

8/15/16



MMP ENROLLMENT LINE

TRAINING MANUAL



Rhode Island's Integrated Care Initiative 2016

8/15/16

MMP Enrollment Line Training Manual

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1. Financial Alignment Demonstration (FAD)

A. Overview

The Financial Alignment Demonstration (FAD) is a new Federal program or ‘demonstration’ that is designed to improve care for individuals who have health coverage through both Medicare and Medicaid. It’s authorized under the Affordable Care Act and administered by the Office of Coordinated Care at the Center for Medicare and Medicaid Services (CMS). The goal of the FAD is to combine all the covered services in Medicare and Medicaid to improve care for ‘dual eligible’ beneficiaries and better align financing.

Rhode Island is the thirteenth state to enter into an agreement with the federal government (CMS) under the Financial Alignment Demonstration program. Rhode Island’s FAD will start on July 1, 2016 and run through December 2018. CMS has granted an extension for two (2) additional years until December 2020.

B. Rhode Island’s Demonstration

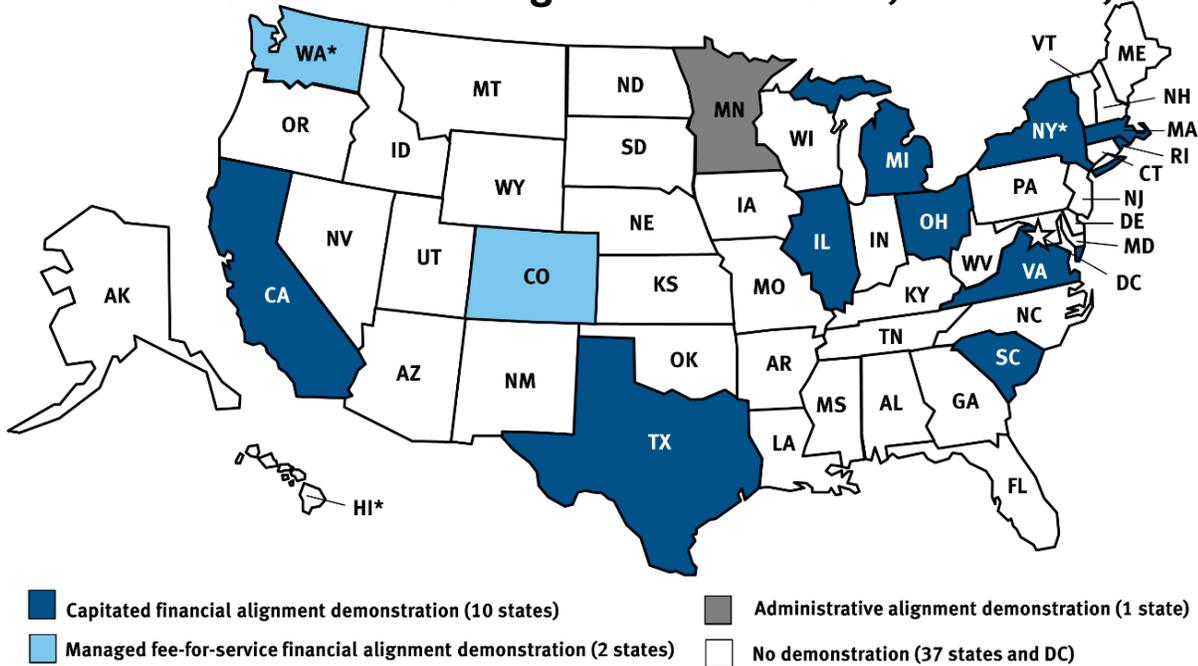
The Financial Alignment Demonstration in Rhode Island is known as the *Integrated Care Initiative* and will be implemented in two (2) phases. Phase 1 of the *Integrated Care Initiative*¹, was launched in November 2013 and managed only the Medicaid covered benefits, not the Medicare benefits.

Phase 2 of the *Integrated Care Initiative* is Rhode Island’s ‘demonstration.’ Only people with both Medicaid and Medicare are eligible to join. The new program will be fully ‘integrated,’ meaning the covered benefits or services will be combined and seamless for people who are enrolled. Rhode Island will contract with one (1) health plan, *Neighborhood Health Plan of Rhode Island*, to administer the program. Neighborhood will operate the new program under a three-way contract between CMS, the State and Neighborhood. The new program is known as a Medicare-Medicaid Plan (MMP). Neighborhood will operate the new MMP under the name *Neighborhood INTEGRITY*.

¹ See Appendix A for a description of Phase 1 of the Integrated Care Initiative.

Figure 1

State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, December, 2015



NOTES: *WA received approval for two demonstrations, but subsequently withdrew its capitated model. NY withdrew its managed FFS proposal and has approval for 2 capitated demonstrations.

SOURCE: [CMS Financial Alignment Initiative, State Financial Alignment Proposals](#) and state websites.



C. Goals of the Integrated Care Initiative

The goals of Rhode Island’s *Integrated Care Initiative (ICI)* are to:

- Provide person-centered care,
- Improve or maintain members’ health and quality of life,
- Integrate primary care, acute care, behavioral health care, and long-term services and supports,
- Increase the proportion of individuals successfully living in a community setting,
- Decrease avoidable hospitalizations and emergency room use,
- Reduce nursing facility admissions and length of stay,
- Improve transitions of care from the hospital or nursing home back to a member’s home, and
- Align financial and quality incentives to improve care.

D. Information on Medicaid and Medicare

1. Medicaid

Medicaid is a federal health program that started in 1965 and is administered by state governments with federal oversight. The federal government mandates that a certain core group of services are covered, and leaves it up to the States to decide which ‘optional’ services to cover. In Rhode Island, the Medicaid program is funded approximately 50 percent by the federal government and 50 percent by the state government.

