailing: efax-carepro-oncology@newcenturyhealth.com
- Call NCH at 1-888-999-7713, Monday–Friday 8:00 a.m. to 8:00 p.m. EST
    - *Medical Oncology and Genomic/Genetic Testing – Option 1*
    - *Radiation Oncology – Option 2*

Specialty Pharmaceuticals

Neighborhood reserves the right to ensure medically necessary specialty drug access at the most cost-effective rate. This may include processes such as white-bagging (where the drug is provided by a specialty pharmacy directly to the provider's office or hospital outpatient facility) or home infusion therapy, as allowed by Rhode Island regulations.

Effective January 1st, 2023, Medicaid and Commercial members utilizing specialty medications will need to obtain their specialty medications exclusively from the following pharmacies: Care New England Specialty Pharmacy (855-981-1908), Lifespan Specialty Pharmacy (401-444-9909), or CVS/Specialty Pharmacy (800-237-2767).

HIV, Hepatitis B and Transplant medications are excluded from the specialty medication requirements and can be filled at any pharmacy (retail or specialty). Limited Distribution Drugs not available at the pharmacies listed above can continue to be filled at the member's current Specialty Pharmacy. A list of medications that need to be filled within the limited specialty pharmacy network is available at the following path:

www.nhpri.org/Providers > Provider Resources > Pharmacy

Section 8: Provider Information

Network Participation
The Role of the Primary Care Provider
The Role of the Specialty Care Provider
Provider Availability

- After-hours

Access to Care Standards
CurrentCare
Closing Your Practice to Members
Member Dismissal from a Provider's Care
Mainstreaming
Provider Termination
Provider Information Changes
Provider Concierge Services

Network Participation

Neighborhood advocates for providers to have open communication with members regarding medically necessary care and appropriate treatment choices, regardless of benefit coverage limitations.

All participating providers are required to comply with the Neighborhood Participating Provider Agreement and the terms therein, including, but not limited to the requirements and expectations as outlined in Neighborhood's Provider Manual, Clinical Medical Policies, Billing and Administrative Guidelines and Payment Policies. All guidelines and policies are available on our website and are subject to change.

The Role of the Primary Care Provider

A primary care provider (PCP) practices in the following areas of medicine:

- Pediatrics, Obstetrics and Gynecology, Family Practice, Internal Medicine, inclusive of nurse providers and physician assistants; and
- Credentialed by Neighborhood as a PCP.

The PCP ensures comprehensive, first-person centered care. In choosing to participate with Neighborhood, PCPs have accepted the following responsibilities:

- Develop, maintain, and monitor a plan of care for each member and arrange for the furnishing of covered services, including admissions to inpatient facilities and coordination between medical, surgical, behavioral health, substance use disorder, and ancillary services.
- Comply with Neighborhood's member to provider ratio of no more than fifteen hundred (1,500) members assigned to any single PCP. A PCP practicing within a primary care team may have up to 3,000 members assigned. A "lead physician" is designated and held accountable within the PCP team.
- Be open for operations five (5) days per week/per site, with a minimum appointment time of forty hours (40) per week/per site, including a minimum of six (6) additional evening or weekend hours. Exceptions will be considered by Neighborhood's Chief Medical Officer based on the site's ability to provide documented CoC and access to services policies and procedures for routine and urgent medical conditions.
- Designated PCP's who have member panels must be available a minimum of seventeen and one-half (17.5) hours of appointment time per week.
- Maintain policies and procedures for ongoing patient education including, but not limited to, orientation to provider's services, self-management of medical problems, disease prevention and a presentation of a written patient bill of rights.
- Coordinate, when required, medically necessary emergency services on behalf of members.
- Provide and administer care and services in accordance with accepted medical practices and professional standards of behavior as set forth by the American Medical Association, The American Osteopathic Association, and the laws governing medical practice in the State of Rhode Island.
- Ensure that all covered services are available and provided at such times and places, including the member's home or elsewhere, as necessary and practical.
- Ensure the member's right to consent to or deny the release of identifiable medical or other information, except when such release is not required by law.
- Ensure the member's right to refuse treatment without jeopardizing future treatment and the member's right to ask for a second opinion in accordance with Neighborhood's policies and procedures.

The Role of the Specialty Care Provider

A specialty care provider delivers medically necessary consultation or ongoing specialty care. Non-participating specialty care providers may also consult and/or provide care to Neighborhood members when medically necessary and with prior authorization from Neighborhood, as applicable.

The specialty care provider is responsible to work in collaboration with the member's PCP, to establish and maintain appropriate medical records for each member and to provide appropriate documentation of their findings to the member's PCP within a reasonable time frame.

Provider Availability

PCPs must maintain patient access twenty-four hours a day, seven (7) days a week. To ensure 24-hour coverage, providers must have one of the following mechanisms in place for incoming member phone calls outside of normal business hours:

- A published after-hours telephone number that allows the member to reach a provider directly or receive instructions for after-hours care.
- An answering machine or answering service that provides detailed instructions for after-hours care.
    - An answering machine must provide instructions for obtaining emergency care (e.g., dialing 911, visiting the closest emergency room when able).
    - An answering machine must provide instructions on how to contact the provider or the designated on-call provider.
    - An answering service must contact the provider or designated on-call provider on behalf of the member.
- Member access to an after-hours call-back within one (1) hour not to exceed two (2) hours, from the primary care or covering provider.
- A voicemail message in place after hours with no provider accessibility is not acceptable.
- The after-hours information available to members should meet the linguistic needs of the patients serviced.
- Providers are encouraged to establish a policy and procedure outlining their after-hours procedures.

Access to Care Standards

Access to health care is a critical measure of Neighborhood's mission to deliver high-quality, cost-effective health care for Rhode Island's residents. Neighborhood monitors its network for compliance with access standards during established business hours as well as after hours.

The following table outlines Neighborhood's access to care standards. Where no specific regulatory requirement exists, Neighborhood expects members to be seen in a timely manner based on the nature of their appointment request.

Access to Care Standards

Appointment Type	Medicaid	Commercial	INTEGRITY (MMP)
Emergency care (including behavioral)	Immediate or emergency facility	Immediate	Immediate
Urgent care (including behavioral)	Within 24 hours	Within 24 hours	Immediate
Medical routine care	Within 30 calendar days	Within 30 business days	Within 30 business days
Behavioral non-emergent, non-urgent, sick visit	Within 10 business days	Within 10 business days	Within 10 business days
Medical non-emergent, non-urgent, sick visit	No specific regulatory requirement	No specific regulatory requirement	Within 7 business days
Physical examination	180 calendar days	No specific regulatory requirement	Within 30 business days
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Within 6 weeks	No specific regulatory requirement	No specific regulatory requirement
New member	30 calendar days	No specific regulatory requirement	No specific regulatory requirement

The following is a summary of Neighborhood's access to care standards:

- **Emergency Care:** Immediately or referred to an emergency facility. **This standard applies to all lines of business**.
- **Urgent Care:** Urgent care is provided to Medicaid and Commercial member within 24 hours, either by a provider located on site, by referral to a covering provider, or through emergency instructions. **INTEGRITY members must be seen immediately**. Urgent care describes care that is necessary for a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within 24 hours could reasonably be expected to result in:
    - Placing the patient's health in serious jeopardy; or
    - Serious impairment to bodily function; or
    - Serious dysfunction of any bodily organ or part.
- **Medical Care for Existing Patients:** Appointments for routine care for members will be available within 30 calendar days, or as determined clinically necessary by the medical provider. **This standard applies to all lines of business**.
- **Non-emergent, Non-urgent, Sick Visit:** Appointments for services that are not considered an emergency or urgently needed, but the member requires medical attention, must take place within 7 business days. **This standard applies to the INTEGRITY line of business only**. There is no specific regulatory requirement for Medicaid or Commercial members.
- **Behavioral Health Services:** Appointments for routine behavioral health services must take place within 10 business days.
- **Physical Examinations for Existing Patients**: Appointments for routine physical examinations for Medicaid members will be available within 180 calendar days of the date

of request. **INTEGRITY members must be seen within 30 business days**. There is no specific regulatory requirement for Commercial members.

- **EPSDT:** Appointments for EPSDT will be available within six (6) weeks of the date of request and follow the Rhode Island EPSDT periodicity schedule. **This applies to Medicaid members only**. There is no specific regulatory requirement for Commercial or INTEGRITY (MMP) members.
- **New Medical Patients:** Medicaid members who do not have an existing relationship with the provider/site will be able to obtain appointments within 30 calendar days of the date of request. There is no specific regulatory requirement for Medicaid or INTEGRITY (MMP) members.

Providers who do not meet Neighborhood's access to care standards will be notified and expected to implement corrective action to become compliant.

CurrentCare

Neighborhood supports the Rhode Island Quality Institute (RIQI) and the statewide health information exchange known as CurrentCare. Neighborhood strongly encourages providers to engage with RIQI to gain access to the statewide health information exchange and use patient data and alert notifications for treatment and coordination of care purposes.

Closing Your Practice to Members

Neighborhood participating providers are expected to accept members for care and for PCPs to maintain open panels.

Neighborhood recognizes that it may be necessary for a PCP within a practice to temporarily limit or stop the number of Neighborhood members assigned. Notification to Neighborhood is required if a PCP temporarily closes their panel. Providers should use the "Update Your Information" e-forms available of our website.

Member Dismissal from a Provider's Care

Neighborhood recognizes the importance of positive therapeutic relationships and is committed to supporting a quality patient-provider experience. When a successful patient-provider relationship is threatened, it is the policy of Neighborhood that the provider request assistance from Neighborhood in identifying appropriate action (See Section 2 of this Manual, "Member Education").

The following procedure applies to medical and behavioral health providers contracted with Neighborhood. Providers should request member outreach from Member Services by completing and submitting a **Member Education Request Form** (**www.nhpri.org/Providers** > **Provider Resources** > **Forms**).

The **Member Education Request Form** can be used by providers for assistance with member outreach on matters including, but not limited to:

- Pattern of missed appointments;
- Non-compliance with vaccines and/or pediatric preventive care;
- Disruptive behavior;
- Appropriate use of the emergency room;
- Review of Neighborhood benefits;

- Intent to dismiss a member from a provider/practice.

In the event the issues cannot be addressed to the satisfaction of both parties, or the Neighborhood member has demonstrated an event/action/behavior considered to be serious and significant, the provider must follow the process below in order to dismiss a Neighborhood member from their practice.

