Neighborhood Provider Training

Prior to treating members, and annually thereafter, all Neighborhood providers are required to review this training presentation and attest to your completion.

Updated for 2025

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Training Overview

Neighborhood Health Plan of Rhode Island (Neighborhood) developed this training to assure the quality and integration of services available to members. This curriculum is designed for all network providers and includes a focused training on Neighborhood's Medicare-Medicaid Plan (MMP), INTEGRITY.

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

- **An authorized representative from each provider organization must complete the training and attest to having done so (link to attestation at the end of this training). 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.**

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Neighborhood Member Plans

Medicaid

- High-quality plans for children, families, pregnant women and adults who are eligible for Medicaid through the State of Rhode Island (Contract via Executive Offices of the Health and Human Services [EOHHS])

Oversight: Executive Offices of the State of Rhode Island (EOHHS)

Commercial plans for individuals and families, and small businesses

- Commercial plans for individuals and families cover all essential health benefits at an affordable price. Coverage is also offered for small businesses (2-50 employees). Plans are offered through **HealthSourceRI,** the state-run health insurance exchange.

Oversight: Office of the Health Insurance Commissioner (OHIC)

Neighborhood INTEGRITY (Medicare-Medicaid Plan)

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

Oversight: Neighborhood's "three-way contract" with the Centers for Medicare and Medicaid Services (CMS) and EOHHS.

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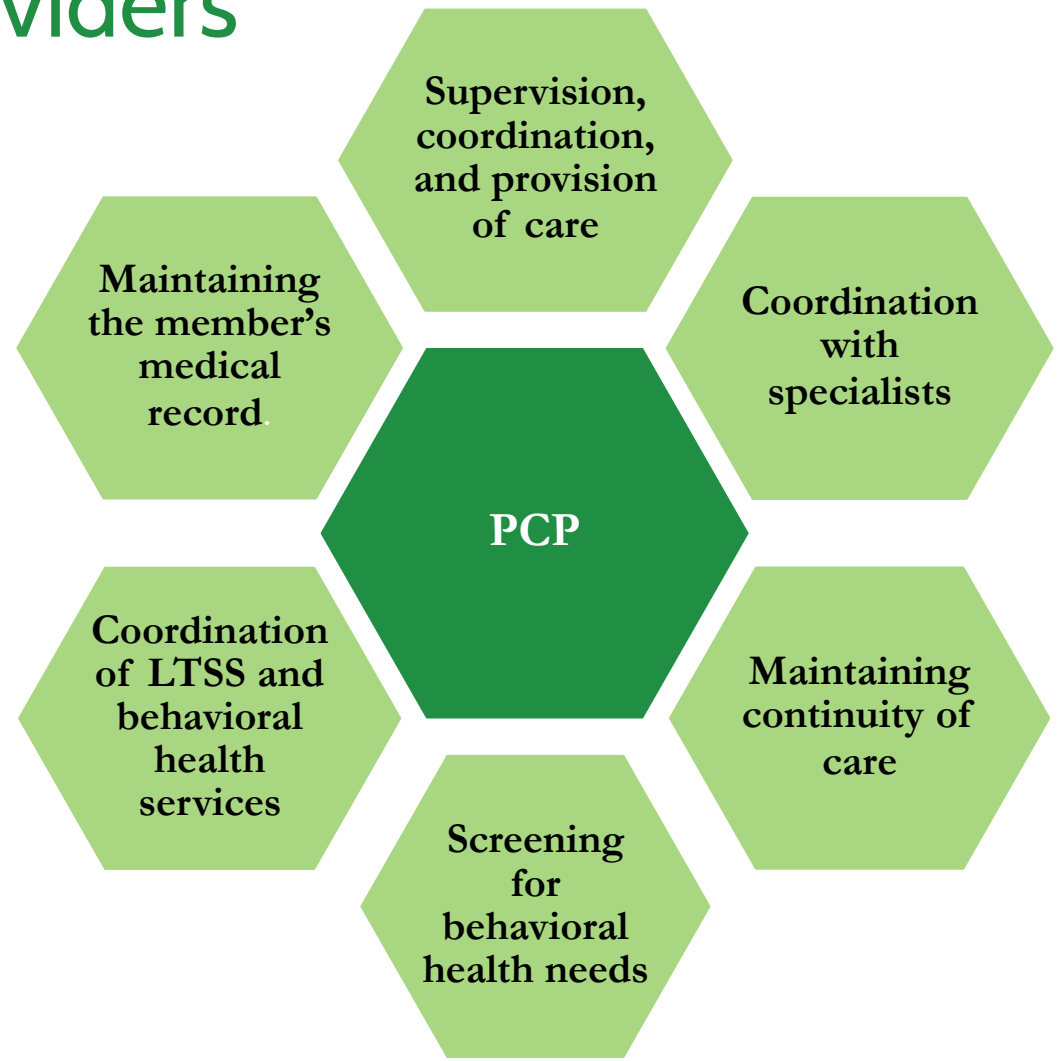
Primary Care Providers

