Neighborhood Provider Training

A curriculum designed for all network providers with focused training on Neighborhood's dual special needs plans.

Effective 2026

Neighborhood Health Plan OF RHODE ISLAND™

Speakers

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1

Training Overview

What You'll Get From this Session

- Understanding of provider responsibilities in doing business with Neighborhood
- Overview of Neighborhood's product offerings and eligible members
- How to deliver coordinated, person-centered care that fully aligns with the Model of Care (MOC) supporting high-quality outcomes for D-SNP members
- Resources for navigating questions about claims payment, authorizations and appeal rights for providers and members

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How to Comply With the Training Requirement

1. Prior to treating members and annually thereafter, Neighborhood providers must complete this provider training requirement.
2. An authorized representative from each provider organization must complete the training and attestation. By attesting, the representative has agreed to review Neighborhood's training with all providers in their organization who provide direct member care.
3. Maintain log of training participants as this information may be requested for auditing purposes.

Options for completing the training are noted on the Provider Training Page and include training webinars and self-guided reviews

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2

Neighborhood Products

Neighborhood Member Plans

Medicaid Plans

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

- 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.

Commercial Plans

Plans for small businesses, individuals and families cover all essential health benefits at an affordable price.

- Neighborhood Commercial members have different cost-sharing and benefits based on the plan variation in which they are enrolled.

Neighborhood Member Plans

Neighborhood INTEGRITY for Duals (HMO D-SNP) – New for 2026

A fully integrated dual special needs plan (FIDE-SNP) that integrates ALL covered **Medicare and Medicaid** managed care benefits into one plan. INTEGRITY (MMP) members will automatically transition to INTEGRITY for Duals on 1/1/26.

- ❑ Members enrolled in Neighborhood INTEGRITY for Duals will have their Medicare and Medicaid claims processed by Neighborhood without the provider having to resubmit the claim for Medicaid payment.

Neighborhood Dual CONNECT (HMO D-SNP) – New for 2026

A coordination-only dual special needs plan (CO D-SNP) where only **partial dual eligible individuals** who participate in the Rhode Island Medicare Premium Payment Program are eligible.

- ❑ Neighborhood manages the Medicare portion, while providers must submit copays/coinsurance amounts and **Medicaid only** benefits to the RI EOHHS for reimbursement. **Providers can not bill members for cost-share.**

For more information about benefits under these plans please refer to the Member Materials page for INTEGRITY for Duals and Dual CONNECT.

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What is a Dual Special Needs Plan (D-SNP)?

A Medicare Advantage plan designed for individuals who qualify for both Medicare and Medicaid.

D-SNP plans help members get the care and services they need, with better coordination and support.

Required to follow a Model of Care (MOC) that includes health risk assessments, individual care planning, and interdisciplinary care teams.

Providers play a key role in helping D-SNPs deliver person-centered, coordinated care.

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Who Can Enroll in D-SNP Plans?

INTEGRITY for Duals

- Age twenty-one (21) or older, or anyone with disability; and
- Individual incomes at or below 120% FPL monthly income limit $1,565
- Entitled to or enrolled in Medicare Part A; and
- Entitled to or enrolled in Medicare Part B; and
- Eligible for full Medicaid benefits under the Rhode Island Medicaid State Plan
- INTEGRITY (MMP) members will automatically transition to INTEGRITY for Duals on 1/1/26.

Dual CONNECT

- Enrolls a new population of Neighborhood members
- People 65 or older, and 18+ with disabilities
- Individual incomes below 100% FPL, Individual monthly income limit $1,304
- Entitled to or enrolled in Medicare Part A; and
- Entitled to or enrolled in Medicare Part B; and
- Eligible for Partial Medicaid benefits under the Rhode Island Medicaid Plan

Deemed Eligibility

- A temporary period where members continue to receive Medicare Advantage benefits after losing Medicaid eligibility.

  - ❖ INTEGRITY for Duals (90 days)
  - ❖ Dual CONNECT (30 days)

- Medicaid benefits, cost-sharing and premium coverage may be paused during this time. Members may be responsible for out-of-pocket costs or increased cost-sharing for Medicare covered services.

- Neighborhood works with members to restore Medicaid eligibility and adjusts claims once it's reinstated.

