

2027 Neighborhood Provider Training

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

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

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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Neighborhood Member Plans

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, durable medical equipment, and behavioral health.

HR-1 Updates

- ❖ HR-1 (One Big Beautiful Bill Act) passed in 2025 with a wide variety of impacts, most significantly an increase in renewal cadence and community engagement requirements for the Expansion population in 2027. In 2026, coverage for non-US citizens will be impacted, resulting in statewide loss of an estimated 3,700 Medicaid members.
- ❖ Neighborhood continues to work with state partners to understand compliance and how it can best support its members and community.

Neighborhood Member Plans

Commercial Plans

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]).

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.

An overview our Commercial plans is available on our [website](#). Neighborhood Commercial members have different cost-sharing and benefits based on the plan variation in which they are enrolled.

Neighborhood Member Plans

Dual Special Needs Plans

Neighborhood INTEGRITY for Duals (HMO D-SNP) A fully integrated dual special needs plan (FIDE-SNP) that integrates ALL covered **Medicare and Medicaid** managed care benefits into one plan. 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.

- ☐ Members enrolled in INTEGRITY for Duals may NOT be billed for Medicare cost share amounts for covered services.

Neighborhood Dual CONNECT (HMO D-SNP)

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**.*

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.

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 \$1,596
- 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

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 \$1,330
- 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](http://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.
- ⊕ **D-SNP plans** have copays for Part D prescription drugs depending on the plan and the member's low-income subsidy (LIS) level:

INTEGRITY for Duals

- \$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)

Dual CONNECT

- Cost-share for all drugs (25% or LIS copay)



Extra Supplemental Benefits (D-SNP)



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 &more debit card
- 120 hours of iADL support through Papa Pals (Neighborhood INTEGRITY for Duals)

Reward and Incentive Programs

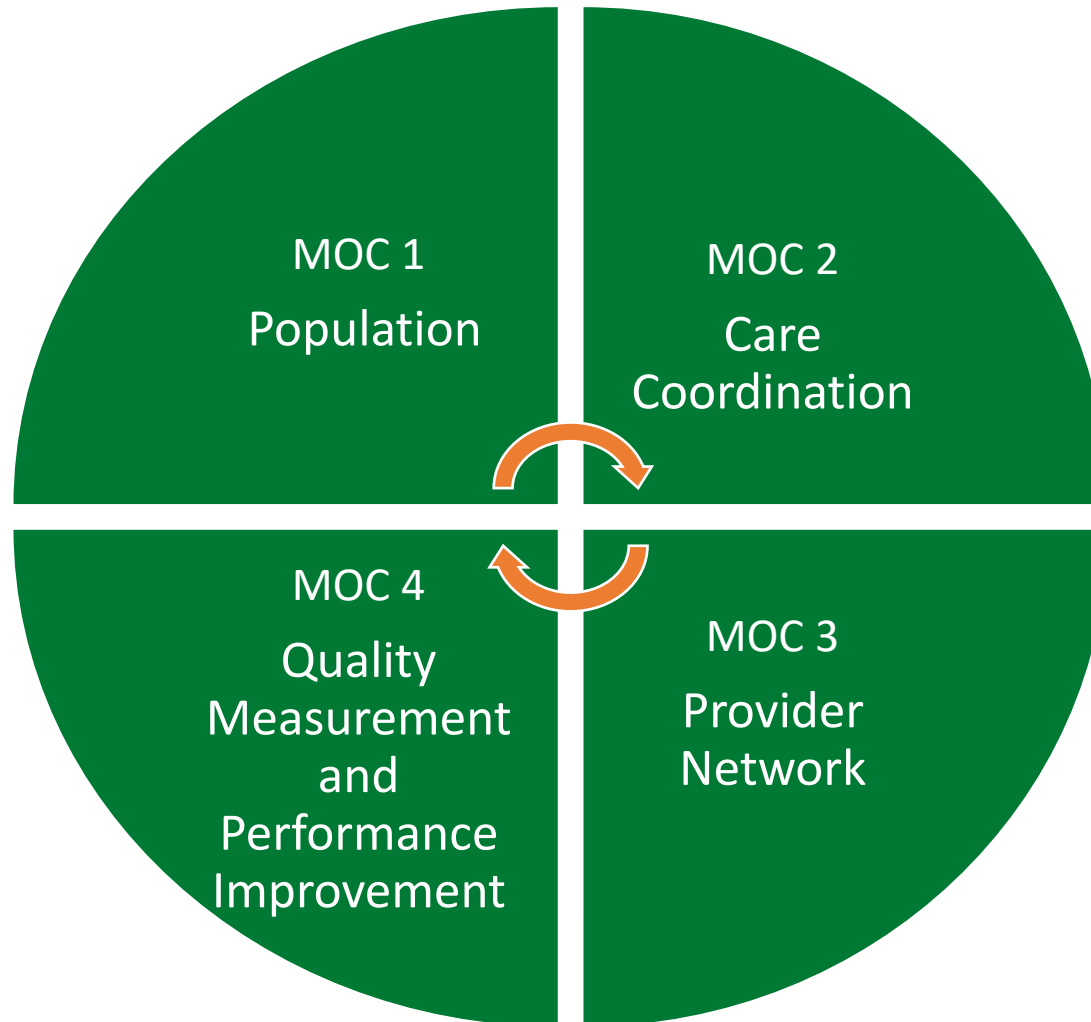
Neighborhood's Reward and Incentive Program incentivizes a member to engage in health promoting services and/or activities to improve or maintain their overall health and well-being.