The Primary Care Provider (PCP) serves as the **"medical home"** for the member. The "medical home" concept assists in establishing a patient-provider relationship and ultimately better health outcomes.



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Referrals and Specialty Care

Referrals	• Neighborhood does **NOT** require members to have a referral to see specialists
Out of Network Authorizations	• Out-of-network care requires prior authorization from Neighborhood • 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** found on **Neighborhood's website** to determine which services require prior authorization

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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: INTEGRITY and Medicaid members do not have copayments or deductibles.

Providers may NOT bill members for missed appointments.

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What is INTEGRITY?

INTEGRITY is a Medicare-Medicaid Plan (MMP)for seniors and adults with disabilities who have both Medicare and Medicaid coverage. A MMP includes doctors, hospitals, pharmacies, long-term services and supports, and other providers. Members are assigned a care manager and a care team to help manage their providers and services.

Individuals eligible for INTEGRITY are considered "dual eligible" or "duals"

Member Eligibility

- Seniors 65 and older
- Adults with disabilities age 21-64
- Rhode Island resident
- Medicare Part A and Medicare Part B coverage and eligible for Part D
- United States citizen or are lawfully present in the United States
- Eligible for Rhode Island Medicaid

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INTEGRITY Member Characteristics

Elderly

Disability/impairment challenges
- May need assistance with daily living activities

Severe and persistent mental illness

Multiple medications

Multiple chronic conditions
- Diabetes, BH disorders, heart disease, etc.

SDOH* Challenges

Food insecurity

Social isolation

Housing insecurity

Transportation needs

*SDOH = Social Determinants of Health

1 in **4** dual eligible Rhode islanders belong to Neighborhood Integrity

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Advantages of INTEGRITY

Provides all acute and long-term services for enrollees

Provides members with a better care experience with better coordination of benefits and services

Individual care plans provide customized service delivery

Person-centered care - Click here for more information on using person-centered language from the Resources for Integrated Care

Single health plan meeting unique needs of each member as a whole

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

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INTEGRITY Benefit Highlights

No Monthly Premium
No Deductible
No Copayment

PCP and specialist visits

Mail order and prescription drugs

Over the counter drugs

Chiropractic services

Eye exam, lenses, frames and contacts

Hearing exam and hearing aids

Diabetes self-management services and supplies

Durable medical equipment

Labs/x-rays

Hospital stays (inpatient and outpatient

Skilled nursing facility

Note: Prior authorizations may apply to some services. Refer to the Provider Manual for a complete list of benefits.

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Long-Term Services and Supports

Long-term services and supports (LTSS) are benefits that help members with everyday tasks like bathing, dressing, grocery shopping, laundry, and taking medicine. Most of these services are provided in the home but they could also be provided in a facility such as an adult day center or a nursing home.