Pharmacy

- Neighborhood maintains separate formularies by line of business, available at nhpri.org. Certain drugs require prior authorization, step therapy, or have quantity limits.
- Specialty medications for Medicaid and Commercial members must be filled through an approved specialty pharmacy network.
- **Effective 1/1/26, D-SNP plans** will have copays for Part D prescription drugs depending on the plan and the member's low-income subsidy (LIS) level:

INTEGRITY for Duals	Dual CONNECT
• $0 cost share for tier 1 (Preferred Generic) and Tier 2 (Generic) • Tiered cost-share for Brand-name drugs, non-preferred drugs and Specialty medications (Tiers 3-5) (25% or LIS copay)	• Cost-share for all drugs (25% or LIS copay)

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Extra Supplemental Benefits

1. Dental (Neighborhood INTEGRITY for Duals only)

$1250 Annual Allowance offered by Delta Dental of Rhode Island. Comprehensive Services included but not limited to: preventative, diagnostic and restorative services, in addition to RI FFS Medicaid Benefit.

2. Over-the-Counter Medications

- $25 monthly amount (Neighborhood Dual CONNECT)
- $28 monthly amount (Neighborhood INTEGRITY for Duals)

3. Fitness Benefit

Gym memberships with select YMCA locations that include a fitness tracker.

4. Post Discharge Meals-

This benefit covers up to fourteen meals for two weeks and is limited twice per year after a discharge from an inpatient hospitalization or surgery.

5. Chronically Ill Enrollees:

- Healthy Food: $125/month non-rolling allowance on their Soda Health debit card
- 120 hours of iADL support through Papa Pals (Neighborhood INTEGRITY for Duals)

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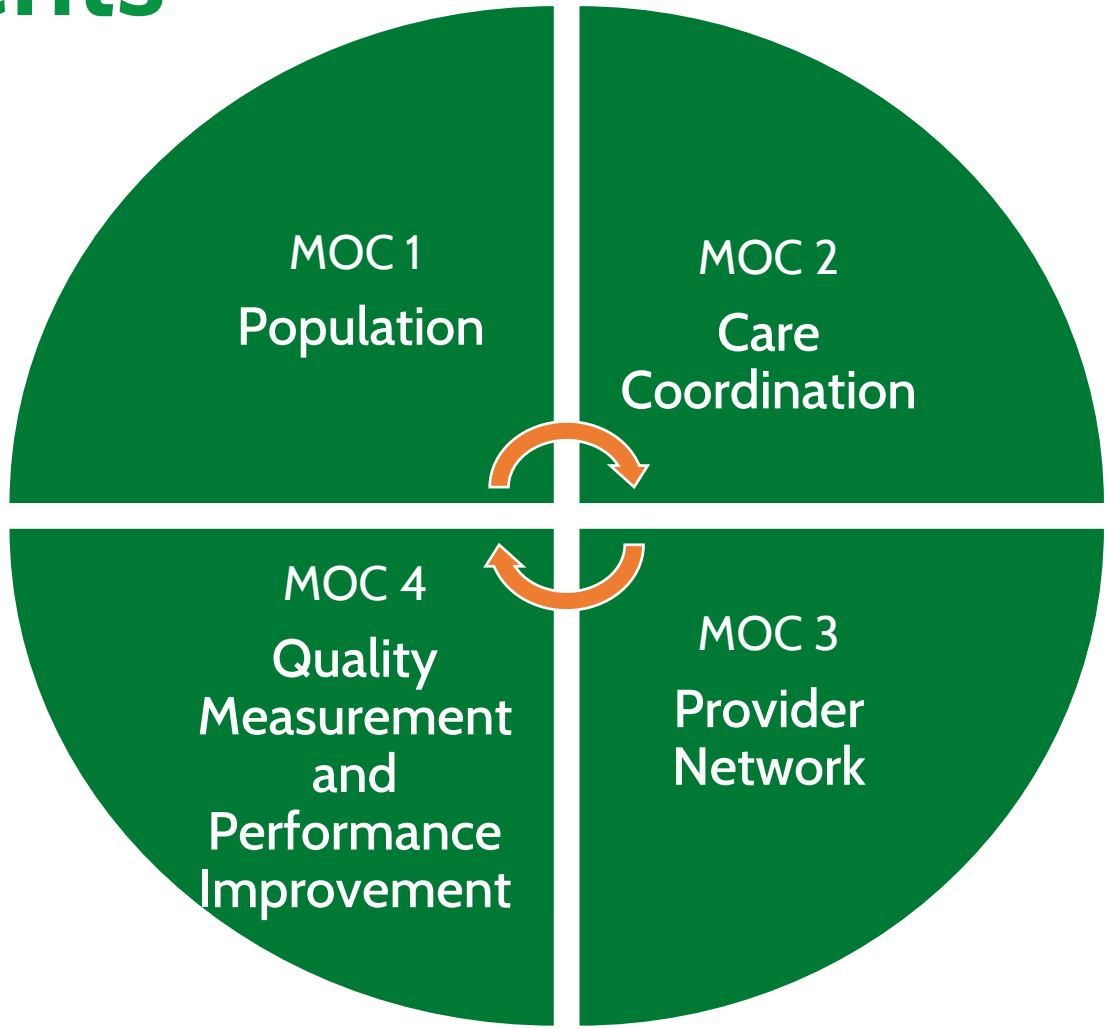
3