Eligibility for Medicaid is complex but it is usually based on a person’s annual income and resources (assets). For individuals who are disabled or who have certain medical conditions, eligibility is also based on a person’s clinical needs, disability and/or functional status.

Rhode Island administers its Medicaid program primarily through Managed Care Organizations (MCOs) or health plans. Currently two (2) health plans have contracts with the State to provide comprehensive health care to beneficiaries. They are UnitedHealthcare Community Plan (UHC-CP) and Neighborhood Health Plan of Rhode Island (NHPRI), often referred to as ‘Neighborhood.’

For more information on the Rhode Island Medicaid Program, see **Appendix B**.

2. Medicare

Medicare is a federal health insurance program that is administered by CMS and is similar in every state in the nation. Medicare is usually thought of as one large program, but it has different parts with distinct coverage. The most common parts are Part A, B, C and D.

- *Medicare Part A* covers inpatient hospital services and brief stays (less than 100 days) for rehabilitation or convalescence in a skilled nursing facility if certain criteria are met.
- *Medicare Part B* helps pay for some services and supplies not covered by Part A, such as physicians and surgeons as well as for medically necessary outpatient services such as emergency room, laboratory, X-rays and

diagnostic tests and certain durable medical equipment (DME) and supplies.

- *Medicare Part C* stands for a “Medicare Advantage” Plan. Medicare Advantage plans are offered by private health insurance companies and include Medicare Part A and B. Some Medicare Advantage plans also include Part D.
- *Medicare Part D* covers prescription drugs. Consumers have a choice of Prescription Drug Plans to choose from. Part D was added to the Medicare Program in 2006.

Medicare Parts A and B are sometimes called “Original Medicare.”



If a person has Medicare Part A, B, and D, he/she is considered to have ‘full’ Medicare coverage. If a person has only A or B, but not both, he/she will not be eligible for Rhode Island’s demonstration.

Medicare eligibility covers individuals 65 years and older who qualify, as well as people under 65 who have disabilities as determined by the Social Security Administration. People with end-stage renal disease (ESRD) also are eligible for Medicare coverage.

E. Eligible and Excluded Populations

Eligible Populations must meet ALL of the following criteria:

- Live in Rhode Island
- Be age 21 or older
- Have Medicare Part A and Part B and be eligible for Medicare Part D
- Have full Medicaid benefits

Excluded Populations, include people who...

- Have only Medicare Part A or Part B

- Do not have ‘full’ Medicaid benefits(i.e., have spend down or ‘flex’ Medicaid benefits)
- Participate in the Medicare Premium Payment Program (i.e., QMB,SLMB or QI). See Appendix N for more information.
- Are receiving hospice care at the time of enrollment
- Incarcerated individuals
- Live in an institution (Tavares or Eleanor Slater Hospital) or in an out-of-state hospital
- Enrolled in the Sherlock Plan (health coverage for adults with disabilities who are working)

F. Dual Eligibles in Rhode Island

‘Dual eligibles’ are individuals who have both Medicare and Medicaid coverage. Those who are eligible to participate in the Integrated Care Initiative, Phase 2 must have Medicare Part A, Part B and be eligible for Part D, and also have full Medicaid benefits.

As a group, dual eligible beneficiaries often have multiple health conditions and are considered a particularly vulnerable population. Many experience barriers to quality health care due to poverty, limited education, and/or cultural barriers. As a group they may be more socially isolated and have lower literacy skills than people with Medicare only. Rhode Island data shows that they may also have chronic mental health conditions, use emergency rooms more frequently for routine care, and have higher rates of hospitalizations than people with Medicare only.

There are approximately 30,370 dual eligibles in Rhode Island who qualify for Neighborhood INTEGRITY. Within this group, there are two populations- *Elders* (adults over age 65) and *Adults with Disabilities* (adults age 21 and older who have a disability or chronic health condition).

- 17,024 individuals live at home or in the community,²
- 3,135 individuals live at home or in the community and receive Long-Term Services and Supports (LTSS),³ and
- 5,123 individuals live in a nursing home.

Of the 30,370 individuals, approximately,

- 2,579 individuals have Serious and Persistent Mental Illness (SPMI), and
- 2,509 individuals have an intellectual or developmental disability.

² “In the community” means- in an Assisted Living residence or in a group home.

³ See Appendix C for information on Long Term Services and Supports (LTSS).

2. Neighborhood INTEGRITY, a Medicare-Medicaid Plan

Neighborhood INTEGRITY, the new Medicare-Medicaid Plan (MMP), will serve the entire state of Rhode Island. The following sections give a detailed description of the program including: Covered Services, the Benefits of Enrolling, Care Management, Provider Network, and Continuity of Care provisions.

A. Covered Services

When a person enrolls in Neighborhood INTEGRITY, they will receive all their covered services including Medicare Part A, Part B, and Part D and all their Medicaid services through the health plan.

If a person receives Medicaid Long Term Services and Supports (LTSS), those services will continue and will be coordinated through the health plan. Individuals who are currently paying a contribution to the cost of their care for LTSS services (often called ‘patient share’) will continue to pay this amount even if they enroll in Neighborhood INTEGRITY.

See **Appendix D** for a list of what is typically covered under Medicare vs. what Medicaid covers.

B. Benefits of Enrolling

There are many benefits to enrolling in INTEGRITY. They include:

- NO copays for prescription drugs
- One Customer Service number for questions and resolving issues
- Nurse Advice Line, 24 hours per day/7 days per week.
- Care coordinator dedicated to the enrollee
- Easier experience for members because both programs are combined; one ID card replaces the Medicare (red, white and blue) and the Part D Prescription Drug Plan card.
- Neighborhood Health Plan of Rhode Island is a trusted health plan with excellent service. They have been ranked a top health plan in the country for 22 years in a row.
- Neighborhood can help enrollees get supports and services to help them live safely at home. Typically, if a person is starting to need some help around the house, with food shopping or preparing meals, this is not usually covered in a health plan. A person would have to apply through the Department of Human Services, Division of Elderly Affairs or apply for Medicaid Long Term Services and Supports (LTSS) to see if they are eligible to have the state pay

for these services. Neighborhood can actually put some of these services in place while the enrollee applies for Medicaid LTSS.