Members of Neighborhood INTEGRITY will receive an assessment to help determine their LTSS needs. If eligible for LTSS, Neighborhood INTEGRITY provides coverage for:

- Skilled Nursing Services
- Home Delivered Meals
- Assisted Living Facility
- Shared Living
- Home Care
- Personal Choice
- Adult Day Care

MMP members may also access self-directed models that allow members to be part of the hiring process for their personal care assistants to help them stay at home or in the community.

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No-Cost Extra Supplemental Benefits

1. **In Home Support Services –** A trained companion helps with everyday tasks, transportation needs, and more. Coverage includes up to 120 hours per year of companion care.

2. **Healthy Food and Nutrition** - A healthy food savings card through *healthy benefits*. With this card, members get $25 every month, plus weekly coupons for additional savings.

3. **Fitness Benefit** - Gym memberships with select YMCA locations that include a fitness tracker.

4. **Home Delivered Meals** - Meal delivery service with Meals on Wheels includes home-delivered meals after discharge from an inpatient hospitalization or surgery. This benefit covers fourteen (14) meals for two weeks and limited to twice (2) per year.

For more information, call Neighborhood Member Services at 1-844-812-6896

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Behavioral Health & Substance Use Services

Neighborhood INTEGRITY benefits include inpatient and outpatient behavioral health and substance use services. These benefits are managed by our partner Optum®.

Covered benefits have a $0 copay, coinsurance or deductible.

- Day treatment
- Opioid Treatment Program (OTP) – Integrated Health Home (OTP-IHH)
  - Integrated Health Homes (IHH)
  - Assertive Community Treatment (ACT)
- Psychiatric rehabilitation day programs
- Mental Health Psychiatric Rehabilitation Residence (MHPRR)
- Substance abuse residential treatment
- Partial hospitalization
- Intensive outpatient services
- Methadone maintenance

Note: Prior authorization may apply to some services. Contact Optum® directly at 1-401-443-5995 for more information on these services.

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Pharmacy

- Neighborhood contracts with CVS/Caremark, a national pharmacy benefits management company, to administer the Medicare Part D pharmacy benefit provided to INTEGRITY members.
- In addition to many smaller independent pharmacies, Neighborhood's pharmacy network includes CVS, Rite Aid, Walgreens, Walmart and many others. A complete list of contracted pharmacies is available on our web site, www.nhpri.org
- Providers must comply with all CMS regulations that govern the MMP product including all Medicare Part D requirements.

Click here to visit the 2025 MMP Pharmacy Benefits webpage for more information on MMP pharmacy benefits.

Click here for more information on Medicaid and Commercial pharmacy benefits.

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Care Management

What is a care manager?

A care manager helps members manage their providers and services. Every member is assigned a lead care manager which can be a licensed clinician or a non-licensed care coordinator depending on the member's complexity and prioritized needs.

Care manager responsibilities:

- Provide education on benefits, address medication needs and create care plans.
- Coordinate medical services and assist members in adhering to plans of care.
- Ensure collaboration between the PCP and other providers involved in member's care.

Conflict-free care management must be provided

Individuals performing evaluations, assessments, and plans of care cannot be 1) Related by blood or marriage to the individual or the individual's paid caregiver or 2) Financially responsible or empowered to make financial or health-related decisions for the member.

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Comprehensive Functional Needs Assessment (CFNA)

Who receives a CFNA?	INTEGRITY Members living in the community who are: (1) receiving long-term services and supports; (2) determined to be "high risk" based on the results of risk stratification or other means of identification; (3) for any transitions event, change in condition or member/provider request regardless of LTSS or risk status.
Goal	Identify the multi-disciplinary conditions and needs of the member including but not limited to: medical, behavioral health, functional condition, long-term care, social services, informal support system, housing conditions, other conditions. We also identify member's needs for advance directives, power of attorney (POA) or other legal consents.
Tool	**Approved CFNA, user-friendly, culturally and linguistically appropriate.**
Location	The CFNA is done in the community or in the member's home (with member consent).