D-SNP Model of Care

D-SNP Model of Care (MOC) Elements



Model of Care Elements

- Defines who qualifies for the D-SNP
- Describes common characteristics
- Outlines language needs, cultural considerations and literacy levels
- Informs risk stratification and tailoring of care plans based on population complexity

MOC 1

Population

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Model of Care Elements

MOC 2

Care Coordination

- Staff structure and oversight
- Staff training
- Health Risk Assessment (HRA)
- Face to Face encounters (F2F)
- Interdisciplinary Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Transitions of Care (TOC)

Model of Care Elements

MOC 3

Provider Network

- Robust Provider Network
- MOC Training
- Clinical Practice Guidelines (CPGs)
- Transition of Care Protocols

Model of Care Elements

MOC 4

Quality Measurement & Performance Improvement

- Quality Performance Improvement Plan and Process
- Identification and Measurement of goals and health outcomes

Care Manager Support

*Your **partner** in coordinating whole-person care*

Provider Role in Care Coordination

Partnering with the Care Manager

HRA	ICP	ICT
Encourage members to complete the HRA Share relevant clinical updates (new diagnoses, hospitalizations) Notify the Care Manager of concerns or condition changes	Review and update the ICP with the Care Manager Ensure goals and treatment plans reflect patient priorities Alert the Care Manager to adjust the plan when needed	Participate in the ICT discussions for high-risk members Share progress, barriers, and treatment recommendations Help align care across providers involved in a member's care

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Care Coordination

Face to Face Visits

- Conducted at least annually to support care coordination and care planning
- Assesses member's physical, mental, functional, and environmental status
- Findings are used to validate and update the Health Risk Assessment (HRA) and individualized care plan (ICP)
- Supports integrated care management across Medicare and Medicaid
- Telehealth is acceptable when clinically appropriate and aligned with member

Required for both FIDE and Coordination-Only D-SNPs

Care Coordination Process

Transitions of Care (TOC)

Neighborhood's TOC Team Leads Coordination

Manages and coordinates all aspects of member transitions, ensuring timely, safe, and seamless continuity of care.

Provider Partnership Is Critical

Although the TOC team initiates and facilitates the process, active provider collaboration is essential to success. Providers play a vital role in executing the care plan, closing gaps, and ensuring members remain supported through every step of the transition.

Care Coordination Process
Transitions of Care (TOC)

Triggers	Actions	Requirements
Hospital admissions Discharges Changes in health status	Providers are expected to collaborate with the care coordination team Follow-up appointments Timely post discharge outreach (48 hours) Medication reconciliation	Must address both Medicare and Medicaid services, especially for LTSS or behavioral health needs Notify care manager when aware of a member's admission or discharge

Enhanced requirements for FIDE SNPs; still required for Coordination-Only D-SNPs

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TOC Team Responsibilities

Transitions of Care Protocols

Shares relevant ICP and discharge info with the PCP and receiving providers (e.g., SNF, HHA) to ensure smooth hand-offs and continuity.

Routine Follow-Up

Coordinates follow-ups with providers and members post-discharge. Helps ensure care appointments are scheduled, and necessary tests are ordered.

Care Manager Contact Information

Provides direct contact information to for any care coordination questions or urgent needs.