Members can earn up to \$90 towards the OTC supplemental benefit when participating in the health measures identified below.

Reward	Amount
Annual Wellness Visit	\$25
Breast Cancer Screening	\$25
Diabetic (A1C)	\$10
Diabetic Care (Blood Pressure)	\$10
Diabetic Care (Kidney Health)	\$10
Diabetes Eye Exam	\$10

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

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

- 📄 Encourage members to complete the HRA
- 📄 Share relevant clinical updates (new diagnoses, hospitalizations)
- 📄 Notify the Care Manager of concerns or condition changes

ICP

- 🎯 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

ICT

- 👥 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

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

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

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.

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.

Enhanced Integration of LTSS and Behavioral Health

LTSS



Behavioral Health

- 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

- 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](https://www.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

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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 (OON) requires prior authorization for INTEGRITY for Duals and Dual CONNECT and for Behavioral Health Services (all lines of business.) For Medicaid and Commercial plans, certain services may require prior authorization. Providers must complete an [Out of Network Prior Authorization E-Form](#) when seeking approval to refer a member OON.

Prior Authorizations

- Use the [Prior Authorization Search Tool](#) to determine which services require prior authorization

Member ID Cards

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.

Please note: As of January 1, 2027, **Commercial members will no longer have their PCP listed on their ID card.** Providers should refer to NaviNet for Commercial members' PCP information.

INTEGRITY for Duals

Front of Member ID Card

 Neighborhood Health Plan OF RHODE ISLAND™ INTEGRITY For Duals	 Medicare ^{Rx} Prescription Drug Coverage
Member Name: <Cardholder Name>	RxBIN: 004336
Member ID: <Cardholder ID#>	RxPCN: MEDDADV
PCP Group/Name: <PCP/Group Name>	RxGRP: RX21KD
PCP Phone: <PCP Phone>	
MEMBER CANNOT BE CHARGED	
Copays: PCP/Specialist: \$0 ER: \$0	
H7635	001

Dual CONNECT

Front of Member ID Card

 Neighborhood Health Plan OF RHODE ISLAND™ DUAL CONNECT	 Medicare ^{Rx} Prescription Drug Coverage
Member Name: <Cardholder Name>	RxBIN: 004336
Member ID: <Cardholder ID#>	RxPCN: MEDDADV
PCP Group/Name: <PCP/Group Name>	RxGRP: RX21KF
PCP Phone: <PCP Phone>	
MEMBER CANNOT BE CHARGED	
Copays: PCP/Specialist: \$0 ER: \$0	
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Claims Submission



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

Electronic claims payer ID number for all lines of business:

05047

Paper claims are 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.

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.

- Members enrolled in INTEGRITY for Duals may NOT be billed for Medicare cost share amounts for covered services.
- 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 and Equal Access

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

- Providers must agree to accept all members, including all eligible Medicaid populations, for treatment pursuant to the [Rhode Island Code of Regulations section 210-RICR-30-05-2.13](#) to provide and administer care with the same standard of care, access, availability, skill, and diligence customarily provided to all his/her patients.
- Providers may not use discriminatory practices such as separate waiting rooms, appointment days, office space or locations, or preference for private-pay patients.
- Providers must maintain open or closed panels for all Neighborhood Products.
- Providers must not exclude treatment or placement of members for authorized behavioral health services on the basis of state agency discharge, or referral, from an Institute of Mental Disease.

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 that accommodate 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 Culturally Competent

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.



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.

Language Interpreter Services Process



Obtaining Interpreter Services

Providers can request interpreter services through Neighborhood via completion of the [Interpreter Request E-form](#). Members can call Member Services to request an interpreter.