1. Providers must notify Neighborhood's Provider Relations (PR) department of their intent to dismiss a member from their practice and email their PR Representative the following information:
    a. Documentation of attempts to address member issue(s) and/or cause of dismissal;
    b. Documentation of any concerns for clinical care;
    c. Copy of the draft letter to be sent to the member;
    d. Member's name, date of birth, address, and member ID number;
    e. Location/practice information including provider and practice name, NPI, and TIN.
2. Provider Relations will review the request with the Medical Director and respond to the provider within 5 business days of the approval/denial of the dismissal.
3. In order to dismiss a member, the provider must send a written letter a (giving a minimum 30 days advance notice) to the member and document the notice in the member's medical record. The letter should include, at a minimum;
    - The existing provider's responsibility for medication refills (controlled substances are not required to be refilled if there is a suspicion of diversion).
    - The existing provider's availability for routine, urgent and emergent care for a minimum of thirty (30) days from the date of the letter.
    - The provider must notify their PR Representative via email when they have mailed the dismissal letter to the member and attach a copy of the letter to the email.
4. It is the expectation of Neighborhood that all providers who dismiss a member from their practice comply with all applicable legal and regulatory requirements, as well as, Neighborhood's standards for continuity of care for members in active treatment, including but not limited to:
    - Members who are being treated for an acute medical condition;
    - Members being treated for an acute episode of a chronic illness;
    - Members in their second or third trimester of pregnancy;
    - Members for whom a practitioner with comparable or greater expertise is unavailable in-network.

If at any time a Neighborhood member exhibits behavior or actions, including, but not limited to damage of physical property, perceived/exhibited threats, violence, etc., providers can expedite a member dismissal for a serious and significant event by notifying Neighborhood's PR department of the circumstance considered "serious and significant."

It is the expectation of Neighborhood that individual providers/practices have their own policy on patient dismissals.

Mainstreaming

Neighborhood requires providers to agree they will not treat Neighborhood members any differently than members of another health plan with whom they participate.

- All providers must offer the same hours of operation to all patients regardless of patient's insurance coverage.
- All providers must provide and administer care and services with the same standard of care, access, availability, skill, and diligence customarily provided to all of his/her patients.
- Any covering PCP shall perform services in the same manner in which the PCP provides services to his/her other patients.

Provider Termination

Neighborhood providers are obligated to follow their Participating Provider Agreement to inform Neighborhood of their desire to terminate their agreement. Neighborhood expects that the provider will notify its patients in writing of any termination agreed upon between the provider and Neighborhood, and will follow all continuity of care (CoC) requirements.

Provider Information Changes

Providers and provider offices are required to notify Neighborhood of any important changes, including but not limited to: changes in office hours, location, phone/fax number, the availability of providers, billing information, changes and/or hospital privileges, etc. Please use the online electronic forms available on our website to update your information, found via the following path:

www.nhpri.org/Providers > **Update Your Information**

Provider Concierge Services

Concierge services, generally defined as services in which a consumer pays a fee, monthly or annually, to gain access to an enhanced level of services such as unlimited direct access to providers with little to no waiting or scheduling delays. Such services are similar to a "retainer" payment one may pay for legal services. Providers must disclose to Neighborhood if/when they offer concierge services and require concierge fees. These services and fees are not covered by Neighborhood. If an in-network provider choses to offer concierge services and remain in Neighborhood's network, they must also offer access to services without the requirement of a Neighborhood member to pay the concierge fee or retainer payment.

Section 9: Credentialing and Standards of Care

Medical Record Keeping, Documentation Standards, and Confidentiality
Credentialing and Re-credentialing
Assessment of Organizational Providers
Remedial and Disciplinary Action Procedures

- Remedial Action
- Disciplinary Action
- Appeal Process

Medical Record Keeping, Documentation Standards, and Confidentiality

It is the expectation of Neighborhood that all providers maintain comprehensive medical records detailing all aspects of our enrolled members' care and treatment to assure coordination of care.

Neighborhood requires all participating providers' medical record keeping and practice be compliant with state and federal regulation, and records are assessable to Neighborhood and/or other providers as necessary.

Providers must adhere to all state and federal requirement in protecting the confidentiality of members health information.

Neighborhood shall have the right, upon request, with reasonable notice, to review any medical records maintained pertaining to covered services provided to members, and to copy the same. Neighborhood can release medical information to the Executive Office of Health and Human Services (EOHHS) for purposes directly related to the administration of the Medicaid Program. Reviews external to EOHHS are made in accordance with applicable state and federal regulations and law.

Credentialing and Re-credentialing Procedures

Neighborhood effectively manages the credentialing and re-credentialing of providers through a thorough review process. Neighborhood's credentialing and re-credentialing standards are consistent with managed care standards 42CFR§438.214 and 42 CFR§422.204, regulatory requirements from the Centers for Medicare & Medicaid Services (CMS), §27-18.8 Health Care Accessibility and Quality Assurance Act, the Executive Office of Health and Human Services (EOHHS), and National Committee for Quality Assurance (NCQA) standards.

Neighborhood uses the Council for Affordable Quality Healthcare (CAQH) application for provider credentialing and re-credentialing. Neighborhood re-credentials its network providers every 3 years to ensure the provider continues to meet Neighborhood's standards for network participation. Neighborhood's Clinical Affairs Committee is responsible for reviewing and approving all providers credentialing and recredentialing applications.

The process for credentialing and re-credentialing is conducted in a confidential, non-discriminatory manner and decisions are based on established criteria and recruitment standards. Credentialing and re-credentialing of providers include primary source verification of information provided on the application and information collected from monitoring other secondary source verification. Neighborhood renders a decision regarding the provider's credentialing and recredentialing within 45 calendar days of receipt of a complete application. Providers are notified of the status of their application at least once every 15 calendar days, informing providers of any missing information. Providers are informed within five (5) business days when the application is deemed complete.

Applicants that meet all Neighborhood's credentialing criteria are considered "clean files" and are reviewed and approved by the Medical Director or physician designee. The provider's network effective date is the date approved by the Medical Director or physician designee. Applicants that do not meet all Neighborhood's credentialing criteria are reviewed by Neighborhood's Clinical Affairs Committee (the Committee) for a determination. If approved for network participation, the network effective date is the date of the Committee's decision. The Committee reserves the right to approve, suspend and terminate providers above and beyond the decision of the Medical Director or physician designee.

Providers have the right to:

- Check on the status of their application by calling the credentialing department at 401-459-6000. Neighborhood will provide a response by phone and/or in writing within two (2) business days of the request. Neighborhood can only share information that is permissible by law;
- Review information submitted to support their credentialing application and correct erroneous information at any time by submitting a written request to the credentialing department;
- Be informed of the status of the application at least once every 15 calendar days;
- Be informed that the application is deemed complete within five (5) business days;
- Be informed of the credentialing decision within 45 calendar days from receipt of a complete application;
- Appeal the credentialing decision.

A credentialing application is considered complete when all of the following applicable documents have <u>been received:</u>

1. CAQH application is current and available for downloading, including name, current mailing address;
2. Current valid license, registration or certificate required in order for the professional provider to practice;
3. History of any revocation, suspension, probationary status or other disciplinary action regarding provider's license, registration or certificate;
4. Clinical privileges at a network hospital or coverage arrangement through other network provider or hospitalist group;
5. Valid Drug Enforcement Administration (DEA) and Controlled Substance certificate/registration in the state of practice when applicable (DEA and Controlled Substance Registration (CSR)/Controlled Dangerous Substances (CDS) are not required for providers whose scope of practice does not require prescribing of narcotics);
6. Evidence of board certification if the professional provider states that he/she is board-certified;
7. Evidence of professional liability insurance that meets Neighborhood's limits of insurance requirement;
8. History of professional liability claims and description of any settlements or judgements paid to a claimant in connection with professional liability claim.

Additional documentation required by Neighborhood for review:

- Attestation for providers working at Urgent Care facilities (as applicable);
- Work history for past five (5) years by including a curriculum vitae (CV) and/or provided on the CAQH application (gap in work history that exceeds six (6) months must be explained in writing);
- Copy of current CLIA certificate (when applicable);
- Onsite visit (when applicable).

Types of practitioners who are credentialed and re-credentialed on an ongoing basis:

- Acupuncture (DA)
- Asthma Educator (AE-C)
- Certified Diabetic Outpatient Educator (CDE/CDOE)
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Chiropractor (DC)
- Dietician and Nutritionist (LDN)
- Doctor of Medicine (MD)
- Doctor of Osteopathy (DO)
- Doula (CD)
- Lactation Consultant (LLC)
- Massage Therapy (MT)
- Nurse Practitioner (NP)
- Occupational Therapy (OT)
- Optometry (OD)
- Oral Surgery (DMD/DDS)
- Physical Therapy (PT)
- Physician Assistant (PA)
- Podiatry (DPM)
- Speech and Language Pathology (SLP)
- Tobacco Treatment Specialist (TTS)

Neighborhood credentials and recredentials the following independent licensed behavioral health clinicians:

- Psychiatrist (MD)
- Psychologist (PhD, PsyD, EdD)
- Clinical Nurse Specialist (CNS)
- Nurse Practitioner-Behavioral Health
- Physician Assistant – Behavioral Health
- Licensed Applied Behavioral Analyst (LBA)
- Licensed Chemical Dependency Professionals (LCDP)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Mental Health Counselors (LMHC)
- Licensed Marriage and Family Therapy (LMFT)

Neighborhood delegates the credentialing and re-credentialing of dental providers. This includes primary source verification of credentials and decision making for credentialing and re-credentialing of providers. Dental providers must contact Delta Dental of Rhode Island at 1-800-846-3582 to request credentialing and re-credentialing.

Credentialing and re-credentialing of providers includes primary source verification of information provided on the application and information collected from monitoring other secondary source verifications.