TOC Provider Responsibilities

Review and Act on TOC Communications Promptly
Collaborate with the TOC team when communication is initiated
Review discharge summaries and care instructions in a timely manner
Allow for and Prioritize Post-Discharge Follow-Ups
Ensure availability for follow-up appointments, labs, and services
Help initiate care promptly after discharge to avoid gaps
Coordinate Closely with ICM and the ICT
Participate in Interdisciplinary Care Team (ICT) meetings
Share clinical updates impacting the Individualized Care Plan (ICP)
Identify and Address Gaps in Care
Recommend additional supports or referrals as needed
Communicate care gaps to the Care Manager for prompt resolution

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TOC Provider Responsibilities

Support LTSS and Special Needs Coordination
Report changes in ADLs, caregiver support, or home environment
Assist in monitoring or authorizing home health or personal care services
Ensure Member Understanding and Engagement
Reinforce discharge instructions and medication adherence
Ensure members know their next steps and how to seek help
Document and Escalate Barriers Promptly
Notify Neighborhood of service delays or access barriers
Partner on solutions to maintain care continuity

By engaging fully in these responsibilities, providers help deliver safe, effective, and person-centered care aligned with the Model of Care.

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Advance Directives

- Members can create, update, or revoke advance directives at any time.
- Providers must honor and document these choices.
- Supports member autonomy across all care settings.
- Care teams are responsible for incorporating directives into care planning.
- Ensures compliance with federal and RI state laws.

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Enhanced Integration of LTSS and Behavioral Health

LTSS

- Manages & authorizes Medicaid LTSS (home health, adult day)
- Coordinates with waiver agents, HCBS providers, caregivers
- Ensures in home supports & equipment during transitions

Who's Involved?

- LTSS Providers
- Care Coordinators
- Family/Caregivers

Behavioral Health

- Coordinates Medicaid BH services (CMHSP & contracted providers)
- Collects BH information via HRA and adds to ICP
- Collaborates on crisis planning, medication management, & referrals

Who's Involved?

- BH Providers/CMHSP
- PCPs & Specialists
- ICT Team

State Integration and Member Education

State Integration

- Collaboration with the State to meet requirements for:
  - ❑ **Person-centered planning**
  - ❑ **Freedom of choice**
  - ❑ **Level of Care Determination (LOCD)**
- Medicare and Medicaid services are integrated, reducing duplication in:
  - ❑ **Authorizations**
  - ❑ **Care coordination**
  - ❑ **Service delivery**
- Coordination includes Medicaid-only benefits like dental, vision, non-emergency rides, etc.

Member Education/Advocacy

- D-SNP Care Managers help members:
  - Understand and navigate both Medicare and Medicaid benefits
  - Identify service options across funding streams
- The care model reinforces the member's right to:
  - Choose their providers
  - Decide where care is received

Clinical Practice Guidelines (CPGs)

What Are CPGs?

- Evidence-based recommendations for managing specific health conditions
- Developed from research and national protocols (e.g., ADA, AHA, GOLD, CDC)
- Ensure consistent, high-quality, and effective care across the provider network

Neighborhood's Use of CPGs

- Guidelines publicly available on NHPRI.org and in Provider Manual
- Include Medicare NCDs/LCDs, Medicaid guidelines, and Milliman/InterQual criteria
- Reviewed and approved by the Clinical Affairs Committee and Medical Directors

CPG Provider Responsibilities

How Providers Use CPGs:

- Integrate into care planning and decision-making
- Used in Utilization Management reviews to determine medical necessity
- Guide treatment plans, preventive care, and chronic condition management

When Guidelines May Be Modified:

- Complex comorbidities or contraindications
- Member preferences, religious/cultural factors, or end-of-life considerations
- Frailty or clinical needs of older adults not addressed in standard guidelines

What Providers Must Do:

- Document the reason for deviation in the care plan
- Justify the decision based on clinical need and member goals
- Discuss and align with the ICT and member/family
- Monitor and adjust care based on outcomes and safety

Monitoring and Oversight of CPGs

Neighborhood Monitors Guideline Adherence Through:

- HEDIS, CAHPS, HOS, and Provider Satisfaction Surveys
- Medical record reviews, claims analysis, and UM audits
- Utilization patterns (e.g., ER visits, LOS, DME usage, pharmacy)

Continuous Improvement and Education:

- Clinical Affairs Committee and Medical Director oversee updates
- Quality Improvement team oversees adherence
- Provider performance data shared regularly
- Updates communicated via newsletter, website, and onboarding