- Neighborhood INTEGRITY will also help members develop a personalized care plan where the member is at the center of the decision-making.

C. Care Management

Care management and coordination are at the heart of Neighborhood INTEGRITY. Care coordination services help beneficiaries and their families navigate the health care system and coordinate the full range of services a person may receive. That may include medical, behavioral, long-term services and supports and social supports. The role of the care manager is to advocate for the consumer, help answer questions and concerns, and ensure that all their health care needs are being met.

When an individual joins Neighborhood INTEGRITY, they will be contacted by Neighborhood to assess their needs. The health plan will outreach to the member to do an initial health assessment. These assessments are different depending on each person's level of need, but all the assessments are used to identify members that may need extra help or services. Once the assessment is complete, some members with greater needs, will receive a care manager, who is available to work with the member, their family caregiver, or providers, to develop an individual care plan. A care plan will reflect the member's strengths and goals, and can include input from caregivers, family members and physicians or other providers. If a member is already receiving care management services, Neighborhood will work with that person to coordinate and not duplicate services.

D. Provider Network

Neighborhood has a large provider network. Neighborhood Member Services can help a member find a new doctor, specialist or other provider if they need one. Also, if a person needs a second opinion on a surgery or other treatment, Member Services can help. Individuals should be encouraged to check to see if their providers are in Neighborhood's network.

If an individual's provider is not in Neighborhood's network, they will be able to continue seeing that provider for the first six (6) months that they are enrolled in Neighborhood INTEGRITY. After that point, they will either have to switch to a provider that is in Neighborhood's network or get authorization from Neighborhood to keep seeing that provider or request that the provider join Neighborhood's network. Neighborhood's network is available online at www.nhpri.org or by calling Neighborhood Member Services at 1-844-812-6896

(TTY 711). The Customer Service Representatives (CSRs) should refer potential INTEGRITY enrollees to Neighborhood for questions about providers.

E. Continuity of Care

Neighborhood is required to honor all existing authorizations for services and prescription drugs for the duration of the ‘continuity of care’ period.

1. Medical and Long-Term Services and Supports

For medical and long-term services and supports, the following rules apply:

- A member who is seeing an out-of-network primary care doctor or specialist can continue to see that provider for the first six (6) months he/she is enrolled in Neighborhood INTEGRITY. After the first six (6) months, a member will be required to use providers in Neighborhood’s network. If a member would like to keep seeing the out-of-plan provider, he/she would have to request approval from Neighborhood before seeing that provider.
- A member who is currently receiving Long-Term Services and Supports, will continue to receive the same number of (authorized) hours for the first six (6) months of enrollment in INTEGRITY or until Neighborhood does an initial health assessment whichever occurs first.
- Members who are permanent residents of nursing facilities or assisted living residences may remain in their nursing facility or assisted living residence, regardless of whether that nursing facility or assisted living residence is in Neighborhood’s network.

2. Prescription Drugs

Most prescription drugs are covered by Neighborhood under Medicare Part D. Some drugs may be covered under Medicaid. If an individual is on a prescription drug that is not covered by Neighborhood INTEGRITY, the following rules will apply:

- For Part D drugs, enrollees in INTEGRITY will get a one-time fill of a 30-day supply (unless a lesser amount is prescribed) of medication within the first 180 days of their enrollment.

3. Enrollment

There are two (2) types of enrollment, *Opt-In* and *Passive* enrollment.

A. Opt-in Enrollment

Individuals who are identified for the '*Opt-In*' enrollment group will be mailed an enrollment packet that includes (1) an enrollment letter (*blue*), (2) application and (3) FAQ. Individuals can either call the MMP Enrollment Line to apply over the phone or send in a paper application. Once they have submitted an application, the State will verify their eligibility with CMS and will mail a notice either verifying or denying their enrollment. No one in the *Opt-In* enrollment group will be automatically enrolled in INTEGRITY; they have to take an active step and apply to be enrolled.

See **Appendix E** for a copy of the *Opt-In* enrollment packet (notice # 32, 1, and FAQ).

B. Who's Eligible for Opt-In Enrollment

Individuals who are eligible for *Opt-In* enrollment include:

- People who are currently not enrolled in Neighborhood UNITY.
- People who are enrolled in Neighborhood UNITY and have one or more of these characteristics:
 - Also enrolled in a *Medicare Advantage* plan.
 - Identified by CMS as having employer or union sponsored insurance (in addition to Medicare and Medicaid).
 - Identified by CMS as having been auto-enrolled in a part D Prescription Drug Plan within the last calendar year. CMS guidelines state that Medicare members can only be auto-enrolled one (1) time per calendar year.
 - Identified by the State's MMIS system as having comprehensive health insurance coverage (in addition to Medicare and Medicaid).

1. People Enrolled in Medicare Advantage Plans

A Medicare Advantage plan includes Part A and B and sometimes prescription drugs (Part D) are included. Someone who is enrolled in a Medicare Advantage plan has made a choice to enroll in that plan, therefore, he/she cannot be automatically enrolled into the MMP. Members cannot be enrolled in both INTEGRITY and a Medicare Advantage plan at the same time.