Providers must meet the following criteria, which is primary sourced verified prior to the decision rendering date:

- **Medical and/or professional education and training**: Primary source verification that the practitioner successfully completed education and training in the specialty of practice, including post graduate training relevant to the practitioner scope of practice, and is eligible to take boards. Listing in the Provider Directory consistent with the specialty and credentials of the provider.
- **Board certification**: Verification of board certification if the practitioner states that he/she is board certified. Neighborhood recognizes those boards certification recognized by the American Board of Medical Specialties (AMBS) or the American Osteopathic Association (AOA), the American Board of Podiatric Medicine (ABPM), the American Board of Foot and Ankle Surgery (ABFAS), or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM).
- **Current licensure or certification**: Primary source verification that the applicant has a valid and current license to practice, without restrictions, conditions, or other disciplinary action in all states where the practitioner provides care to members.
- **Valid DEA and CSR/CDS**: verification that the practitioner's DEA and CSR/CDS certificate is current in each state where the practitioner provides care to members.
- **Medicare/Medicaid Sanction**: Practitioner must not be excluded, debarred, or precluded from participating in the Medicare and/or Medicaid and related stated and federal programs.
- Compliance with Cures Act requirement to be screened by and enrolled with RI Medicaid.
- **Work History**: Review of most recent five-year work history. A written explanation of work gaps that exceeds six (6) months is required and must be reviewed and accepted by the Credentialing Committee.
- **Liability Insurance**: Evidence of current and active liability insurance with a minimum coverage of $1 million and $3 million. Neighborhood accepts limits of coverage of $1 million/$1 million for doula providers.
- **Malpractice History**: History of professional liability claims and settlements or judgements paid.
- **Sanction and Limitation on Licensure**: History of licensure and hospital sanctions, restrictions on licensure and limitations on scope of practice in all state where the practitioner provides care to members.
- **Hospital Privileges**: Clinical privileges at a network hospital or coverage arrangement through another network provider or hospitalist group.
- Certification by the Rhode Island Board Certification as applicable
- **Affirmative Response to disclosure question on the application**: Applicants are required to provide details of affirmative response to disclosure questions on the credentialing and re-credentialing application.
- **Facility assessment / office site visit**: When applicable, applicant must agree to allow the credentialing staff to conduct an office site visit, including review of office policy and assessment of medical record keeping and/or complete a facility assessment questionnaire and submit office policies for review. A passing score is required. Site visit must be completed prior to the decision date.

Neighborhood credentialing staff conducts site assessments to ensure that individual patient care site(s) meet Neighborhood's standards for quality, safety, and accessibility. The areas of review are physical accessibility; physical appearance; adequacy of the waiting and examining room space; medical record

keeping standards; emergency response, office policy and procedures, supplies which is applicable to urgent care/walk-in treatment centers only.

Office site visits are conducted:

- At all provider offices, in response to individual complaints received from a member or a member representative about the quality, safety and/or accessibility of the office site where care is delivered; and in response to data analyses or medical record chart reviews that reveal opportunities for improvement.
- Primary care and obstetrics & gynecology providers must attest to the following areas of competencies by completing a Neighborhood Facility Attestation form and submit to credentialing department for review. Neighborhood retains the right to conduct an on-site assessment prior to the provider joining the network if criteria are not met:
    - Ability to handle medical emergencies;
    - Physical accessibility and maintenance;
    - Medical record keeping and confidentiality;
    - Office internal policies and procedures.

Assessment of Organizational Providers

Neighborhood conducts initial and ongoing assessments of organizational providers to ensure providers meet Neighborhood's requirements for participating in the network.

Prior to contracting with an organizational provider and every three years thereafter, Neighborhood evaluates each organizational provider to verify that:

- The provider has met all state and federal licensing and regulatory requirements, including Medicare and Medicaid (CMS) certification;
- The provider has been accredited by an organization approved by CMS. The medical director of the facility is credentialed with Neighborhood.

Neighborhood accepts the CMS or state quality site review in lieu of a site visit for initial assessment and reassessment of an organizational provider under the following circumstances:

- The CMS or state site quality review is no more than three years old.

The organization obtains a copy of the survey report or letter stating that the facility was reviewed and passed the inspection from either CMS, the state or from the provider or agency.

Neighborhood reserves the right to conduct an onsite visit at all organization providers to address quality complaints and concerns, and the right to suspend onsite visits during periods of public health or other emergencies.

The following types of facilities are credentialed:

- Adult Day Care
- Assisted Living
- Behavioral Health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting

- Dialysis Clinic
- Freestanding Ambulatory Surgical Center
- Home Health Care and Home Infusion provider
- Hospice provider
- Hospital
- Independent Clinical Laboratory
- Skilled Nursing Facility
- Physician ambulatory surgery centers

Accrediting bodies accepted by Neighborhood:

- Accreditation Association for Ambulatory Healthcare (AAAHC)
- Accreditation Commission for Health Care, Inc (ACHC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- Center for Improvement in Healthcare Quality (CIHQ)
- Center for Medicare and Medicaid Services (CMS)
- College of American Pathologists (CAP)
- Community Health Accreditation Program (CHAP)
- Clinical Laboratory Improvement Amendments (CLIA)
- Commission on Office Laboratory Accreditation (COLA)
- Det Norske Veritas Healthcare (DNV)
- The Joint Commission (TJC)

Neighborhood requires the following documentation for initial assessment and every three (3) years thereafter:

- A completed Neighborhood organizational provider application;
- Documentation of unrestricted state licensure (Note: An actual copy of the state license is required; attesting to the accreditation is not sufficient);
- Documentation of DOH site visit and report as necessary;
- Malpractice and general liability certificate of insurance;
- Malpractice claim history;
- Medicare and Medicaid sanction information;
- Proof of accreditation status with an approved accrediting body (**Note:** An actual copy of the accreditation report is required; attesting to the accreditation is not sufficient);
- Copies of the CMS certificate / report and the provider's quality improvement program description and evaluation may be submitted as necessary.

Remedial and Disciplinary Action Procedures

To assure safety of the members and delivery of high-quality health care treatment and service, Neighborhood exercises remedial and disciplinary action procedures and peer review processes to address substandard care provided by network providers, in accordance with established Rhode Island General Laws §5-37.3-7, the Health Care Quality Improvement Act, 42U.S.C. §11101 et seq., Neighborhood's policies and procedures and the participating provider's contract with Neighborhood. Neighborhood maintains procedures for reporting disciplinary action and serious quality concerns to appropriate authorities.

Remedial Action

Remedial action is undertaken due to peer review activity conducted by the Quality Assurance Committee (QAC), the Clinical Affairs Committee (CAC), by the Chief Medical Officer (CMO) and Medical Director in collaboration with QAC and CAC upon identification of a clinical quality care complaint or concern and for administrative reasons identified by the Provider Administrative Review Committee.

Remedial Action may include one of the following activities with the provider under review:

- Telephone discussion with the involved provider
- Written correspondence with the involved provider
- Formal or information provider education
- Review of medical records
- On-site assessment
- Implementation of a corrective action plan and other measures as appropriate

Remedial action is warranted before disciplinary action occurs, except for those circumstances in which the Neighborhood's CMO and/or Medical Director believe that failure to take action may pose an imminent danger to the health of a member.

Disciplinary Action

Neighborhood's CMO and Medical Director are responsible for identifying circumstances requiring disciplinary action and forwarding the matter to CAC and the Board of Directors. Disciplinary action is warranted if the provider does not comply with Neighborhood's remedial action request. At a minimum, these circumstances include:

- A pattern of refusal to comply with plan's, local, state, or federal requirement or regulations on clinical or administrative practice;
- A pattern or clinical practice that falls below applicable standards and expectations;
- Failure to maintain full and unrestricted license to practice in the State of practice;
- Failure to comply with accepted ethical and professional standards and behavior.

A provider under review receives written notification of the prospect of disciplinary action and the reason therefore, the right to request a hearing, and his/her rights at such a hearing.

Appeal Process

Neighborhood provides network providers or those seeking to become network providers, a fair process, based on objective evidence and patient-care consideration, when: (a) providers are not approved for network participation; and (b) participating providers lose, or have their network privileges adversely altered, for any reasons, including quality or discipline.

Providers are informed in writing of the action taken, the reason for the action and the provider's right to appeal the decision or action, and the process for requesting the hearing.

Upon receipt of a formal hearing request, Neighborhood schedules the hearing and informs the provider in writing of the hearing date, instructions for the day of the hearing, and the provider's rights at the hearing. The hearing may take place virtually or in-person.

The provider has the right to:

- The name of the person who will present Neighborhood's rationale for proposed action to the Committee.
- Be represented by an attorney or other person of the provider's choice.
- Present argument and other support, verbal and in writing, accepted as relevant by Neighborhood's Joint Appellate Hearing Committee ("The Committee"), regardless of whether that evidence would be admissible in a court of law.
- Submit a written statement at the close of the hearing.
- Receive a written decision of The Committee, including a statement of the basis for the decision, within sixty (60) calendar days of the hearing.
- Request a record of the proceedings (copies of which are available to The Committee).

Section 10: Compliance and Fraud, Waste, and Abuse

Compliance at Neighborhood
Definitions of Fraud, Waste, and Abuse (FWA)
FWA Audits and Investigations
Onsite Audits
Laws Related to Fraud, Waste and Abuse
Federal False Claims Act
State of Rhode Island False Claims Act
Civil Money Penalties for False Claims in Federal Health Care Programs ("CMPL")
Federal Anti-Kickback Statute
Federal Anti-Self-Referral Statute (Stark Laws)
Health Insurance Portability and Accountability Act (HIPAA)
Implementing a Compliance Program
Legally Responsible Individuals
Sanction Monitoring

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 to detect, correct, and prevent known instances of fraud, waste, and abuse in the delivery of covered health care 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.

Definitions of 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. Fraud is punishable by imprisonment and/or fines and can result in the exclusion of individuals and organizations from participation in government health care programs, such as Medicare and Medicaid. Exclusion means that you could be barred (i.e., not able to work for any company in the health care industry that contracts for government health care programs) for a number of years or permanently.

Waste includes overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a government health care 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 health care 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. Typically, situations categorized as abuse may be characterized as inconsistent with accepted medical or business practices, or which are improper or excessive. Abuse includes provider practices that are inconsistent with sound fiscal, business, or medical services that are not medically necessary or that fail to meet professionally recognized standards of health care. It also includes member practices that result in unnecessary cost to a government health care program resulting in increased costs or utilization of medical services or products. Abuse can result in fines and other penalties.

The following are common examples recognized as fraud, waste and/or 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.

Some common examples of potential fraud, waste and/or abuse by members:

- Excessive use or overuse of benefits;
- Using another individual's benefits card to obtain service(s). Lending, altering, or duplicating a benefit card or information;
- Altering or forging prescriptions;
- Providing incorrect eligibility information to obtain services;
- Simultaneously receiving benefits in Rhode Island and other states;
- Knowingly assisting providers in furnishing services to defraud Medicaid;
- Residing outside the State of RI and receiving Rhode Island (RI) Medicaid coverage.