4

How to Work With Neighborhood

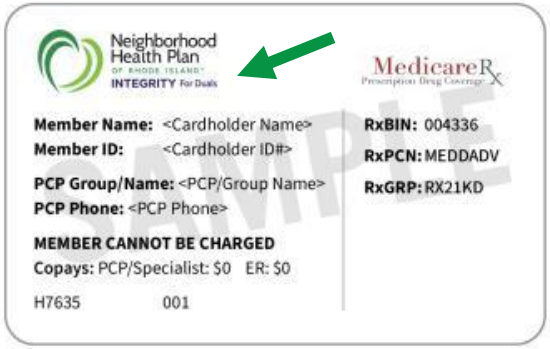
Referrals and Authorizations

Referrals	• Neighborhood does **NOT** require members to have a referral to see specialists
Out of Network Authorizations	• Out-of-network care requires prior authorization. Providers must complete an Out of Network Prior Authorization E-Form to receive approval to refer a member out-of-network
Prior Authorizations	• Use the Prior Authorization Search Tool to determine which services require prior authorization

Member ID Cards

All Neighborhood members are assigned a primary care provider (PCP) displayed on the member's Neighborhood identification card.

Primary care providers (PCP) must verify the member is assigned to the provider group and one of the group's participating PCPs to receive reimbursement for services rendered.



All D-SNP members (both **Neighborhood Dual CONNECT** and Neighborhood **INTEGRITY for Duals**) will be issued new member ID cards in **mid-December** with ID numbers that:

- **Are 12 digits in length**
- **Start with "12" as an identifying prefix**

Claims Submission

- All claims **must be filed electronically** except:

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

  - Medical records
  - Single case agreements

- Complete claims must be received within 180 days from the date of service unless otherwise specified in the provider's contract.

Electronic claims payer ID number for all lines of business (effective 1/1/26):

05047

Paper claims can be mailed to:
Neighborhood Health Plan
of Rhode Island
P.O. Box 28259
Providence, RI 02908-3700

Note: All coordination of benefit (COB) claims, also known as secondary claims, must be submitted electronically.

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Billing Members

Other than allowable co-payments or deductibles for certain lines of business, in **no event can the provider bill, balance bill or have any recourse against Neighborhood members** for services rendered by the provider under their agreement with Neighborhood.

Note: Neighborhood Dual CONNECT members cannot be billed any cost-share due to Qualified Medicare Beneficiary (QMB) status.

Providers may NOT bill members for missed appointments.

Access to Care

Access to healthcare 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 and after hours.

Medical Accessibility Standards for Appointments

Appointment Type	Standard
Emergency care	Immediate
Urgent care	Within 24 hours
Routine care (primary and OB/GYN)	Within 15 business days
Routine care (specialty)	Within 30 business days
Non-emergent, non-urgent, sick visit	Within 7 business days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within 10 calendar days
Physical examination (for **Medicaid** Only)	Within 180 days
Early and Periodic Screening, Diagnostic and Treatment (**Medicaid** Only)	Within 6 weeks
New member (for **Medicaid** Only)	Within 30 calendar days

Mainstreaming/Rights and Responsibilities

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

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

Note: 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.

ADA Compliance

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

Persons with disabilities must have:

- ✓ Access to programs
- ✓ Opportunities for effective communication
- ✓ Physical accessibility (parking, exam rooms, restrooms, etc.)

Neighborhood's approach to ADA compliance includes:

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

Click here for more information on ADA standards for accessible design.

Culturally Competent Member Care

🤔 What is cultural competence?

Understanding and responding to the diverse values, beliefs, and behaviors of the members you serve.

😊 Why does it matter?

- Builds trust and safety with patients
- Reduces health disparities
- Improves care outcomes

Cultural competence enables providers to deliver services that are **respectful** of and **responsive** to the health beliefs, practices and cultural and linguistic needs of diverse patients. Integrating cultural knowledge into standards, policies, and practices leads to better quality of services and outcomes

Becoming a Culturally Competent Provider

1. **Value diversity and acceptance of differences**

   Consider each person as an individual

2. **Be conscious of the impact of bias during interactions**

   Bias can influence how providers interact with patients and impact the quality of care delivered. Recognizing and addressing bias helps ensure equitable, respectful treatment for all members.

3. **Knowledge of member's culture**

   Consider the member and their family's background in determining what services are appropriate. Members may consider and use alternatives to Western health care.

4. **Tailor treatment plans**

   Develop plans that include members race, country of origin, native language social class, age, gender and sexual orientation

Advancing Health Equity

- Neighborhood's 4Report outlines how equity is embedded across the organization. It focuses on two pillars: **Equity4People**, driving internal inclusion, and **People4Equity**, addressing community health disparities.

- A supporting document, the 4Report Scorecard, tracks progress, impact, and next steps. Overall, the 4Report promotes transparency and accountability in advancing equity for all.