- Members who are enrolled in a Medicare Advantage plan and choose to enroll in INTEGRITY, will be automatically disenrolled from the Medicare Advantage plan they selected.
- This process also works in reverse. If a member who is enrolled in Neighborhood INTEGRITY decides to enroll in a Medicare Advantage plan or a Part D plan, they will be automatically disenrolled from INTEGRITY.
- Dual eligible beneficiaries are not limited to an open enrollment period for Medicare Advantage; they may choose to enroll or disenroll from a Medicare Advantage or Part D plan at any time.
- Medicare Advantage members who are enrolled in Neighborhood UNITY (Rhody Health Options) should be informed that this program does not interfere with their choice of Medicare coverage; however, enrollment into Neighborhood INTEGRITY will change their Medicare coverage.

2. People With Employer or Union Sponsored Insurance

Members who have been identified by CMS as having employer or union sponsored insurance may lose their coverage if they enroll in Neighborhood INTEGRITY.

- These individuals should be strongly encouraged to check with their other insurance carrier prior to enrolling in INTEGRITY.
- Loss of an employer or union sponsored insurance plan may be permanent, and any spouse or dependent covered by that insurance plan will lose their coverage too. Neighborhood INTEGRITY **does not** cover spouses or dependents.
- Members with employer or union sponsored coverage should be aware that Neighborhood UNITY (Rhody Health Options) enrollment does not affect their enrollment in other health insurance plans.

3. People Who Were Auto-Assigned into a Part D Plan

Members who have been auto-assigned to a part D Prescription Drug plan within the last calendar year, are excluded from passive enrollment into Neighborhood INTEGRITY per CMS guidelines.

Members who wish to enroll in INTEGRITY should be aware that Neighborhood INTEGRITY includes prescription drug coverage (Part D), therefore, they will be disenrolled from their existing Part D plan if they enroll. Neighborhood will send enrollees an INTEGRITY card which covers all their Medicare (Parts A, B and D) and Medicaid benefits.

4. People with Comprehensive Health Insurance Coverage

Members identified by the State as having comprehensive commercial coverage should contact their current insurance plan prior to enrolling in Neighborhood INTEGRITY.

C. Passive Enrollment

Individuals who are identified for the *Passive* enrollment group will be mailed two (2) enrollment letters (*yellow*), one 60 days prior to their start date and a reminder letter 30 days prior to their start date. (Allow up to an additional 5 days for processing or if mail date occurs on a weekend.) People in the *Passive* enrollment group need to call the MMP Enrollment Line to **stop** the automatic enrollment, or ‘cancel/opt-out,’ if they do not want to be enrolled in Neighborhood INTEGRITY.

See **Appendix E** for a copy of the *Passive* enrollment letters (notice # 31, 5, and FAQ).

D. Who’s Eligible for Passive Enrollment

Individuals who are eligible for *Passive* enrollment into Neighborhood INTEGRITY have met **ALL** of the following criteria:

- They have ‘full’ Medicaid coverage
- They have Medicare Parts A, B and are eligible for Part D
- They are currently enrolled in Neighborhood UNITY (Rhody Health Options) for their Medicaid benefits
- They do not have any comprehensive commercial coverage, or employer or union sponsored insurance
- They are not currently enrolled in a Medicare Advantage plan
- They have not been passively enrolled in a Part D Prescription Drug plan within the last calendar year

E. Part D Prescription Drug Coverage and Passive Enrollment

It is important to note that a person in the *Passive* enrollment group will receive a notice from their Part D plan telling them they will be disenrolled from their Part D Plan. They will receive this notice around the same time, or shortly after, they receive the initial *Notice 31* from the State. This is because Neighborhood INTEGRITY includes the Medicare Part D benefit and people can’t be enrolled in both. This notice may be very disconcerting for the member because they never took any action to cancel their Part D plan. Just the fact that they are receiving an automatic enrollment letter (*Passive* enrollment) will trigger a cancellation of their Part D plan. There should be no gap in prescription drug coverage; a

person's Part D plan will end the day before their Neighborhood INTEGRITY coverage begins. If they choose to cancel their enrollment in Neighborhood INTEGRITY, their Part D should stay the same.

F. Enrollment Timeline

1. Enrollment Start Date

The program will start on July 1, 2016, but consumer letters will be mailed about 30 days prior to the start of the program (last week of [month]). There will be three (3) months of *Opt-In* enrollment mailings followed by six (6) months of *Passive* enrollment mailings. Each month another group of eligible individuals will receive letters.

2. Enrollment Waves [Dates listed below are subject to change.]

See **Appendix F** for a list of when different populations will receive enrollment letters.

- *Opt-In* enrollment letters will be sent 30 days before the start of the program. These individuals can choose to enroll at any time.
- *Passive* enrollment letters will be sent 60 days before an individual's enrollment start date and another reminder letter will be sent at 30 days before the enrollment start date.

Wave	1 st letter sent	2 nd letter sent	Start Date
1	May 27	n/a	July 1*
2	Jun 27	n/a	Aug 1*
3	July 28	n/a	Sept 1*
4	July 28	Aug 27	Oct 1
5	Aug 28	Sept 27	Nov 1
6	Sept 27	Oct 27	Dec 1
7	Oct 28	Nov 27	Jan 1
8	Nov 28	Dec 28	Feb 1
9	Dec 27	Jan 26	Mar 1

Please note:

- * A person may apply any time after they receive the *Opt-In* enrollment packet. Enrollment occurs on a monthly basis.

G. Enrollment Process

1. Successful Enrollment

- [*Opt-In*] If an individual chooses to enroll in Neighborhood INTEGRITY and submits the application before the 10th of the month, he/she will be enrolled on the first day of the following month. If the application is submitted after the 10th of the month, he/she will be enrolled the first day of the next month.
 - If the enrollment is successful, the enrollee will receive *Notice 4: Acknowledgement of Receipt of Completed Enrollment Request/Confirmed Enrollment*.
- [*Passive*] If an individual does not contact the MMP Call Center prior to their start date, as stated in the enrollment letter, he/she will be automatically enrolled in Neighborhood INTEGRITY.
- Once a member has enrolled in Neighborhood INTEGRITY, there should be no distinction between *Opt-In* or *Passive* enrollees.