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 Benefit Appeals

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

- **Medicaid**

Members who are not satisfied with the outcome of a member benefit appeal may request a State Fair Hearing with EOHHS or Independent Review Organization within 120 days of Neighborhood's internal appeal denial.

- **Commercial**

No second-level appeal rights after decision made by Neighborhood.

- **INTEGRITY for Duals**

Member benefit appeals will automatically be forwarded to the CMS Independent Review Entity (IRE) contractor in accordance with CMS requirements for Medicare covered services. Members can also request state fair hearing for Medicaid covered services

- **Neighborhood Dual CONNECT**

Member benefit appeals will automatically be forwarded to the CMS Independent Review Entity (IRE) contractor in accordance with CMS requirements.

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 the date of the initial denial
• Commercial/Exchange	Within 180 days of the date 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. Must be filed to Quality Improvement Organization (QIO)

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

- **Standard appeals** - resolved within thirty calendar days, unless an extension is needed, and then an additional 14 days will be added
- **Standard Part B and Part D Medication** – resolved within seven calendar days and are not eligible for an extension
- **Expedited appeals** - resolved within 72 hours, unless an extension is needed, and then an additional 14 days will be added (excluding Part B Appeals)
- **Post-service or payment appeals** - resolved within 30-60 calendar days of receipt and are not eligible for expedited appeal timeframe or extensions

Provider Appeals

Administrative Appeals are requests 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.

Clinical Appeals are requests 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.

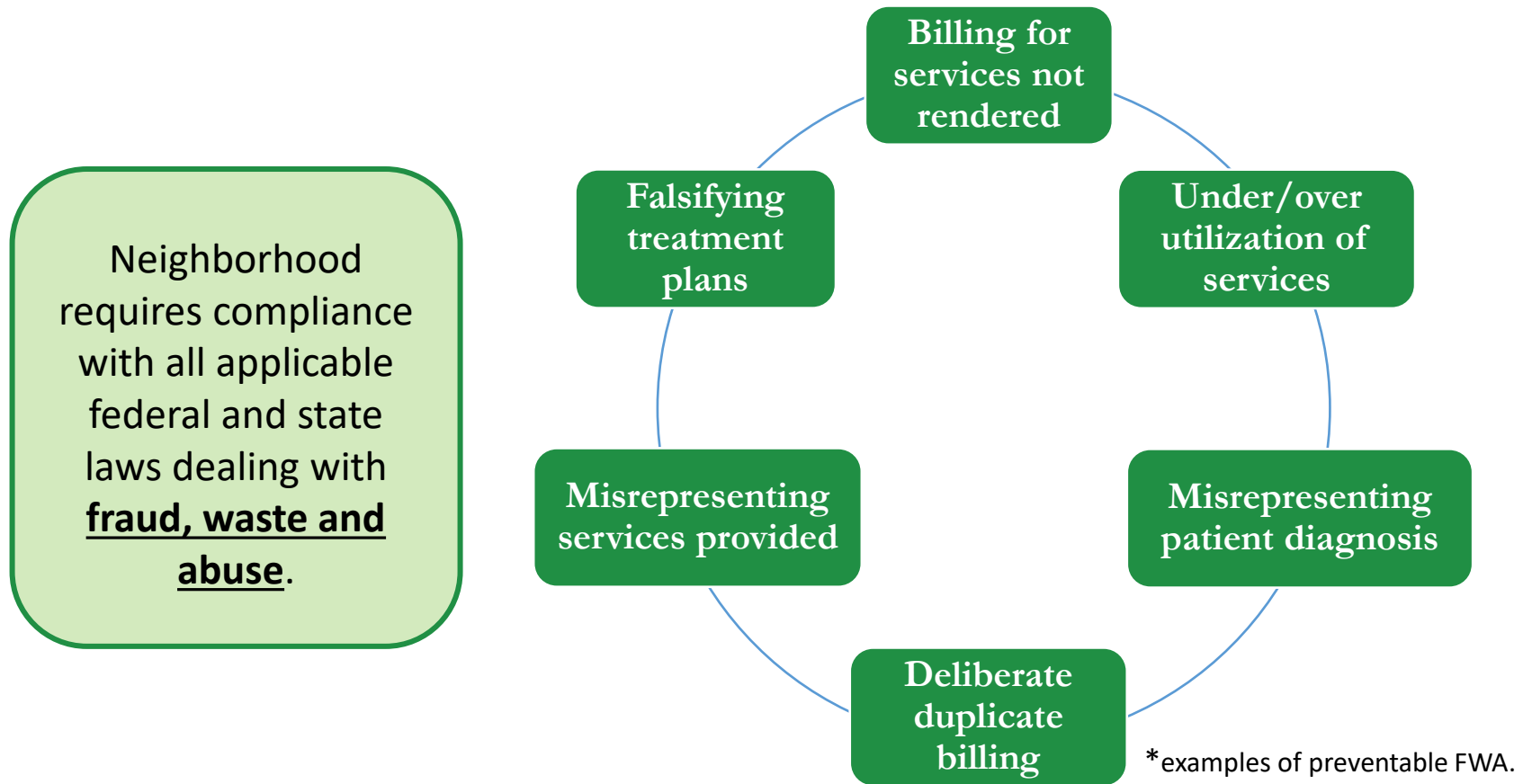
- ❑ To meet this goal, Neighborhood's program targets clinical quality of care, member and provider satisfaction and internal operations. Annually the Quality Improvement Program Description is approved by Neighborhood's Board of Directors.
- ❑ Providers are responsible for ensuring compliance with quality improvement standards including Model of Care.