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Language Interpreter Services

How to identify patients who require language assistance

- Patient uses your bilingual staff or a family member to assist on phone or in person.
- Patient is quiet, simply says yes or no, or has trouble communicating in English.
- Patient's primary language is documented in the electronic health record as not English.
- Review patients' current or previous record for primary language listed.

How to support patients who require language assistance

- Have "I speak" language identification cards available so patients can easily identify their language option.
- The government offers free downloadable cards in 38 different languages, so you don't have to do the translation work during the identification process

Language Interpreter Services Process

Providers or Members can request interpreter services through Neighborhood via completion of the Interpreter Request E-form

Interpreter services are free of charge and made available by telephone and/or in person

Requests for services must be submitted at least 48-72 hours before patient's appointment.

Sign Language interpreters should be requested 2 weeks in advance.

Member Complaints or Grievances

A complaint or grievance is an oral or written expression of dissatisfaction from a member or his/her authorized representative

- Neighborhood reviews any circumstance that gives the member cause for protest, causes disruption of care, creates anxiety, or leads to dissatisfaction with the plan.
- Members may file a complaint or a grievance verbally or in writing directly with Neighborhood or through an authorized representative.
- Neighborhood's Grievance and Appeals Unit (GAU) contacts the office to allow the provider the opportunity to review the concerns and provide a response.
- The provider is required to comply with Neighborhood's request as soon as possible and within seven (7) calendar days.

Note: This information applies to all lines of business.

Member Administrative Appeals

A member administrative appeal is a request to reverse a non-clinical benefit limitation or adverse determination.

- **Medicaid and Commercial**
  Members who are not satisfied with the outcome of an administrative appeal may request a State Fair Hearing with EOHHS within 120 days of Neighborhood's internal appeal denial.

- **INTEGRITY for Duals and Neighborhood Dual CONNECT**
  Administrative appeals for pre-service decisions or post-service member payment/Direct Member Reimbursement (DMR) services that *may* be considered for coverage under Medicare, will automatically be forwarded to MAXIMUS Federal for second level appeal review in accordance with CMS requirements.

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

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Member Clinical Appeals

Medical Necessity

A clinical appeal is a request for reconsideration of an initial adverse clinical determination rendered by the UM Department.

Appeal Filing Timeframes	
INTEGRITY for Duals and Dual CONNECT	Within 65 days of the date of the initial denial.
Medicaid	Within 60 days of receiving the initial denial
Commercial/Exchange	Within 180 days of the initial denial.

Types of INTEGRITY for Duals and Dual CONNECT Appeals:

- **Part C:** An adverse decision for outpatient services such as procedures and DME.
- **Part D:** An adverse decision for prescription drug coverage (processed by CVS).
- **Fast Track:** A discharge dispute from a skilled nursing facility (SNF) or hospital.

Member Clinical Appeals

Resolution Timeframes

Medicaid and Commercial

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

INTEGRITY for Duals/Dual CONNECT Part B Medication

- **Standard appeals** - resolved within seven calendar days
- **Expedited appeals** - resolved within 72 hours
- **Part B Medication appeals** - NOT eligible for extensions

Provider Appeals

An Administrative Appeal is a request to review and reverse a claim denial due to an adverse reconsideration request decision or an adverse adjustment request decision.

- If either of those requests are denied, an administrative appeal can be submitted.
- These requests must be submitted to Neighborhood within 60 days from the date of the claim denial, reconsideration request denial, or adjustment request denial.

A Clinical Appeal is a request for review of an initial adverse clinical determination, such as services requiring prior authorization or those based on medical necessity.

- Medicaid - (within 60 days of receiving the initial denial)
- Commercial/Exchange - (within 180 days of receiving the initial denial)
- INTEGRITY for Duals and Dual CONNECT - (within 65 days of receiving the initial denial/organization determination)