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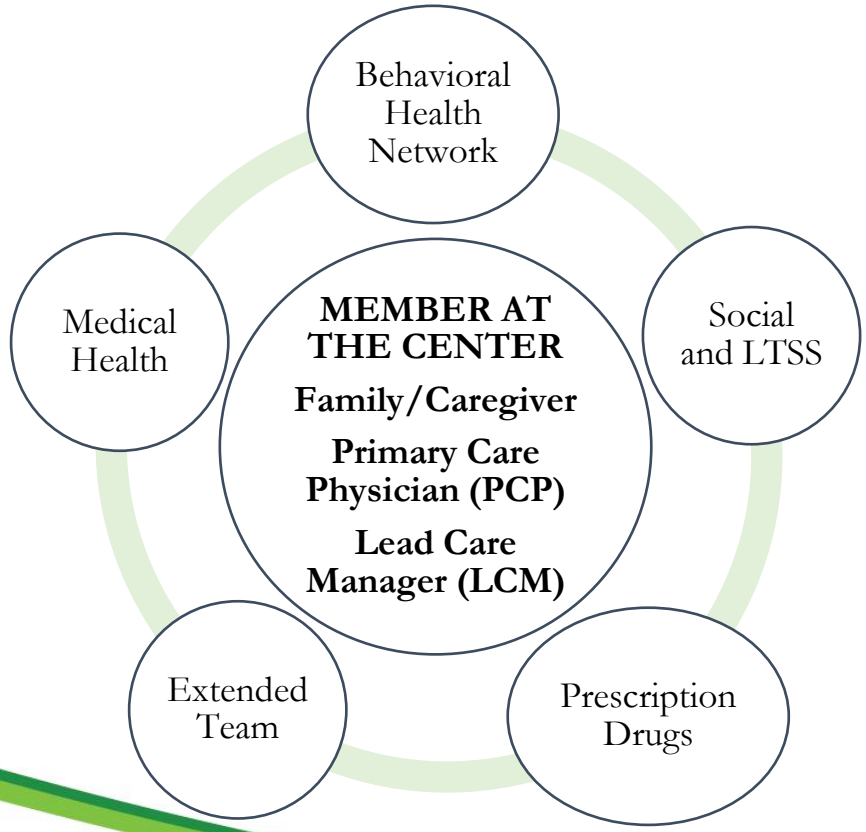
Interdisciplinary Care Team (ICT)

The membership of the ICT is based on the member's goals, priorities and needs. The ICT works together to develop the member's Interdisciplinary Care Plan (ICP).



- The ICP is a member-centric document created with the member and includes services and goals identified during the Comprehensive Functional Needs Assessment (CFNA).
- Every year, the ICT will work with the member to update the care plan if the health services need to change.

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INTEGRITY Enrollment

Enrollee Ombudsman - EOHHS contracts with Rhode Island Parent Information Network (RIPIN) to provide Ombudsman services for the Medicare-Medicaid eligible population in Rhode Island.

- The enrollee ombudsman can answer questions and help enrollees understand how to resolve an issue. For more details, visit RIPIN.

Enrollment Counselor - EOHHS contracts with an independent entity to process all enrollment and disenrollment.

- The enrollment counselor provides unbiased education on MMPs and other enrollment choices and ensures ongoing service for eligible individuals.

Neighborhood Member Advocate - The member advocate ensures the interests of members are understood, promoted and addressed by Neighborhood.

- The advocate responds to member issues, works with EOHHS to resolve problems and assists members in navigating the health plan and the health care system.

INTEGRITY Marketing Guidelines

Neighborhood's contract with CMS and EOHHS defines how Neighborhood and our providers can market and advertise INTEGRITY. Providers will comply with marketing guidelines outlined in the Medicare Marketing Guidelines including any limited English proficiency provisions.