2. Canceling Enrollment

- [*Opt-In*] If an individual submits an application to enroll in INTEGRITY and then changes his/her mind BEFORE their start date, they may call to 'cancel' their enrollment. They will receive *Notice 11: Acknowledgement of Request to Cancel Enrollment*. These individuals will be automatically enrolled into Neighborhood UNITY even if they were not previously enrolled in UNITY.
- [*Passive*] If an individual wishes to 'opt-out' or 'cancel' their enrollment, they may do so up until the last day of the month prior to their enrollment start date (listed on his/her enrollment letter). This date should correspond with the date in MMIS. Individuals who opt-out will remain in Neighborhood UNITY. In most cases, the person can keep their original Neighborhood UNITY card.

If the cancellation of enrollment is successful, for either situation above, (*Opt-In* or *Passive*) the enrollee will receive *Notice 11: Acknowledgement of Request to Cancel Enrollment*.

- If an individual wants to disenroll from Neighborhood UNITY, he/she has to call the *Adults in Managed Care Info Line* at (401)784-8877 and request

to disenroll from UNITY. He/she will be enrolled in Medicaid Fee-For-Service (FFS) for their Medicaid covered services.

3. Timing of Opt-Outs

Individuals who call after the 2nd financial cycle of the month (usually about the 19th or 20th day of the month) or close to the end of the month, should be encouraged to wait and disenroll the following month to avoid complications with coverage and billing. If a member still wishes to opt-out at that time, they will remain in Neighborhood UNITY.

Individuals who opt-out can call 1-800-MEDICARE at any time if they would like to select a Part D or Medicare Advantage Plan. If they don't want to choose a health and/or prescription drug plan, they will be automatically enrolled in Original Medicare and will be assigned a Part D plan.

4. Unsuccessful Enrollment

If the enrollment request was incomplete, an individual will receive *Notice 6: Notice for Requesting Information*. If the request for additional information is not answered in 30 days, *Notice 9: Denial of Enrollment* will be sent.

If an enrollment request was complete but CMS or the State rejects the enrollment, the individual will receive *Notice 9: Denial of Enrollment*.

Notice 9: Denial of Enrollment may be sent for one or more of the following reasons:

- The individual was found ineligible for the program by the State and/or CMS
- The individual submitted an incomplete application and did not respond to the request for additional information within the 30-day timeframe
- The individual was identified as having employer or union sponsored coverage and did not confirm their decision to enroll

Enrollment is voluntary; Individuals can disenroll at any time.

4. Disenrollment

A. Disenrollment Process

- Disenrollment is distinct from opting-out or cancelling enrollment. In order for an action to be considered a disenrollment, a member must be actively enrolled in the Medicare-Medicaid Plan (Neighborhood INTEGRITY). CSRs should be very precise when using the terms ‘disenroll’ ‘cancel’ or ‘opt-out’ so they don’t confuse callers.
- Individuals who disenroll from the MMP will be automatically enrolled in Neighborhood UNITY. If they do not wish to remain in Neighborhood UNITY, they can call the *Adults in Managed Care Info Line* at (401)784-8877 to disenroll. Members who disenroll from UNITY will be in Medicaid Fee-for-Service for their Medicaid benefits/services.

B. How to Disenroll from Neighborhood INTEGRITY

1. Call the MMP Enrollment Line

If an individual who is enrolled in INTEGRITY does not wish to be enrolled, they can disenroll at any time. In most cases, their disenrollment will be effective the first day of the following month. Individuals who successfully disenroll from INTEGRITY will receive *Notice 16: Notice to Confirm Voluntary Disenrollment*. This notice will only be sent once CMS has confirmed the disenrollment and the State has ended that individual’s enrollment segment in MMIS.

2. Call 1-800 MEDICARE

Individuals may also disenroll by calling 1-800-MEDICARE or by signing up for a Part D Prescription Drug Plan or a Medicare Advantage plan. Members may not realize that they cannot be enrolled in both INTEGRITY and a Medicare Advantage and/or Part D plan at the same time.

Individuals should be encouraged to call the MMP Enrollment Line rather than 1-800 MEDICARE if they want to disenroll because 1-800 MEDICARE will not have information on Rhode Island’s program and cannot tell them about their Medicaid options, timing of opt outs, etc.

After a disenrollment is confirmed, individuals will receive *Notice 16: Notice to Confirm Voluntary Disenrollment*.

C. Denial of Disenrollment

If the disenrollment is denied by CMS the member will receive *Notice 17: Denial of Disenrollment*. If a member receives *Notice 17*, it is due to one of the following reasons:

- An unauthorized individual requested disenrollment on a members behalf or
- A member did not complete their disenrollment request

D. Timing of Disenrollment

Individuals who call after the 2nd financial cycle of the month (approximately the 19th or 20th day of the month) should be encouraged to disenroll early the following month to avoid complications with coverage and billing. If a member still wishes to disenroll, their disenrollment effective date will always be the last day of the month they disenroll.

E. What Happens After a Person Disenrolls

1. What Happens to Medicare

Individuals who disenroll from Neighborhood INTEGRITY will continue to have all their Medicare and Medicaid benefits.

If a member disenrolls from INTEGRITY, he/she will be automatically enrolled in 'Original' Medicare (Part A and B) for his/her Medicare health benefits and a Part D plan for their prescription drug coverage. If a member prefers to choose a Medicare Advantage or Part D plan they should call 1-800-MEDICARE. Help is also available from SHIP Counselors for in-person options counseling.