FWA Audits and Investigations

Neighborhood, and/or its designees, utilize various methods to audit and/or investigate participating and non-participating provider's compliance with all applicable billing and coding guidelines, 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 and may be subject to a medical record review and/or an onsite visit. Medical record requests will be based on all contractual agreements and regulatory guidelines.

Requests for Medical Records involving FWA audits and investigations:

- May be performed onsite or requested via certified mail, secure email or fax;
- Onsite visits will be scheduled upon reasonable notice;
- May vary in frequency, the type of audit or investigation (pre-payment, post-payment, quarterly, or semi-annually to annually).

In alignment with all State and Federal regulations, FWA audits and investigation time frames will not exceed ten (10) years from the original date of service. Results will be communicated, in writing, post review.

In the event Neighborhood determines that an overpayment has been made to a Provider inaccurately or due to the identification of potential fraud, waste, and/or abuse in the Provider's submission of claims, the

Provider agrees that an amount equal to that overpayment may be withheld, via claim retractions or offset of future payments, by Neighborhood. In the event funds are not available to retract or offset against, providers will be responsible to submit payment in full to Neighborhood. If payment is not received within a reasonable time frame, Neighborhood reserves the right to pursue legal recourse against the provider and/or practice.

Neighborhood reserves the right to perform claim dollar retractions that result from audits and investigations, as dictated by the False Claims Act. Applicable federal and state agencies overseeing Neighborhood programs have a right to conduct audits, under Neighborhood's Agreements with the State and CMS.

Neighborhood's expectation is that all contractual obligations are fulfilled, as outlined in provider contracts. Neighborhood utilizes CMS billing guidelines, Neighborhood Clinical Medical Policies, Neighborhood's Administrative/Coverage Summaries and Billing Guidelines, National Uniform Billing Guidelines along with American Medical Association Current Procedural Terminology (CPT®) guidelines, 1997 Documentation Guidelines for Evaluation and Management Services Standards and other state and federal laws and regulations as they apply to and define services billed. Neighborhood utilizes, but is not limited to, these resources to ensure that audits are conducted in a fair manner as these are widely acknowledged national guidelines for billing practices and support the concept of uniform billing for all payers.

Onsite Audits

An onsite audit allows an auditor to visit a provider to review the medical record and billing documents in person. Neighborhood has the following on-site audit guidelines:

- Upon reasonable notification by Neighborhood or its designee an onsite visit will be scheduled by contacting the provider via telephone or email;
- Neighborhood or its designee will notify the provider in writing of the audit findings following SIU's standard audit process;
- Providers will be given the opportunity to dispute findings as outlined in the audit findings letter by responding in writing within 15 days of the date on the letter. This response should include additional documentation or resources to support the dispute.

Laws Related to Fraud, Waste and Abuse

Providers should familiarize themselves with laws involving health insurance fraud as well as the criminal health care fraud statute summarized below. Providers who violate these laws could face exclusion from participation in federal health insurance programs as well as civil monetary penalties and assessment and criminal penalties and incarceration.

Federal False Claims Act

The False Claim Act (FCA) is a federal law that makes it illegal for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state health care system.

Under FCA, "knowingly" does not require proof of specific intent to defraud. "Actual knowledge of the information" or acting "in deliberate ignorance of the truth or falsity of the information" or "in reckless disregard of the truth or falsity of the information" is enough.

Examples of the types of activities prohibited by the FCA include billing for services that were not actually rendered, double-billing for items or services, up-coding (the practice of billing for a more highly reimbursed item or service than the one provided) or unbundling (the practice of billing services separately to secure a higher reimbursement).

Moreover, the Affordable Care Act (ACA) mandates that providers and suppliers who are aware that they have retained Medicare or Medicaid funds in error must report and return those funds within sixty (60) days. Under ACA, "overpayments" are defined as "any [Medicare or Medicaid] funds that a person receives or retains...to which the person, after applicable reconciliation, is not entitled." Any overpayment retained after the deadline becomes an "obligation" for purposes of the FCA. Accordingly, a failure to return overpayments by the deadline may result in a false claim liability for the provider.

Violation under the federal False Claims Act can result in significant fines and penalties. Financial penalties may be imposed on a person or organization including recovery of three times the amount of the false claim(s), plus an additional penalty of over $10,000 per claim. An individual (called a qui tam plaintiff or relator) who is an original source of information can sue for violations of the False Claims Act. Under both the federal False Claims Act and qui tam plaintiff can receive between 15-25% if litigated by the qui tam plaintiff.

The federal False Claims Act has provisions to protect individuals who report a violation of the law in good faith.

In addition to the FCA, 18 U.S.C. sec. 287, is a federal criminal statute that sets outs criminal penalties for making false claims. The penalties include prison for up to five years and substantial fines.

State of Rhode Island False Claims Act

In addition to the federal law, the state has adopted similar laws under the Rhode Island False Claims Act. The Rhode Island False Claims Act is designed to prevent fraud, kickbacks, and conspiracies in connection with government health care programs (e.g., Medicare/Medicaid).

Any person or entity that violates the provisions of the Rhode Island False Claims Act is liable to the state for a civil penalty of over $10,000 per claim, plus three times that amount of the damages which the state sustains because of the act of that person. In addition, the person that violates this law will also be liable to the state for the costs of a civil action brought to recover any such penalty or damages.

The Rhode Island False Claims Act allows whistleblowers to bring suit in the name of the State of Rhode Island where an individual is identified as engaging in conduct that defrauds the state or local governments of taxpayer dollars. The Rhode Island False Claims Act provides protection for whistleblowers against retaliation for filing a claim or assisting the state with its own claim.

Civil Money Penalties for False Claims in Federal Health Care Programs ("CMPL")

CMPL provides for monetary penalties of up to $100,000 and assessments up to three times the amount of the services or the remuneration against anyone who presents a claim to a federal or state officer, employee, or agency that he or she knows or should have known was not provided as claimed. CMPL can also be imposed on a provider who:

1. Submits a bill for services provided by a person who is not licensed or is excluded from federal or state health care programs;
2. Violates the anti-kickback statutes; or
3. Violates the prohibition on physician self-referral, or Stark Laws Criminal Penalties for False Claims in Federal Health Care Programs.

A fine of up to $50,000.00 and/or imprisonment may be imposed on any person in connection with the furnishing of items or services under a federal health care program and who is convicted of a felony for knowingly and willfully:

- Making a false statement or representation of material fact in any application for a benefit or payment under or for use in determining rights to such benefit or payment in a federal health care program; Concealing or failing to disclose, with intent to defraud, any event affecting his or her initial or continued right to any benefit or payment;
- Presenting or causing to be presented a claim for a provider's service for which payment may be made under a federal health care program and knowing that the individual who furnished the service was not a license provider; or
- For a fee, counseling or assisting an individual to dispose of assets in order for the individual to become eligible for medical assistance under a state Medicaid program if disposing of the assets results in the imposition of a period of ineligibility for such assistance.

Federal Anti-Kickback Statute

The Anti-Kickback Statute was designed to prevent fraud and abuse in federal health care programs by making it a crime for anyone who knowingly and willfully solicits, receives, or pays anything of value (remuneration) including any kickback, bribe, or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program. Punishment for felony conviction for violating the anti-kickback law is a fine of not more than $100,000 or imprisonment or both, administrative civil money penalties of up to $100,000 per violation plus three times the amount of the remuneration, and exclusion from participation in federal health care programs. The law contains several "safe harbors" that provide protection from prosecution for certain transactions and business practices with further guidelines provided in 42.C.F.R. §1001.952. A violation of the Federal Anti-Kickback Statute constitutes a false and fraudulent claim under the Federal False Claims Act.

Federal Anti-Self-Referral Statute (Stark Laws)

Subject to specific exceptions, the law prohibits a physician from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. No specific intent is required. A financial relationship is either a direct or indirect ownership interest or compensation arrangement. Certain regulatory exceptions apply. The law prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral. A physician who violates the Stark Laws is subject to

substantial civil money penalties and exclusion from participation in the federal health care program for improper claims.

The Stark Laws impose specific reporting requirements on entities that receive payment for services covered by federal health care programs. Failure to report would subject the entity to civil money penalties of up to $10,000 for each day which reporting is required to have been made. Persons collecting amounts billed in violation of the law must refund amounts on a timely basis. There is a potential for $15,000 civil money penalties for each service and exclusion from participation in federal health care programs for knowing violations. Physicians or entities that enter into a prohibited referral scheme and directly make such referrals are subject to a civil penalty of not more than $100,000. Intent is required for civil monetary penalties.

Health Insurance Portability and Accountability Act (HIPAA)

As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. (18 U.S.C. §1347)

If you suspect fraud, waste, or abuse, please call our Compliance Hotline at 1-888-579-1551

Implementing a Compliance Program

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.

Elements of an effective compliance program include, but are not limited to, the following:

- Develop and distribute written standards of conduct and policies to promote commitment to compliance (e.g., by including compliance as part of staff evaluations) and address potential fraud areas, such as claims management and financial relationships with other providers;
- Appoint a Chief Compliance Officer and others to run and monitor the compliance program;
- Implement regular compliance training for staff;
- Implement processes (such as a confidential hotline) to receive potential fraud complaints;
- Create procedures to protect the anonymity of those who report actual or perceived wrongdoing and protect whistleblowers from retaliation;
- Deal well with potential fraud, waste and abuse complaints and take appropriate disciplinary action(s) if staff violate compliance requirements;
- Audit and monitor for compliance;
- Investigate and solve systemic problems found.

For more information, see the compliance guidance documents prepared by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG):

- **For individual and small group physician practices** (65 Fed. Reg. 59434; October 5, 2000): https://oig.hhs.gov/authorities/docs/physician.pdf
- **For hospitals** (63 Fed. Reg. 8987; February 23, 1998 and 70 Fed. Reg. 4858; January 31, 2005): https://oig.hhs.gov/authorities/docs/cpghosp.pdf and https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2006053221-hi-012705hospsupplementalguidance.pdf.
- **For ambulance suppliers** (68 Fed. Reg. 14245; March 24, 2003): https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2006053221-hi-032403ambulancecpgfr.pdf
- **For clinical laboratories** (63 Fed. Reg. 45076; August 24, 1998): https://oig.hhs.gov/authorities/docs/cpglab.pdf
- **For the durable medical equipment, prosthetics, orthotics and supply industry** (64 Fed. Reg. 36368; July 6, 1999): https://oig.hhs.gov/authorities/docs/frdme.pdf
- **For home health agencies** (63 Fed. Reg. 42410; August 7, 1998): https://oig.hhs.gov/authorities/docs/cpghome.pdf
- **For hospices** (64 Fed. Reg. 54031; October 5, 1999): https://oig.hhs.gov/authorities/docs/hospicx.pdf
- **For nursing facilities** (65 Fed. Reg. 14289; March 16, 2000 and (73 Fed. Reg. 56832; September 30, 2008): https://oig.hhs.gov/authorities/docs/cpgnf.pdf
- **For third-party medical billing companies** (63 Fed. Reg. 70138; December 18, 1998): https://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf

Legally Responsible Individuals

For Medicaid products, Neighborhood does not make payments to legally responsible individuals for furnishing any health care related services. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or (b) a spouse. Except at the option of the State and under extraordinary circumstances specified by the State, Neighborhood cannot make payment to a legally responsible individual for the provision of any health care related services that the legally responsible individual would ordinarily perform on behalf of a Medicaid beneficiary regardless of the professional qualifications of the legally responsible individual.