Providers may not include any references to their affiliation with INTEGRITY in their marketing or advertising without prior approval. Neighborhood will submit all designated marketing materials and scripts to CMS and EOHHS to obtain approval prior to distribution or display.

Note: Please contact Neighborhood prior to beginning any communications or marketing initiatives.

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

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

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Accommodation Requirements

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

- Provide large print (at least 16-point font) versions of all written materials to individuals with visual impairments.
- Provide reading notices and other written materials to patients upon request.
- Provide TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for persons who are deaf.
- Assist patients with filling out forms over the telephone.
- Ensure effective communication email, telephone, personal assistance, etc.

Click here for information on ADA standards for accessible design.

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Culturally Competent Member Care

Culture - The customary beliefs, social forms, and material traits of a racial, religious, or social group + **Competence –** The ability to do something successfully or efficiently

What is cultural competence?

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

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

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

Becoming a Culturally Competent Provider

Value diversity and acceptance of differences

Consider each person as an individual

Be conscious of the impact of culture during interactions

Respect cultural differences regarding physical distance and contact, eye contact, and rate and volume of voice.

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.

Tailor treatment plans

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

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Barriers to Culturally Competent Care

Structural Racism	Oppression	Discrimination
Lack of Access to Interpreters	Cultural Insensitivity	Physical Space and Equipment
	Lack of education on healthcare disparities	

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Support for 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

Tips to Create an Effective Translation Program for Limited-English Proficiency Patients

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Support for Language Interpreter Services

Obtaining Interpreter Services through Neighborhood	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.

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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 will review any circumstance that gives the member cause for protest, causes disruption of care, creates anxiety, or leads to dissatisfaction with the plan or treatment received from a plan provider.
- 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) will contact the office in question 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 fourteen (14) calendar days.

Note: This information applies to all lines of business.

Clinical (Medical Necessity) Appeals

A clinical appeal is a request for reconsideration of an initial adverse clinical determination rendered by the Utilization Management Department. It can be filed by a member, a provider on behalf of the member or a member's legal representative.

Filing Timeframes

- **INTEGRITY appeals** must be filed within 60 days of the date of the initial denial.
- **Medicaid appeals** must be filed within 60 days of receiving the initial denial.
- **Commercial/Exchange appeals** must be filed within 180 days of the initial denial.

Types of INTEGRITY 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.

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Clinical Appeal Resolution Timeframe

Neighborhood's GAU sends a written acknowledgement to the appellant within five (5) calendar days of receipt of the appeal.

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

Note: Above timeframes apply to all lines of business.

INTEGRITY Part B Medication Appeals

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

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Member Administrative Appeals (non-clinical)

An administrative appeal is a request to reverse an administrative (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** administrative appeal denials for pre-service decisions or post-service member payment/Direct Member Reimbursement (DMR) appeal for 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 by Neighborhood's GAU.

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

Note: A member's physician can submit an appeal on behalf of the member.

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Provider Appeals

Administrative Appeals

A provider administrative appeal can only be submitted if a provider has first submitted a claim adjustment request or claim reconsideration request. If either of those requests are denied, an administrative appeal can then 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

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. Providers should use this form in the following circumstances:

- Medicaid appeals (within 60 days of receiving the initial denial)
- Commercial/Exchange appeals (within 180 days of receiving the initial denial)
- INTEGRITY (MMP) appeals (within 60 days of receiving the initial denial/organization determination)

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Provider Complaints

A provider can initiate a **Complaint** with Neighborhood's Provider Services Department to express dissatisfaction with the plan. Provider Services will assist and may escalate the issue if appropriate to Neighborhood's Grievance and Appeals Unit.

GAU 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.

Review the Complaints and Appeals section of the Provider Manual for more details.

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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 evidenced-based practices.