2. What Happens to Medicaid

If a member chooses to disenroll from Neighborhood INTEGRITY, they will be automatically enrolled in Neighborhood UNITY for their Medicaid benefits.

3. What about the ID Cards?

Individuals who were previously enrolled in UNITY will only receive a new UNITY card if they have been out of the UNITY plan for over 12 months. (This information should be available on MMIS.)

- The exception to this is if the MMIS system sends a name or other demographic change to Neighborhood. This action would prompt Neighborhood to generate a new ID card.
- If the individual has been out of the UNITY plan for more than 12 months, they will receive a new UNITY card.

Individuals who disenroll from INTEGRITY but were not previously enrolled in UNITY will also be enrolled in UNITY. They will receive a UNITY card and a welcome packet.

F. Involuntary Disenrollment

Individuals can be involuntarily disenrolled from the Medicare-Medicaid Plan for several reasons.

1. Loss of Medicare Part A and/or Part B

If an enrollee has been disenrolled due to loss of Medicare Part A and/or B, they should receive *Notice 24: Disenrollment Due to Medicare Part A and/or Part B Termination*.

These individuals will be automatically disenrolled from Neighborhood INTEGRITY and enrolled in Neighborhood UNITY for their Medicaid benefits. If an individual thinks this information is incorrect, they should be directed to call the Social Security Administration (SSA) to have their information corrected. Once their information has been corrected, they can call the MMP Call Center to confirm that they have been reinstated into Neighborhood INTEGRITY.

2. Loss of Medicaid

If an enrollee has been disenrolled due to a loss of Medicaid eligibility, they should receive *Notice 21: Notice for Loss of Medicaid Status*.

If the member believes this information is incorrect, they should be directed to their DHS field office. If an individual does not know their DHS case worker, they should call the DHS Info Line at 1-855-697-4347. Members have a right to appeal this decision with the State. Information on how to submit an appeal is included in their notice.

Individuals who have received this notice may still have Medicare but will no longer be enrolled in the Medicaid program.

3. Enrollee Moved Out of the Service Area

If an enrollee has been disenrolled due to a reported address that is outside of Rhode Island, they should receive *Notice 19: Notice for Disenrollment Due to Out of Area Status*.

If a member believes this information is incorrect, they should be directed to call the DHS Info Line at 1-855-697-4347 or visit a DHS office in-person to correct their address information. Members have a right to appeal this decision with the State. Information on how to submit an appeal is included in their notice.

Members who receive this notice may still have Medicare, but may or may not still have Medicaid coverage. If they have moved out of state, they should call the Social Security Administration to update their address. Medicaid allows eligible individuals to leave the state for up to six (6) months as long as they have 'an intent to return'. Medicaid eligibility is determined by the RI Department of Human Services (DHS).

4. Enrollee Has Been Incarcerated

If an enrollee has been disenrolled due to incarceration, they should receive *Notice 25: Disenrollment due to Incarceration*. They will receive this notice **only** if Medicare has informed the State of their incarceration. If a member believes this information is incorrect, they should be directed to contact the Social Security Administration (SSA) to have their records corrected.

5. Date of Death is Reported

This occurs if CMS has informed the State that a date of death has been recorded in the federal system (SSA). If an enrollee has been disenrolled due to a reported date of death, their estate will receive *Notice 23: Disenrollment Due to Death*.

If the date of death was reported erroneously, the caller should be directed to SSA to update their records. Once their records are updated, they should call to confirm that they have been reinstated into Neighborhood INTEGRITY.

5. SHIP/ADRC Counselors

There are two programs that are administered by the Department of Human Services, Division of Elderly Affairs (DEA) - the State Health Insurance Program (SHIP) and the Aging and Disability Resource Center (ADRC).

- *The State Health Insurance Program (SHIP)* is a network of community agencies that provide in-person information and counseling for seniors. They provide information on Medicare, Medicare Advantage and Part D plans. Every fall they help seniors during open enrollment but are also available to help at other times of the year.
- *The Aging and Disability Resource Center (ADRC)* is called “The POINT” in Rhode Island. It is a Call Center that provides information and referrals on a number of publicly-funded, government programs. The POINT is located at United Way of Rhode Island in Providence.

Rhode Island also has a 211 Info Line that is co-located with The POINT at United Way. The 211 Info Line takes calls 24-hours/7 days per week.

The SHIP/ADRC network consists of a total of 24 agencies across the state. There are six (6) regional SHIP/ADRC agencies that contract with several other community agencies to make up this statewide network. Each of the six regional SHIP/ADRC agencies have a relationship with “The POINT,” the state’s ADRC.

There will be three (3) dedicated SHIP/ADRC staff members called ‘MME Counselors’ (stands for: Medicare-Medicaid Eligible) that will have expertise on the new Medicare-Medicaid Plan (MMP) or INTEGRITY. The MME Counselors will be responsible for helping Medicare-Medicaid Eligible individuals understand their options. They can help consumers understand their health and drug plan options, including Original Medicare, Medicare Advantage, Part D Prescription Drug Plans, as well as Neighborhood INTEGRITY and Neighborhood UNITY. The MME Counselors will also train the other 24 SHIP/ADRC agency staff on Neighborhood INTEGRITY. This training is intended to give all SHIP Counselors a basic understanding of Neighborhood INTEGRITY. The SHIP Counselors will help to empower consumers to make informed decisions regarding their health care and will refer eligible individuals to the MME Counselors when appropriate.

The Division of Elderly Affairs (DEA) will work closely with the Executive Office of Health and Human Services (EOHHS) on training and outreach to eligible consumers. The three (3) MME Counselors will be mobile and can go to any area or location in the State.

8/15/16

Staff at the MMP Enrollment Line can 'warm transfer' inquiries to The POINT when a consumer would like one-on-one options counseling. In addition, the SHIP/ADRC Counselors can transfer consumer calls to the MMP Enrollment Line for general information and/or enrollment and disenrollment.