Sanction Monitoring

As part of detecting and preventing fraud, providers are responsible to ensure that they are not employing or contracting with individuals or entities that are excluded from participation in state or federal health care programs. Providers are expected to conduct initial and ongoing monthly checks of employees, consultants, subcontractors, and governing individuals, including any individual with a direct or indirect controlling interest of any percentage in the provider or anyone else performing services on behalf of the provider, against OIG LEIE & SAM databases to ensure that individuals or entities are not excluded from participation in state and federal health care programs. Provider will notify Neighborhood immediately of any identified excluded individuals or entities.

Section 11: Quality Improvement

Overview of Quality Improvement Program

Quality Improvement Methodology

- Plan
- Do
- Study
- Act

Performance Measure and Quality Improvement

Neighborhood's Quality Improvement Activities

- Healthcare Effectiveness Data Information Set (HEDIS) and Quality Rating System (QRS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Qualified Health Plan Enrollee Experience Surveys (QHP EES)
- Medicare Health Outcomes Survey (HOS)
- Provider Satisfaction Survey

Clinical Practice Guidelines

Peer Review Activity

Quality of Care Complaints

Overview of Quality Improvement Program

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. In order to meet this high-level goal, Neighborhood's QI Program targets clinical quality of care, member and provider satisfaction and internal operations. The Neighborhood Board of Directors has the ultimate oversight for the health care and services provided to its members and annually approve the QI Program Description and Work Plan.

Within the scope of its QI Program, Neighborhood monitors and evaluates care and services rendered to members, with particular emphasis on access to care, availability of services, member satisfaction, and health outcomes, as captured through routine health plan reporting, annual HEDIS, QRS, CAHPS, and HOS results, assessment of provider and member satisfaction, accessibility and availability standards, utilization trends, and especially designed quality improvement studies. Neighborhood assesses its performance, including the performance of its contractors and its network providers, against goals and objectives that are evidence-based and align with industry standards. Neighborhood expects all providers to cooperate with quality improvement activities and to allow Neighborhood to use provider performance data to enhance the success of its QI Program.

Neighborhood recognizes the critical role that provider involvement plays in the success of its QI Program, and highly encourages provider involvement in various levels of the process through provider representation. Neighborhood encourages primary care providers, specialists, and OB/GYN representation on key quality committees such as the Clinical Affairs Committee, Clinical Management Committee and Pharmacy and Therapeutics Committee.

Quality Improvement Methodology

Neighborhood has chosen the Plan Do Study Act (PDSA) quality improvement methodology as the systematic approach employed across all departments to ensure continuous quality improvement in the Plan's clinical and service performance and operational functions and efficiencies.

The following are the steps applied to all quality improvement initiatives undertaken by Neighborhood:

Plan

Neighborhood monitors a variety of performance measures covering clinical care and series delivery to identify opportunities for improvement. Neighborhood uses HEDIS and CAHPS® results, program evaluation results, member and provider satisfaction surveys, the Member Services member call logs, claims, utilization data, disease and case management data, medical records, patient safety data, accessibility and availability surveys, member and provider focus groups, and other sources of data to guide and inform the quality improvement process. The available data are analyzed to assess performance over time, across providers, and among member sub-groups.

Causal analysis is conducted, often in collaboration with network providers and/or member representatives, to better understand trends in the data and identify opportunities for improvement. Based on the data, the Plan's QI committee, subcommittees, and ad-hoc QI workgroups identify, prioritize, and implement interventions to address the opportunities for improvement.

Do

The QI team leaders, in collaboration with their improvement work groups, carry out the interventions designed based on the analysis of the data.

Study

The improvement work group monitors the effectiveness of the interventions carried out based on the goals and measures previously identified. The data is collected and analyzed, and the results are reported to the appropriate committee based on the targets established for each activity using the PDSA methodology, including the identification of barriers and the interventions for overcoming the identified barriers.

Act

The QI team leaders in collaboration with their improvement work groups modify the interventions as necessary and identify the next steps. Successful interventions are monitored for sustainability and transferability.

To ensure that quality improvement is continuous and the identified goals and/or objective are being met, each quality improvement activity is reviewed and discussed by the designated committee or subcommittee regularly. Modification to the initiatives is implemented as necessary and incorporated into Neighborhood's annual Quality Improvement Work Plan.

Performance Measure and Quality Improvement

To assure compliance with established medical record standards, Neighborhood conducts review of medical/health records of their enrollees using standard HEDIS measurement criteria as outlined in the HEDIS Technical Specifications. HEDIS development and maintenance is sponsored and supported by the National Committee for Quality Assurance (NCQA). HEDIS is the most widely used set of standardized performance measures in the managed care industry.

Each HEDIS measure is collected using one of three methodologies: administrative, hybrid or survey. The administrative method uses claims data and other administrative data files to identify the denominator and numerator. In this case, the denominator will include all members who meet the eligibility criteria based on the technical specifications defined under each measure. The hybrid method uses both administrative and medical record data to identify the denominator and numerator. The hybrid denominator consists of a systematic sample of members drawn from Neighborhood. Member satisfaction is assessed through the Customer Assessment of Healthcare Providers and Systems (CAHPS) survey. Careful sample requirements include continuous enrollment information. All measurement processes must pass an external audit by an NCQA-certified HEDIS auditor.

Neighborhood contracts with an NCQA-certified software vendor to calculate its HEDIS measures. To comply with regulations, these rates are submitted both to NCQA and to the Executive Office of Health and Human Services every June. Neighborhood collects reports and uses HEDIS results in the development of our quality work plans and in the development of continuous improvement processes.

Neighborhood's Quality Improvement Activities

Healthcare Effectiveness Data Information Set (HEDIS) and the Quality Rating System (QRS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). The Quality Rating System (QRS) is a measure set for Qualified Health Plans under the ACA Exchange that includes HEDIS and Pharmacy Quality Alliance (PQA) measures. HEDIS and QRS provide purchasers and consumers the ability to distinguish between health plans based on comparative quality. HEDIS is one of the most widely used systems of health care performance measures in the United States. As both Federal and State governments move toward a health care system that is quality driven, HEDIS performance is becoming increasingly important for providers as well as for health plans. HEDIS results are based on statistically valid samples of members and are rigorously audited by an NCQA certified HEDIS auditor using a process designed by NCQA. NCQA requires accredited health plans to report the required audited HEDIS performance measures to NCQA. Similarly, CMS requires all Qualified Health Plans to collect and submit QRS to CMS.

HEDIS measures are collected and calculated in two methodologies: administrative and hybrid.

- The administrative method uses claims data and other administrative data files submitted to Neighborhood to identify the denominator and numerator. In this case the denominator will include all members who meet the eligibility criteria based on the HEDIS Technical Specifications defined under each measure. Examples of HEDIS measures that are collected through this method include: Chlamydia Screening in Women, Breast Cancer Screening and Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.
- The hybrid method uses both administrative and medical record data to identify the denominator and numerator. The hybrid denominator consists of a systematic sample of members drawn from Neighborhood. The hybrid data requires review of a random sample of medical records to extract data relative to services provided but not reported to Neighborhood via claims or encounter data. Examples of HEDIS measures that usually require chart review are childhood immunizations, cervical cancer screening, controlling high blood pressure, and postpartum care.

How Can Providers Improve Their HEDIS Rates?

- Submit claims and encounter data for every service that is delivered;
- Submit accurate and timely claims and encounter data;
- Document services completely and accurately in the medical record;
- Understand the HEDIS Technical Specifications for each HEDIS measure;
- Identify patients who meet the HEDIS measure specification and ensure they receive those services.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Qualified Health Plan Enrollee Experience Survey (QHP EES)

The CAHPS survey is a standardized survey administrated annually to Neighborhood members by an NCQA-certified survey vendor, and it is required as part of HEDIS submission and NCQA Accreditation. The collection and reporting of QHP EES rates are required by CMS for Qualified Health Plans. CAHPS and QHP EES assess members' experience with the services provided by Neighborhood and the services provided by the members' providers.

Neighborhood uses the results from the annual CAHPS survey to identify areas of member dissatisfaction and opportunities for improvement. CAHPS survey results are supplemented with regular review of member complaints and appeals for a more robust assessment of members' needs.

Medicare Health Outcomes Survey (HOS)

The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care. The goal of the HOS is to collect data to facilitate targeted quality improvement activities and resources; to monitor health performance and reward top-performing health plans; and to help Medicare beneficiaries make informed health care choices. All the Medicare health plans are required to participate in the HOS survey, including Neighborhood's integrated Medicare-Medicaid health plan, Integrity. HOS is annually administered by an NCQA-certified vendor.

Provider Satisfaction Survey

Neighborhood conducts an annual Provider Satisfaction survey to assess and identify opportunities to improve providers' satisfaction with Neighborhood's services to providers and support for clinical practice. Neighborhood partners with an external vendor to administer this survey. The survey assesses satisfaction with Neighborhood operational areas and the Neighborhood provider network as well as overall satisfaction and health plan loyalty. The information obtained is used to develop quality improvement initiatives across the organization to increase providers' satisfaction with Neighborhood and to ensure high quality care for Neighborhood members.

Clinical Practice Guidelines

Neighborhood's Medical Directors' Office develops and/or adopts and maintains clinical practice guidelines to ensure the delivery of age-appropriate, evidence-based care to enrolled members. Neighborhood annually assesses provider adherence to the guidelines by analyzing related HEDIS measures to identify opportunities for performance improvement. Clinical practice guidelines for medical or behavioral health services are updated no less than every two (2) years and are accessible to network providers via the Neighborhood website.