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Performance & Health Outcome Measurements

Plan of care completion rate	Network adequacy
Ambulatory 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 development of their 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

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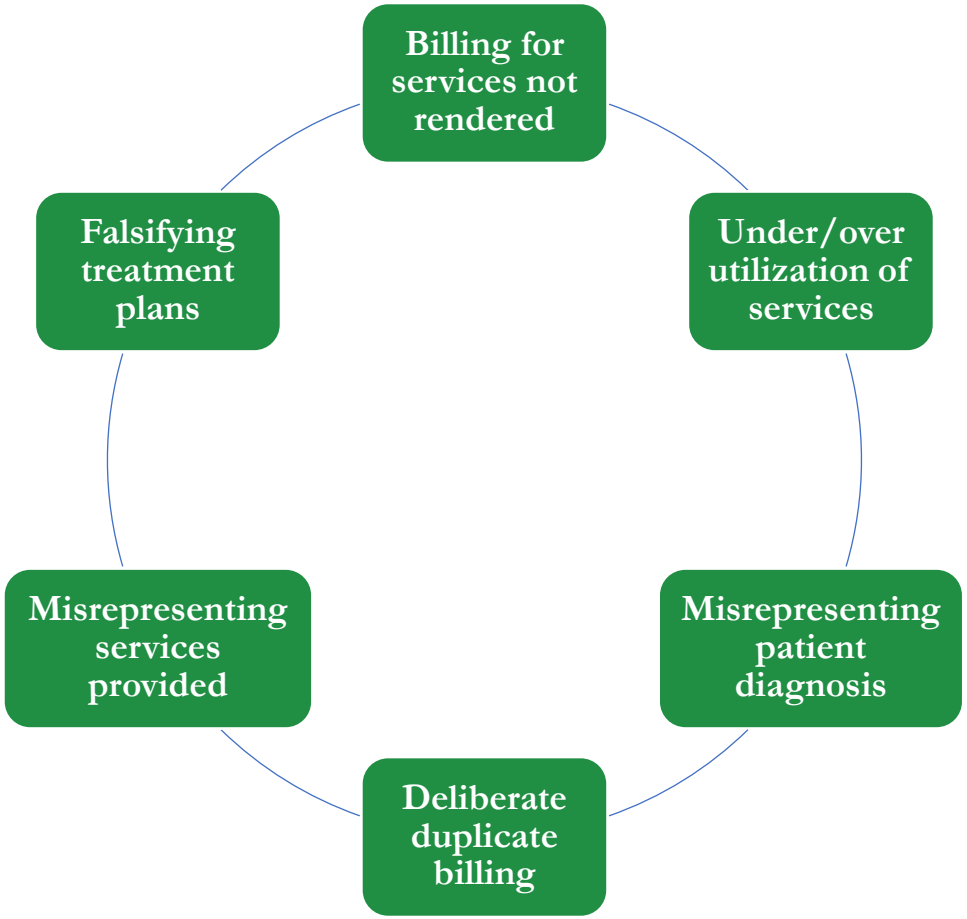
Identifying Fraud, Waste and Abuse (FWA)

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

Neighborhood utilizes various methods to investigate provider compliance with all applicable billing and coding guidelines.



Implementing a Compliance Program to Prevent FWA

Neighborhood strongly recommends that providers, their business associates and subcontractors **develop their own compliance programs** and regularly evaluate their effectiveness. Effective compliance programs can help create a work culture that prevents, detects, and resolves misconduct.

Providers should take **ongoing action** to understand health insurance compliance requirements and meet them fully and consistently.

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

Click here to view Neighborhood's Provider Manual.