The MME Counselors will provide in-person options counseling that is objective and timely. Information and counseling in-person or by phone will be available for both existing enrollees and those who become newly eligible.

6. ICI Ombudsman

A. Program Description

As part of the Integrated Care Initiative, Rhode Island will have an Ombudsman Program dedicated to individuals who are eligible and/or enrolled in Neighborhood INTEGRITY. The goal of the ICI Ombudsman Program will be to ensure that members, caregivers and authorized representatives have person-centered assistance in resolving problems related to Neighborhood INTEGRITY.

Specifically, the ICI Ombudsman Program will:

- Empower beneficiaries and support them in resolving problems with their health care, behavioral health care, and long-term services and supports (LTSS),
- Investigate and work to resolve problems with Neighborhood INTEGRITY, and
- Develop materials for beneficiaries, their caregivers and representatives, that includes education, self-help skills, and empowerment,
- Facilitate coordination with other state agencies, including but not limited to SHIP/ADRC counselors, HealthSource RI navigators and State Protection and Advocacy Programs.

B. When Should Callers be Referred to the ICI Ombudsman?

- If they require assistance understanding their rights and responsibilities
- If they have been denied enrollment or have been involuntarily disenrolled and still want to be members of INTEGRITY

The Ombudsman can assist these individuals in filing an appeal with the State of Rhode Island (State Fair Hearing) or with correcting information with the Social Security Office.

Callers who need assistance with *Appeals* or *Grievances* should first be directed to call the health plan. If they are having difficulty filing an appeal, or do not feel that their needs are being met by the health plan staff, they should be directed to call the ICI Ombudsman. Customer Services Representatives may warm transfer callers to the ICI Ombudsman.

C. Appeals

Individuals who need help understanding an appeals notice or need help filing an appeal with Neighborhood INTEGRITY should be referred to the ICI Ombudsman

Program. Appeals are usually filed when a particular medical service or prescription drug is not covered or there's a problem with the way it's covered; or there may be problems related to payment for medical care or prescription drugs. Members, their family, or providers can file an appeal when they do not believe the health plan made the right decision about a covered service or drug. The ICI Ombudsman can help individuals and their families or caretakers understand a decision made by the health plan. They can also help them file an appeal or handle billing issues.

In Neighborhood INTEGRITY, Medicare and Medicaid appeals can be handled very differently depending on what the service is and whether the service is usually covered by Medicare or by Medicaid. This process can be very confusing for members, and often the Ombudsman can help a member and their family or caregiver understand who is reviewing their appeal and why. The Ombudsman can help with both Medicare and Medicaid appeals. Information on appeals is also available in Chapter 9 of the Neighborhood INTEGRITY Member Handbook that is sent to all new enrollees by the health plan.

D. Grievances

A grievance is generally considered to be a formal complaint. Members should first be directed to call the health plan. If a caller does not feel like their complaints are being dealt with properly by the health plan, or if they have a problem with covered services or drugs (see "Appeals" above), callers should be directed to the ICI Ombudsman.

E. Enrollment and Disenrollment Issues

If a caller is having difficulty appealing a disenrollment or if they need help to correct their records with SSA or the State, they can call the ICI Ombudsman. The ICI Ombudsman can help the individual file an appeal, or correct their records with SSA or the State so that they can continue getting services through Neighborhood INTEGRITY.

7. Consumer Materials

A. Consumer Notices

All enrollment, disenrollment and reinstatement information will be communicated to enrollees through notices that are generated and mailed by the State. There are a total of 18 notices which are included in **Appendix G**. Some notices are common to all, for example, every eligible enrollee will receive either Notice 32 or Notice 31 and 5. Some notices are rarer, in that, not everyone would be expected to receive them. Please remember that members may have trouble reading or may not open their mail right away, or they may wait for a family member to read their mail. The information on the notices may be difficult to understand. CSRs need to be clear when discussing the notices and should be familiar with the actions associated with each notice.

See **Appendix G** for copies of all the notices and a brief description of each.

B. Health Plan Member Materials

In addition to the State notices, individuals who enroll in Neighborhood INTEGRITY will be sent print materials by the health plan. The timing of the mailing of these materials will vary depending on if a person is an *Opt-In* or *Passive* enrollee.

1. *Opt-In* enrollees will receive:

- A Welcome Letter
- Summary of Benefits (mailed if requested)
- Drug Formulary
- Member Handbook
- INTEGRITY ID card
- Provider and pharmacy directory (mailed if requested)

All materials, except the Member handbook and ID card, will be mailed 10 days after Neighborhood receives an enrollment file from the State. The Member Handbook and ID should be received no later than the last day of the month before the enrollment start date.

2. *Passive* enrollees will receive:

- A Welcome Letter
- Summary of Benefits
- Drug Formulary
- Member Handbook

- INTEGRITY ID card
- Provider and pharmacy directory (mailed if requested)

The first four (4) items will be mailed about 30 days prior to the enrollment start date. The Member handbook and ID card will be mailed no later than the last day of the month before the enrollment start date.

See **Appendix H** for images of the materials sent to enrollees.

C. Health Plan Marketing Materials

In addition to Health Plan Member Materials listed above, Neighborhood will also be sending additional print materials to consumers, possibly direct mail pieces. They may call potential enrollees (in UNITY) or do other outreach/marketing activities to encourage consumers to join INTEGRITY.

8. Talking with Consumers

A. Frequently Asked Questions

1. If I join but then don't like INTEGRITY, can I switch back to what I have now?

Yes, the program is voluntary. Individuals can switch at any time. Enrollment and disenrollment is on a monthly basis.