Quality Improvement

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

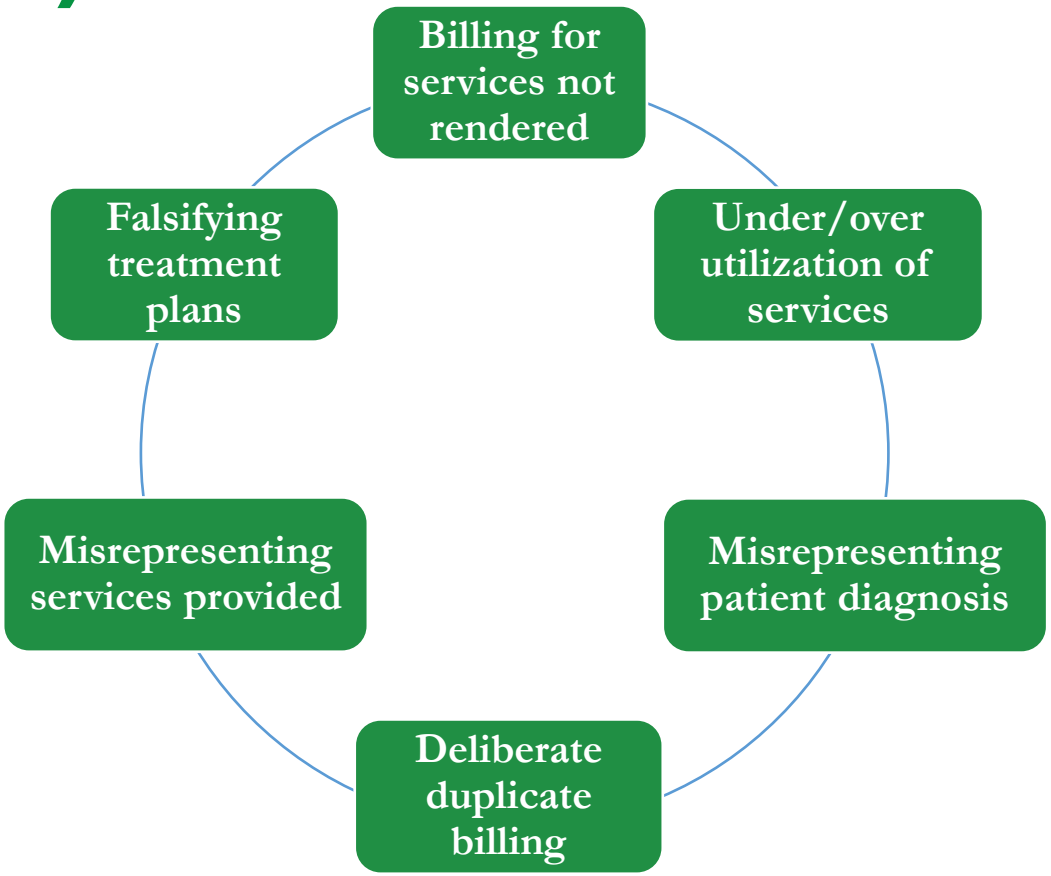
- To meet this goal, Neighborhood's program targets clinical quality of care, member and provider satisfaction and internal operations. Annually the Quality Improvement Program Description is approved by Neighborhood's Board of Directors.
- Providers are responsible for ensuring compliance with quality improvement standards.
- Providers must meet specific levels of quality outcomes using evidence-based practices.

Performance & Health Outcome Measurements

Plan of care completion rate	Network adequacy
Follow up post discharge from acute care facility	Monitoring of complaints, grievances and appeals
Health Outcomes Survey (HOS)	Hospital re-admissions per 1000 members/year
Member involvement in plan of care	Health Effectiveness Data Information Set (HEDIS)
Ambulatory follow-up post SNF or group home discharge	Consumer Assessment of Healthcare Providers and Systems (CAHPS)
Hospital admissions per 1000 members/year	ER visits per 1000 members/year

Identifying Fraud, Waste and Abuse (FWA)

Neighborhood requires compliance with all applicable federal and state laws dealing with fraud, waste and abuse.