Peer Review Activity

Neighborhood's peer review program is conducted according to the Rhode Island Board of Medical Licensure and Discipline Regulations. The Chief Medical Officer (CMO), or a delegate from the Medical Director's Office, e.g., Associate Medical Director, manages the peer review process internally for presentation and review by the Clinical Affairs Committee. Cases requiring peer review are identified through member or provider complaints, utilization review, and other sources. The CMO (or delegate) may perform peer review directly or arrange for review by an appropriate physician or committee of physicians working with a quality assurance specialist in accordance with Neighborhood's policies and procedures. Any necessary remedial and disciplinary actions are implemented in a timely manner in accordance with Neighborhood's Quality Assurance Committee policies and procedures.

Quality of Care Complaints

All clinical complaints or clinical concerns received from members, providers, Neighborhood staff, state agencies, and other entities relative to the quality of clinical care or services rendered to members are forwarded to the Quality Assurance Specialist for investigation, who coordinates the investigation and prepares the findings to be reviewed with a Medical Director (MD) assigned to the case. The moderate and serious quality of care issues are reported to the Clinical Affairs Committee on a regular basis.

Section 12: Neighborhood Commercial Plans

Commercial Plans Overview

Commercial Plan Benefits Overview

Premium Grace Periods

Commercial Plans Overview

Neighborhood believes that offering the most affordable Commercial plans allows us to further our mission to secure access to high quality, cost-effective health care for all Rhode Islander's.

Neighborhood Commercial plans are available both on and off the Exchange.

On Exchange

Neighborhood offers plans through Rhode Island's health insurance exchange, HealthSource RI, for eligible individuals and families and small businesses with 2-50 employees (Small Business Health Options Program [SHOP]).

A significant portion of Rhode Island's population will move back and forth between having coverage through plans available on HealthSource RI and Medicaid, due to fluctuating income. By offering plans through HealthSource RI, Neighborhood helps ensure continuity of care (CoC), maintains member relationships with their patient-centered medical homes, and makes the complicated business of health insurance less cumbersome. Neighborhood is committed to allowing newly enrolled members to continue pre-existing courses of treatment during their CoC period. The CoC period for Commercial members is 90 days from the date of enrollment.

Off Exchange

Neighborhood offers our affordable individual and family plans off exchange through Individual Coverage Health Reimbursement Arrangement's (ICHRA), a type of health reimbursement account for employers to provide tax-free funds to their employees to purchase individual insurance plans. These plans are available to Rhode Islanders eligible for an ICHRA through their employer.

Commercial Plan Benefits Overview

An overview our Commercial plans is available on our website at **www.nhpri.org**.

Neighborhood Commercial members have different cost-sharing and benefits based on the plan variation in which they are enrolled. Appropriate copay amounts will be noted on the member ID cards. Members and/or their appointed designee are instructed to carry their ID card with them and to show their ID card when seeking health care services. We encourage providers to collect these amounts from members as they would members of other Commercial carriers. Any amounts collected at the times of service should be reflected on the claim.

Please refer to the Certificates of Coverage and Summaries of Benefit and Coverage which are available at **www.nhpri.org** for more information about plan benefits.

Premium Grace Periods

In accordance with federal regulation and Neighborhood's contracts, Neighborhood's Commercial members are eligible for premium grace periods. The premium grace period starts at the beginning of the month for which premium has not been paid. During this grace period, information about the member's status will be available through Neighborhood Member Services and Navinet.

Premium grace periods vary by line of business. Please see the chart below.

Line of Business	Premium Grace Period	Process
Individual/Family On Exchange	90 days	• Neighborhood will pay claims submitted during the first month of the premium grace period. • For claims submitted during the second and third months of the premium grace period, Neighborhood will pend claims. • If a member pays past due premiums before the end of the premium grace period, previously pended claims will be automatically reprocessed and paid. Providers do not need to resubmit the claims. • If a member's grace period ends without premiums being paid, pended claims will be denied. For members whose eligibility cannot be verified or who are in the premium grace period, you have the same options available, with respect to billing the member for services, as you do with any other Commercial members.
Small Business (SHOP) On Exchange	60 days	• Neighborhood will pay claims submitted during the 60 day premium grace period.
Individual/Family Off Exchange	30 days	• Neighborhood will pay claims submitted during the first month of the premium grace period. • For claims submitted during the second month of the premium grace period, Neighborhood will pend claims. • If a member pays past due premiums before the end of the premium grace period, previously pended claims will be automatically reprocessed and paid. Providers do not need to resubmit the claims. • If a member's grace period ends without premiums being paid, pended claims will be denied. For members whose eligibility cannot be verified or who are in the premium grace period, you have the same options available, with respect to billing the member for services, as you do with any other Commercial members.

Section 13: Neighborhood INTEGRITY (Medicare-Medicaid Plan)

INTEGRITY Overview

Enrollee Benefits

- Medical, Behavioral Health and Long-Term Services and Supports
- MMP Pharmacy Program

Formulary

- Prescribers of Medicare Part D Drugs
- Prior Authorization
- Step Therapy

Transition Policy

Continuity of Care for INTEGRITY Members

Medication Therapy Management Program

Enrollee Ombudsman Services

Role of the Enrollment Counselor

Quality Improvement

Mandatory Reporting

Alternative Payment Arrangements

Medical Management

Authorization Requirements for INTEGRITY

Member Billing and Hold Harmless Provisions

Care Management

- Care Management for Nursing Home Residents
- Care Management for INTEGRITY Members Residing in the Community

Marketing Guidelines

Provider Education and Training

INTEGRITY Member Appeals

Standard Member Appeals Procedure for Services Covered by Medicare

- Standard Member Appeals Procedure for Services Covered by Part D
- Fast-Track Appeals for Services Covered by Medicare

Standard and Expedited Appeals for Services Covered by Medicare and Medicaid

- General Appeal Information
- Expedited Appeals

Quality of Care Grievances (Clinical Complaints Filed by INTEGRITY Members)

Quality Improvement Organization Complaint Process for Services Covered by Medicare

- Acentra Health

INTEGRITY Overview

Neighborhood operates a three-way contract with the Centers for Medicare and Medicaid Services (CMS) and the State of Rhode Island Executive Office of Health and Human Services (EOHHS). This contract constitutes Neighborhood's Medicare-Medicaid Plan (MMP), known as INTEGRITY (MMP), for persons with disabilities and seniors who are eligible for both Medicare and Medicaid.

The overall goal of INTEGRITY (MMP) is to coordinate high-quality, member-centered, cost-effective care by implementing an integrated, interdisciplinary approach with a focus on high-touch care management.

The INTEGRITY (MMP) plan has the following objectives:

- To 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;
- To 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;
- To 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;
- To improve members' health outcomes by coordinating care efficiently across the plan and with medical, behavioral, and non-medical social supports and providers, with one member ID card; and
- To develop effective, efficient operations that leverage strong interpersonal and technical communications to deliver high-quality clinical and non-clinical care.

Providers must comply with federal and state regulations. They will receive information and be expected to attest to their understanding of the INTEGRITY (MMP) program and cultural competency expectations.

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 (LTSS). In addition, Neighborhood will provide Medicare Part D and over-the-counter drug benefits, through the INTEGRITY (MMP) formulary.

If applicable, members who receive LTSS will be responsible for any patient share that EOHHS determines. Detailed information on INTEGRITY (MMP) benefits is available on Neighborhood's website, www.nhpri.org/INTEGRITY.

INTEGRITY (MMP) Pharmacy Program

As part of the contract providers must comply with all CMS regulations that govern the INTEGRITY (MMP) product including all Medicare Part D requirements. This section outlines the 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 contracts with CVS/Caremark, a national pharmacy benefits management company, to administer the Medicare Part D pharmacy benefit provided to INTEGRITY (MMP) members. In addition to many smaller independent pharmacies, Neighborhood's pharmacy network includes CVS, Walgreens, Walmart, and many others. A complete list of contracted pharmacies is available via the "Find a Doctor" tool on our website, **www.nhpri.org**.

Formulary

The INTEGRITY (MMP) formulary is CMS-approved to include Medicare Part D and over-the-counter drugs. Please refer to Neighborhood's website for more information at **www.nhpri.org/INTEGRITY.**

Prescribers of Medicare Part D Drugs

As of January 1, 2019, CMS is requiring physicians and eligible professionals who prescribe covered Part D drugs be enrolled in Medicare or have a valid record of opting out of Medicare, in order for their prescriptions to be covered under Part D per 42 CFR.423.120(c)(6).

Prior Authorization

Medications on the INTEGRITY (MMP)-approved Medicare Part D and supplemental formularies may require prior authorization before a pharmacy can fill the prescription. Information on how clinicians may request prior authorizations are available at **www.nhpri.org/INTEGRITY**. Information regarding grievances, appeals and exceptions are also available.

Step Therapy

In support of efforts to provide members with the best medical care, Neighborhood has developed step therapy programs that apply to the INTEGRITY (MMP) formulary. These programs initiate drug therapy for a medical condition with the most cost-effective medication and require the use of a sequence of alternative drug therapies as a preceding option fails.

Transition Policy

Neighborhood will provide an appropriate transition process 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 are not on the formulary or require a prior authorization, step therapy or quantity limit edit. Some exceptions apply due to patient safety and the need to confirm that certain drugs are being used for medically accepted indications.

Continuity of Care for INTEGRITY Members

INTEGRITY (MMP) members may continue to see their current health care provider for at least six months after their enrollment during the continuity of care (CoC) period. If you are currently a non-participating provider and caring for an INTEGRITY (MMP) member during their CoC period, Neighborhood invites you to consider becoming an in-network provider. For more information on becoming a Neighborhood provider, please visit the Join Our Network web page via the following path:

www.nhpri.org/Providers > Join Our Network

Medication Therapy Management Program

Neighborhood offers a Medication Therapy Management (MTM) program to members who meet CMS required criteria or plan-specific criteria and have chronic diseases such as asthma, diabetes, or chronic heart failure. If members meet these qualifications, they may be eligible for a comprehensive medication review, telehealth consultation or additional mailings.

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. The goal of the Integrated Care Initiative (ICI) Ombudsman is to ensure that members:

1. Understand their rights;
2. Get help accessing services; and
3. Get help resolving complaints.

The ICI Ombudsman will work closely with and coordinate with the other agencies that are working with consumers who are eligible for and/or enrolled in the Integrated Care Initiative.