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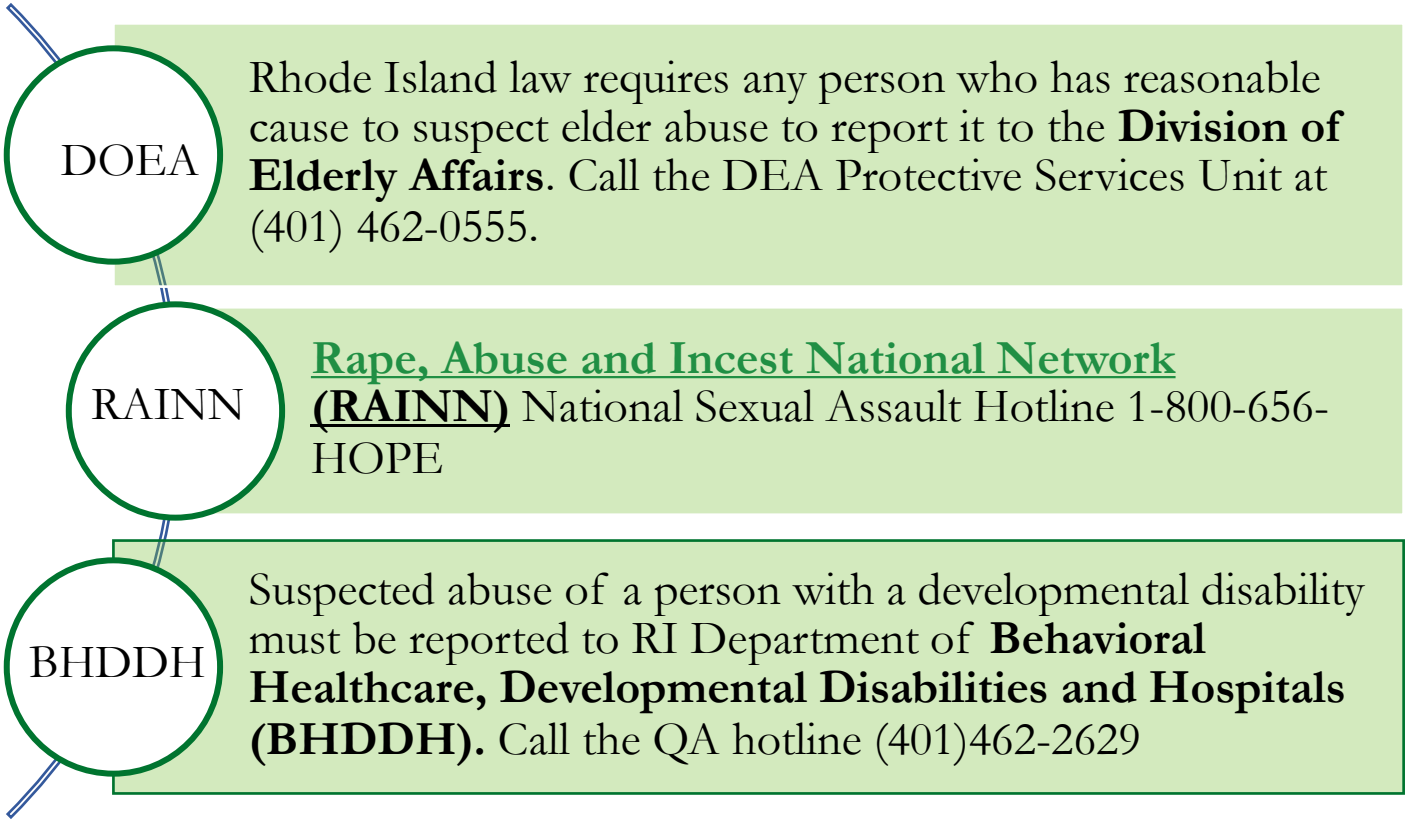
Reporting FWA



Provider Resources

- Neighborhood Resources (Provider Manual, Quick Reference Guide, forms, trainings, pharmacy information and more)
- Medicaid Manual
- Medicare Manual
- Payment Policies
- NaviNet (Eligibility and claims information)
- RI EOHHS Integrated Care Initiative
- Health Resources & Services Administration: Health Literacy

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Training Attestation

- 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 **providertraining@nhpri.org**.

Thank you for completing Neighborhood's annual Provider Training!

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