2. Can I keep my doctor?

Yes. But before you join, check the Neighborhood' provider network to make sure your doctors participate. You can call Neighborhood's Member Services or check online at www.nhpri.org

3. Will I have to pay more money for the new plan (INTEGRITY)?

No. You may actually pay less because there will be no copays for prescription drugs. (Please note that if you receive long-term services and supports and currently have a co-share, you will continue to have a co-share in INTEGRITY.)

4. Julie comes to my home every week and I really like her. Can I still use Julie if I switch to INTEGRITY?

If Julie is a home health aide or certified nursing assistant (CNA), you would have to check with the agency she works for. That agency would have to be in Neighborhood's network to continue to see her. You can call Neighborhood's Member Services or check online at www.nhpri.org

5. Will the amount of hours of in-home services I receive change if I join?

The amount of hours you receive is dependent on your needs. If your needs change, the amount of hours you are eligible for may change.

6. I like what I have now. Why should I change?

See 'Benefits of Enrolling in INTEGRITY' on pages 10-11.

7. My doctor isn't in INTEGRITY, but I'd like to join. Can I continue to see my doctor even though he is not in the network?

You can continue to see your doctors and providers for six months after you enroll in INTEGRITY. After that time, you would either have to select an in-network doctor or provider, have your doctor join Neighborhood (Neighborhood can help with this), or ask Neighborhood for permission (prior authorization) to continue to see your current doctors after you've been

enrolled for six months.

B. Enrolled Populations

Individuals who are eligible to enroll in Neighborhood INTEGRITY will be in one of the following groups:

1. Members living at home or in the community

These members are currently not receiving Long-Term Services and Supports, but they may be at risk for it in the future.

2. Members living at home or in the community with LTSS

These members are currently receiving long-term services and supports (LTSS). LTSS services could include: homemaker services, home care, respite, minor assistive devices, personal response system, etc. For a list of Long Term Services and Supports (LTSS), see **Appendix C**.

3. Members living in a Nursing Home

These members currently live in a nursing home. People may be in a nursing home for a short or a long stay.

C. Special Populations

Some individuals who are eligible to enroll in INTEGRITY may include the following groups:

1. People who have an Intellectual or Developmental Disability (I/DD)

Individuals in this group may be receiving long-term care services through the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH). They are eligible to enroll in INTEGRITY but any long term care services they receive through BHDDH will be provided out-of-plan.

2. People who have a Seriously and Persistent Mental Illness (SPMI)

Individuals in this group receive intensive behavioral health services through an Integrated Health Home program that is associated with a Community Mental Health Center. They will continue to receive these services even if they enroll in the health plan.

D. Sensitivity to Consumer Issues

As you talk to consumers, please note that they may have one or more of the following issues that may impede communications.

- Deaf or hard of hearing
- Cognitive impairment
- Dealing with many complex health problems
- Speaking with a heavy accent
- Cultural or linguistic barriers
- Low literacy and trouble understanding the letters that are sent to them
- Low education levels

Be sure to speak clearly and understand that the material is complex! Simple, short sentences are best. Always be kind and courteous!

Additionally, this population receives a tremendous amount of mail from Medicare, Medicaid, and other health insurance companies. The letters tend to have very complex information that can be hard to understand. By accurately describing the program and using clear and consistent language, CSRs will be able to help avoid confusion among beneficiaries and strengthen their confidence in their choices. To do so, you will need to:

- Clearly explain the major features of the program, including the expected benefits;
- Use terminology carefully and consistently;
- Understand the intricacies of the program, such as enrolling and opting-out;
- Describe the beneficiaries' rights especially the continuity of care provisions;
- Refer people to additional in person options counseling if needed.

E. Protocols for Referrals

These are the general guidelines for referring callers to other agencies and organizations.

Name	Reason to Refer
Neighborhood Health Plan of RI	Provider network, Covered Services, Formulary and covered drugs, Filing appeals and grievances.
SHIP Counselors	Options counseling including Original Medicare, Medicare Advantage plans, Part D plans, Neighborhood INTEGRITY, Neighborhood UNITY.
1-800-MEDICARE	Selecting a Medicare Advantage plan or Part D plan. Also has information on Medicare in general.
ICI Ombudsman	Assistance with understanding Rights and Responsibilities, filing an appeal or grievance with the health plan, and correcting involuntary disenrollments.
RI Department of Human Services	Assistance with Medicaid Eligibility or reporting a change in address.

Social Security Administration (SSA)	Assistance with Medicare eligibility issues or reporting a change in address.
LTC Ombudsman	Issues or concerns regarding LTSS providers and agencies including concerns about abuse or maltreatment.
Adult Managed Care Line	Assistance with disenrolling from Neighborhood UNITY.

See **Appendix I** for the Referral Contact List. It includes phone numbers and addresses and hours of operation.

9. Resources

A. Neighborhood Health Plan of Rhode Island

Neighborhood Health Plan of Rhode Island, a non-profit organization, was founded in December 1993. Neighborhood serves more than 175,000 members in Rhode Island. Approximately 50 percent of Neighborhood's members receive primary care at one of the 29 Community Health Centers in the state.

Provider Network

Neighborhood has approximately:

- 1,300 Primary Care providers
- 3,700 Specialists
- 2,000 Behavioral Healthcare providers
- All the hospitals in the State, and
- Nearly every pharmacy in the state.

B. LTC Ombudsman

The Alliance for Better Long Term Care, also known as 'the Alliance', is a non-profit, independent advocacy organization, that provides ombudsman services for elderly and disabled Rhode Islanders who receive long-term care services in nursing homes and assisted living residences. They will also provide ombudsman services for people who receive licensed home care or hospice services.

The Alliance is the designated Rhode Island State Ombudsman for Long Term Care. Under the federal authority of the *Older Americans Act*, the ombudsman's role is that of healthcare oversight along with monitoring the quality of life and healthcare services of people who reside in long-term care facilities.