RIPIN Healthcare Advocates can be reached Monday – Friday, 8 a.m. to 5 p.m. by calling toll-free 1-855-747-3224 or emailing HealthcareAdvocate@ripin.org.

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.

The State works with the independent Enrollment Counselor and the Ombudsman program to ensure ongoing outreach, education, and support to individuals eligible for the Demonstration.

Providers can receive more information with The POINT/Medicare-Medicaid Counselors by calling 401-462-4444 (TTY 711) during the following hours: Monday – Friday, 8:30 a.m. – 5:00 p.m.

Quality Improvement

Neighborhood's Quality Improvement Program strives to ensure 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.

Neighborhood's INTEGRITY Quality and Operations Committee monitors and review the operations and improvement activities of INTEGRITY. Providers are responsible for ensuring compliance with quality improvements standards. Providers must meet specific levels of quality outcomes using evidenced-based practices.

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

Mandatory Reporting

Neighborhood's INTEGRITY (MMP) 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.

Alternative Payment Arrangements

One of the goals of the INTEGRITY (MMP) duals demonstration is to promote alternative payment models (APM) to transform the delivery of high-quality and cost-effective care within CMS requirements. An APM is a method of payment not solely based on fee-for-service reimbursement, and may include, but shall not be limited to, bundled payments, pay-for-performance, and shared-savings programs. As part of the duals demonstration, Neighborhood is required to utilize APMs to support this delivery system transformation. Neighborhood will collaborate with its network providers in the development of APMs.

Medical Management

The Medical Management department is responsible for ensuring positive patient outcomes by addressing and supporting member's medical and social needs in the most cost effective and efficient way. Medical Management handles many requests including, but not limited to: notification of inpatient admissions or other services requiring prior authorization, inquiries about utilization management policies and procedures, and requests for additional information needed for medical review decision making.

As one of many efforts to improve transitions of care for members, facilities are required to fax Neighborhood a copy of the transition of care document (Rhode Island Department of Health CoC Form) at member's discharge to another setting (hospital, SNF, etc.)

During the transition period, Neighborhood 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' CoC 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.

A fax line is available to members and providers both during and outside of normal business hours for inbound communications and access to Neighborhood's Medical Management Department twenty-four (24) hours a day, seven (7) days a week.

Department staff is physically available from 8:30 a.m. – 5:00 p.m. during normal business hours to receive inbound communication and conduct outbound communication.

A phone messaging system is in place for requests/inquiries both during and outside of business hours. Providers can call 1-800-963-1001 for assistance.

Note: During implementation member's transition period, authorizations already in place for RHO members transitioning to Neighborhood will be honored for a period of six (6) months.

Authorization Requirements for INTEGRITY

Certain benefits for INTEGRITY members require prior authorization. These benefits include both skilled and unskilled services. Please refer to the following documents on the Neighborhood website to determine which services require prior authorization:

Prior Authorization Information: **www.nhpri.org/Providers** > **Policies and Guidelines** > **Prior Authorization Information**

Prior Authorization Request Forms: www.nhpri.org/Providers > **Provider Resources** > **Forms**

Member Billing and Hold Harmless Provisions

Providers accept the lesser of the Neighborhood fee schedule or the provider's billed charges as payment in full. Therefore, providers cannot bill or balance bill members for covered services. Other than allowable co-payments, coinsurance, cost shares or deductibles for certain lines of business, in no event can the provider bill, charge, or have any recourse against Neighborhood members in full or in part, for services provided by the provider under their agreement with Neighborhood. Providers may not bill members for missed appointments.

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.

Care Management for Nursing Home Residents

Neighborhood works in partnership with nursing home social workers and admission staff to ensure INTEGRITY members have access to all available resources to make informed decisions about their health and care. The Care Management department consists of various professionals, all dedicated to assisting members in accessing health care in the most appropriate cost-effective setting while achieving their health and wellbeing goals.

The department has RNs, Social Workers, a Community Care Coordinator, a Housing Specialist and Rehab Specialists all available to help nursing homes assess members' needs, help in obtaining needed services, transitioning from one level of care to another, help guiding members through health care and social services systems. The Care Managers contact members and providers primarily in person or by phone, depending on need and situation. The Care Managers collaborate with all participants of the member's care team (PCP, specialists, agencies, nursing facilities, family) to increase communication and decrease duplication. Referrals come from internal data mining, providers, or members. The following responsibilities will help define this collaboration.

Neighborhood care management staff responsibilities include:

- The Skilled Nursing Medical Manager confirming admission of an INTEGRITY member upon notification and scheduling a visit to facility to initiate collaboration;
- Partnering with facility staff to meet with members and or family;
- Assisting the facility staff and member to develop a discharge plan and make referrals for community-based services and supports when indicated;
- Assisting facility staff in the completion of any program applications (e.g., waivers, Rhode to Home);
- Ensuring member is connected to a PCP and other specialists as needed;
- Ensuring long-term care counseling is provided;
- Assisting with identifying affordable housing options for members transitioning to the community, if indicated;
- Providing ongoing care management to members transitioned to the community through The Rhode to Home program

Nursing facility responsibilities include:

- Providing Neighborhood staff with access to members and their records;
- Assisting Neighborhood in identifying members for discharge opportunities;
- Partnering with Neighborhood in discharge planning meetings;
- Assisting Neighborhood in identifying a member's strengths, needs and goals;
- Partnering with Neighborhood in developing a discharge plan and plan of care;
- Assisting with making referrals to community providers.

Care Management for INTEGRITY Members Residing in the Community

Neighborhood works in partnership with members, community providers and agencies to ensure that INTEGRITY members have access to all available resources to make informed decisions about their health care. The Care Management department consists of various professionals, all dedicated to assisting members in accessing health care in the most appropriate, cost-effective setting while achieving their health and wellbeing goals. The department has RNs, Social Workers, Community Care Coordinators, Peer Navigators, Housing Specialists and Rehabilitation Specialists all available to help address members' medical, behavioral and social needs, assist in obtaining needed services, assistance in transitioning from one level of care to another, or help in guiding members through the health care and social services systems. The Care Management staff contacts members and providers by phone or in person, depending on the need and situation. The Care Managers will coordinate all participants of a member's care team (PCP, specialists, agencies) in order to increase communication and decrease duplication. Referrals come from internal data mining, providers, or members.

The following responsibilities will help define the collaboration for care management for INTEGRITY members residing in the community:

- All INTEGRITY members classified as low to moderate risk receive an initial health screen referred to as a Health Risk Assessment to determine their strengths, weaknesses, goals and needs;
- All INTEGRITY members receiving long-term services and supports or determined to be high-risk receive a comprehensive functional needs assessment to determine their strengths, weaknesses, goals and needs;
- Medical Care Managers refer to and collaborate with providers, social/community agencies, members, and their significant others to ensure members' needs are met;
- Medical Care Manager develops a plan of care to be shared with all involved participants of the interdisciplinary care team that the member identifies during the assessment process.

Marketing Guidelines

Neighborhood's contract with CMS and EOHHS defines specific requirements on how we and our providers are allowed to market and advertise the INTEGRITY (MMP) plan. Provider affiliation announcements made by providers may not include any marketing content (ex., providing cost sharing, use promotional language, etc.) Providers must comply with all regulations set forth in the CMS Medicare Communications and Marketing Guidelines (MCMG) including any limited English proficiency provisions. Please contact Neighborhood prior to beginning any communication or marketing initiative.

Provider Education and Training

Prior to treating members (or within 60 days of notification), and annually thereafter, Neighborhood providers are required to complete the provider training requirement. The provider training offers an overview of Neighborhood, including its plans, policies, and procedures for providers. In addition, the training includes specific education for providers who serve INTEGRITY members, on topics including, but not limited to the following:

- Member Enrollment and Eligibility
- Covered Services, Benefit and Services (including carved-out), Policies and Procedures
- Provider Rights and Responsibilities pertaining to:
    - Complaints, Grievances, and Appeals Procedures and Timelines
    - ADA Compliance, Accessibility and Accommodations
    - Cultural Competency

After viewing and understanding the contents of the training, an authorized representative from each provider organization must complete the training and attest to having done so. The authorized representative also attests that he/she will educate his/her employees using Neighborhood's training. The attestation is completed via e-form and can be accessed on our website via the following path:

www.nhpri.org/providers > **Provider Resources** > **Provider Training**

The provider and/or authorized representative can choose to complete the training by reviewing the training program (recording or PDF) or attending a provider training webinar.

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

Providers must also 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.

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 Complaints and Appeals section, above. However, this section 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:

1. 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). These procedures include reconsideration (internal appeal) by Neighborhood, and if necessary, an independent review entity (MAXIMUS), hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC) and judicial review. Please note that Part B Medication Appeals fall into the Part C appeal category.
2. 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). These procedures include redetermination (internal appeal) by Neighborhood or our delegated entity, CVS Caremark, reconsiderations by the independent review entity (MAXIMUS Federal Services, Inc.), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.
3. 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.
4. A clinical appeal is a request for reconsideration of an initial adverse clinical organization determination.
5. 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

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.

The Grievances and Appeals Unit receives and reviews the appeal request and, if needed, will request additional documentation.

The member can identify an Authorized Representative (AOR) to act on their behalf during the appeal process.

Note: If the member does have an AOR or activated Power of Attorney, all correspondence regarding the appeal must be sent to the AOR.

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. Decisions on standard appeal requests may not exceed 30 calendar days for pre-service requests and must not exceed 60 calendar days for post-service requests from the date the appeal request was received by the Plan. Effective January 1, 2020, the turnaround time Part B Medication appeals is 72 hours for expedited and seven (7) calendar days for standard. At the conclusion of the appeal investigation, all interested parties are notified of the appeal disposition via written correspondence and are provided with additional appeal rights, if available.

Neighborhood can extend a service review time frame up to 14 calendar days, but only if the extension is requested by the member or if Neighborhood determines the delay is in the best interest of the member. For example, an extension may be appropriate if additional diagnostic testing or consultation with medical specialists is pending. Effective January 1, 2020, extensions are not allowed for Part B Medication appeals.

Note: Lack of availability of plan provider medical records is not an acceptable reason for delay in rendering an appeal decision. If the organization determination was not overturned, and the service may be covered by Medicare, the notice informs the member that all relevant information was forwarded to the CMS Independent Review Entity (IRE) contractor, MAXIMUS Federal Services, Inc.

Note: Forwarding an appeal to Maximus does not apply to services or supplies which are covered by Medicaid-only. For services or supplies covered by Medicaid-only, interested parties to the appeal are notified of additional external appeal rights.