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

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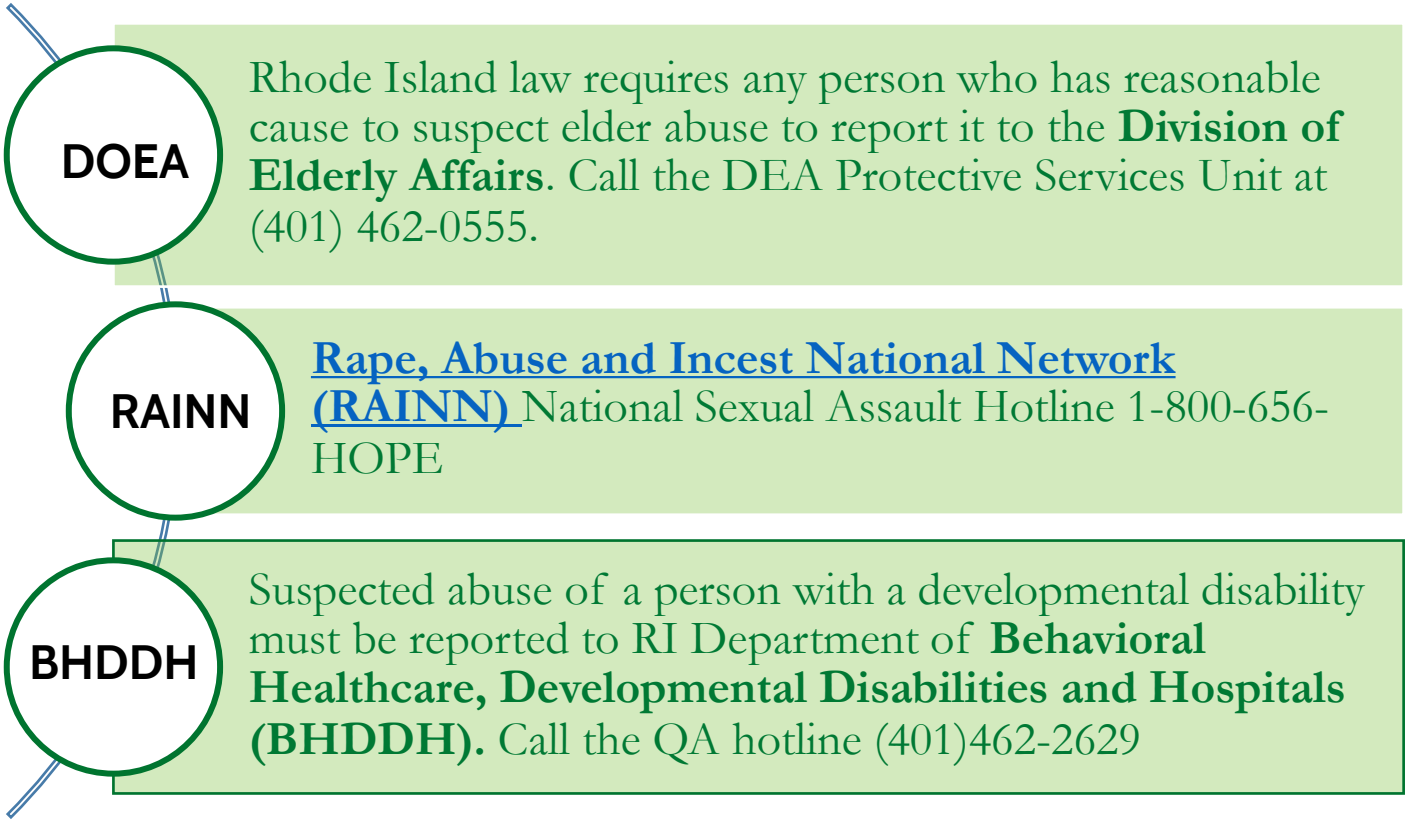
Reporting FWA



Providers may report issues of suspected fraud, waste, and abuse to Neighborhood's Compliance Hotline at (888)-579-1551. Such reports may be made anonymously.

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Key Considerations

Marketing

- CMS and EOHHS have established contractual and regulatory guidelines related to marketing activities such as provider affiliation announcements, locations for marketing activities and the approval of plan marketing materials. **Providers should contact Neighborhood prior to beginning any communication or marketing initiative.**

Critical Incident Reporting

- Providers are required to abide by critical incident guidelines which includes any actual or alleged event that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member.

Privacy/Confidentiality

- Neighborhood's employees are in possession of a broad range of confidential information. Employees have an obligation to protect and properly use all confidential information ethically and in accordance with the law and/or contractual obligations.

Provider Resources

Neighborhood provides various resources to help providers do business with the plan and comply with contractual and regulatory requirements including but not limited to the following:

- D-SNP Provider Resource Page
- Neighborhood Resources (Provider Manual (updated for 2026), Quick Reference Guide, forms, trainings, pharmacy information, payment policies and more)
- NaviNet (Eligibility and claims information)
- Medicaid Manual
- Medicare Manual

Training Attestation

Thank you for completing Neighborhood's annual Provider Training!

- Please click here to attest to your understanding and completion.
- By attesting, the authorized representative has agreed to educate and review Neighborhood's training with all providers in their organization who provide direct member care.
- If you use a social security number as your TIN, the attestation form will **not** auto-populate your NPI and you will be unable to complete the form. We are currently working on a solution for this issue. Please fill out all the required fields and send a screenshot to providercomms@nhpri.org and we will mark you as completed.
- Questions? Email Provider Relations at providercomms@nhpri.org.

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