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)

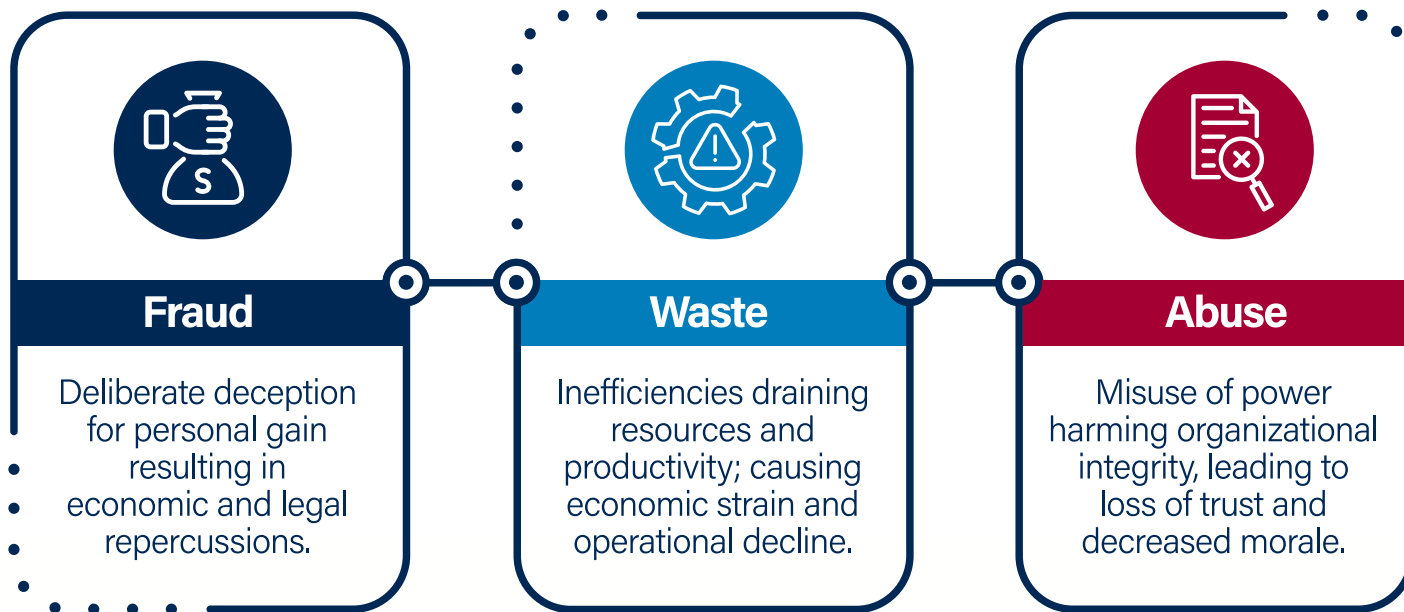


Neighborhood's Provider Manual includes references for compliance guidance documents prepared by the U.S. Department of Health and Human Services (HHS) Office of Inspector General

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.



Reporting Member Abuse

DOEA

Rhode Island law requires any person who has reasonable cause to suspect elder abuse to report it to the **Division of Elderly Affairs**. Call the DEA Protective Services Unit at (401) 462-0555.

RAINN

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

BHDDH

Suspected abuse of a person with a developmental disability must be reported to RI Department of **Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)**. Call the QA hotline (401)462-2629

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 \(Provider Manual\)](#), [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.
- Questions? Email Provider Relations at providercomms@nhpri.org.