Standard Member Appeals Procedure for Services Covered by Part D

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.

The CVS Caremark Coverage Determination and Appeals Department receives and reviews the written appeal and, if needed, will request additional documentation.

The member can identify an Authorized Representative (AOR) to act on their behalf during the appeal process.

Note: If the member does have an AOR or Legal Representative, all correspondence regarding the appeal must be sent to the AOR.

The CVS Caremark Coverage Determination and Appeals Department completes the investigation as expeditiously as the member's health condition requires, not exceeding 72 hours for expedited appeals or seven (7) calendar days for standard appeals from the date the redetermination request was received. No extensions are allowed for Part D appeals.

The member/AOR receives written notice within the above turnaround time frames regardless of whether or not the coverage determination was overturned.

If the coverage determination was not overturned and the drug may be covered by Medicare, the notice informs the member of the right to submit a reconsideration request to MAXIMUS Federal Services, Inc. Included with the decision notice is a Request for Reconsideration notice for the member to send to MAXIMUS Federal Services, Inc.

Independent Review Entity (IRE) Review and Additional Appeal Levels for Services Covered by Medicare:

1. MAXIMUS Federal Services, Inc. is the Independent Review Entity (IRE) that reviews the information provided by Neighborhood and requests any additional documentation needed from either CVS Caremark/Neighborhood or the member. C2C Innovative Solutions, Inc. is a separate entity from the QIO, which (in this area) is Acentra Health.
2. MAXIMUS Federal Services, Inc.'s reconsideration determination is final and binding, unless a request for a hearing before an Administrative Law Judge (ALJ) is filed within 60 calendar days of receiving the reconsideration notice.
3. Anyone, including CVS Caremark/Neighborhood, can request a judicial review (after notifying other parties) of an ALJ decision, if the amount in controversy meets the appropriate threshold (new thresholds are published by CMS every fall) and the Medicare Appeals Council (MAC) denied the member's request for review.

Any decision by CVS Caremark/Neighborhood, MAXIMUS Federal Services, Inc., the ALJ, or the MAC can be reopened for good cause when requested within CMS Regulation time frames. Once a revised determination or decision is issued, any party can file an appeal.

Fast-Track Appeals for Services Covered by Medicare

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

Acentra Health
5201 West Kennedy Blvd.
Suite 900
Tampa, FL 33609
Toll-free Phone: 844-319-8452
TTY: 711
Toll-free Fax: 844-878-7921

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 Acentra Health renders a decision. Acentra Health may be contacted by the member or member's representative, attorney, or court-appointed guardian (either by telephone, in writing, or by fax). Acentra Health is authorized by Medicare to review the services noted above provided to the INTEGRITY member.

When the member contacts Acentra Health 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.

The delivery of a valid NOMNC with specific supporting documentation from the medical record that support the member's discharge from the services noted above will be required for payment of claims for these services for INTEGRITY members. This ensures that all CMS and Neighborhood documentation requirements are being adhered to and to ensure that documentation in the medical record supports the discharge plan. Failure to submit the required components of the medical record and a valid NOMNC upon request by Neighborhood after a Fast Track Appeal has been filed with Acentra Health may result in the denial of the claim for the services noted above.

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.

Please refer to the "Acentra Health Fax Cover Sheet for Fast Track Appeals" for the required medical record documentation list located on the Acentra Health webpage www.acentraqio.com. All sections of the medical record are to be faxed to Neighborhood's Grievance and Appeal Unit at (401) 709-7005.

The specific documentation from the medical record that supports the member's discharge from the current level of services will be required for payment of the claims is as follows:

- Valid IM or NOMNC
- Medical record – at a minimum must include all of the following:
    - All items listed on the Neighborhood Medical Record Collection Sheet for Fast-Track Appeals
        - An attending provider (e.g., MD or NP) progress note – written within two (2) calendar days of delivery of IM or NOMNC, and must include all of the following: A statement that the member's current condition is stable and they are ready for discharge;
        - A statement that member no longer requires or will no longer benefit from current level of services;
        - An outline of the member's discharge plan; where he/she will be discharged to and what the transition of care plan is;
        - A statement that addresses any open medical issues and how they are going to be managed;
        - An attending provider's order to discharge patient from the current level of services, documented in the medical record by the date that the IM or NOMNC is issued;
        - A progress note from each applicable rehabilitation service (PT, OT, ST) which describes the patient's current functional level, stability of their medical condition and a description of the discharge plan including any treatments to be carried out after discharge (examples - met goals, will no longer benefit from current level of services, will be discharged home with outpatient rehab services, will remain at facility at a custodial level, etc.).

During the fast-track appeals process, the member is not to be held financially responsible for coverage of the requested services until an appeal determination has been made by Acentra Health.

If Acentra Health agrees with the member and overturns the decision to discharge, the member will be reinstated. The process recommences if/when the member is ready to be discharged again.

Neighborhood monitors compliance with the time frame associated with Acentra Health hospital discharge appeals. If the member misses the Acentra Health deadline (up until 12:00 p.m. on the day of discharge), he/she has the right to call Neighborhood Member Services at 1-844-812-6896 to request an expedited appeal. Neighborhood generally makes a decision on expedited appeals within 72 hours. During the expedited appeal process, the member is not to be held financially responsible for coverage of the requested services until an appeal determination has been made.

Standard and Expedited Appeals for Services Covered by Medicare and Medicaid

General Appeal Information

A Neighborhood member, a member's authorized representative, or provider acting on the member's behalf, can appeal any of the procedures that deal with the review of adverse organization determinations or coverage determinations a member believes he/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 member).

In most cases, the organization determination and coverage determinations are final unless a member contacts Neighborhood within 60 calendar days of receiving the determination, (or longer, if there is a reason for a good cause extension). If a member requests reconsideration (appeal) of a denial, we follow the Standard Member Appeals Procedure for Services Covered by either Medicare or the Standard Member Appeals Process for Services Covered by Medicaid or a combination of both Standard Member Appeals Procedures. The appeal takes place after the adverse organization determination has been issued by Neighborhood.

Standard appeals are decided as soon as the member's health requires and within 30 days of receipt for pre-service or within 60 days of receipt for post-service and/or payment appeals. Effective January 1, 2020, Part B Appeals are decided within 7 days of receipt.

Expedited Appeals

An expedited appeal is a review of a time-sensitive adverse organization determination or coverage determination that a member believes that he/she is entitled to receive, including:

- Any delay in providing, arranging for, or approving health care services/medications that would adversely affect the health of the member;
- Reduction or stoppage of treatment or services that would adversely affect the member's health.

Note: Time-sensitive is defined as a situation in which applying the standard decision time frame could seriously jeopardize a member's life, health, or ability to regain and/or maintain maximum function.

Members, their authorized representatives, or any treating or prescribing physician (regardless of whether the provider is affiliated with Neighborhood) can request an expedited appeal. Verbal and written requests for expedited appeals are accepted.

If the request meets the necessary time-sensitive criteria, a decision will be made within 72-hours of receipt of the request, unless an extension is needed. Extensions of up to 14 calendar days can be granted if in the best interest of the member. **Note**: Extensions are not allowed for expedited Part D appeals or Part B Medication appeals.

Quality of Care Grievances (Clinical Complaints Filed by INTEGRITY Members)

Per regulatory guidelines and as part of Neighborhood's commitment to ensuring member satisfaction and safety, we have established a forum for members or authorized representatives to express concerns regarding their experiences with health care providers. The member grievance procedure, allows for the documentation and review of member grievances related to quality of care or quality of services, as follows:

Upon receipt of a verbal or written quality of care complaint, the Grievance and Appeals Unit acknowledges in writing that the complaint was received and will be reviewed within 30 calendar days.

All grievances pertaining to clinical care and/or service issues are reviewed within the Quality Assurance Committee which reports to the Medical Director.

As noted in the Appeals and Grievance Section above, all administrative grievances pertaining to operations and activities of Neighborhood or Neighborhood providers/vendors are reviewed within the Grievance and Appeals Unit.

The Quality Assurance Committee and Grievance and Appeal Unit can accept any information or evidence concerning a grievance orally or in writing and collaborate to ensure all aspects (clinical and administrative) of member grievances are addressed.

In most instances, providers or their office managers (depending on the specific situation) are notified either verbally or in writing about the complaint and asked for input.

All grievances are entered into our secure system of record for tracking and trending purposes. This data may become part of the provider's credentialing file.

It is the responsibility of all network providers to participate in our grievance review process.

Please note that the outcome of a quality of care investigation will not be shared with members due to peer review laws protecting the confidentiality of the investigation, outcome/findings. Additionally, quality of care investigations may result in recommendations for provider/facility process improvement and/or Corrective Action Plans (CAP) to ensure the safety of all members.

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.

Response due dates are established to ensure that Neighborhood meets its regulatory and accreditation requirements to ensure continued adherence with all state and federal (CMS) requirements.

If a member is dissatisfied with the response from our Quality Assurance Committee, they may contact Rhode Island's Quality Improvement Organization (QIO) Acentra Health.

Quality Improvement Organization Complaint Process for Services Covered by Medicare

For Neighborhood members concerned about the clinical quality of the care received, members or their AOR can also file a complaint with the Rhode Island Quality Improvement Organization (QIO) Acentra Health at 1-866-815-5440. QIOs, such as Acentra Health, are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. Acentra Health is the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Rhode Island. The Acentra Health review process is designed to help prevent any improper practices. This process is separate and distinct from the Neighborhood grievance (complaint) process.

The QIO is under contract to the CMS to conduct medical reviews and other functions with respect to Medicare beneficiaries.

Acentra Health

Acentra Health is responsible for the quality of care review of services provided to Rhode Island Medicare patients enrolled in Medicare products with CMS. This includes INTEGRITY members.

Acentra Health maintains a review system to ensure that services provided to Medicare beneficiaries enrolled in Medicare health plans are of adequate quality across all settings. This review system addresses the following issues:

- Appropriateness of treatment
- Potential for under-utilization of services
- Accessibility to services
- Potential for premature discharge of patients
- Timeliness of services provided
- Appropriateness of the setting for the provision of services
- Appropriateness of Neighborhood's activities to coordinate care, such as the adequacy of discharge planning and follow-up of abnormal diagnostic studies

Acentra Health will notify Neighborhood regarding issues that include results of Acentra Health's review activities, unless otherwise specified in the Acentra Health/CMS contract. These issues will be identified as quality of care concerns or documentation concerns.

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