FINANCIAL ALIGNMENT INITIATIVE FAQs: PROVIDERS

What is the Integrated Care Initiative (ICI) and the Medicare-Medicaid plan (Neighborhood INTEGRITY)?

The ICI is a joint Medicare and Medicaid demonstration designed to integrate care for Rhode Island beneficiaries who have both Medicare and Medicaid. Beneficiaries participating in the demonstration will receive both Medicare and Medicaid coverage, including Part D prescription drugs, from a single, integrated Medicare-Medicaid Plan (MMP, i.e. Neighborhood INTEGRITY). The demonstration will be jointly administered by the federal Centers for Medicare & Medicaid Services (CMS) and the Rhode Island Executive Office of Health and Human Services (EOHHS).

Who is eligible to enroll in Neighborhood INTEGRITY?

In general, individuals who meet all of the following criteria will be eligible to enroll in Neighborhood INTEGRITY:

- Entitled to benefits under Medicare Part A
- Enrolled under Medicare Parts B and D
- Receiving full Medicaid benefits; and
- Age 21 or greater at the time of eligibility determination.

Eligible individuals include: long-term nursing facility residents; individuals with intellectual and developmental disabilities; individuals with serious and persistent mental illness; individuals eligible for long-term services and supports (LTSS) in the community; individuals residing in the community without LTSS needs; and individuals with End Stage Renal Disease (ESRD) at the time of enrollment.

When can beneficiaries enroll in Neighborhood INTEGRITY?

EOHHS will start sending notices to eligible individuals about their enrollment options in June 2016. The first date of coverage for eligible beneficiaries who sign up for Neighborhood INTEGRITY on or before June 10, 2016 will be July 1, 2016.

Beneficiaries can submit enrollment requests at any time. If the enrollment request is received in the first 10 calendar days of the month, the enrollment will be effective starting the first day of the following month. If the enrollment request is received from the 11th calendar day to the end of the month, the enrollment will be effective starting the first day of the second month after the enrollment is received. For example, an enrollment request submitted on June 10, 2016 would be effective on July 1, 2016 and an enrollment request submitted on June 11, 2016 would be effective on August 1, 2016.

Will there be passive enrollment into Neighborhood INTEGRITY?

Individuals who are in Neighborhood UNITY (Medicaid managed care plan), are not enrolled in Medicare Advantage, and meet eligibility criteria for the Medicare-Medicaid Plan will be passively enrolled, or auto-enrolled, into Neighborhood INTEGRITY. Passive enrollment will occur in waves, meaning that enrollees will transition from UNITY to INTEGRITY over time and not all on the same day. The first effective enrollment date for enrollees passively enrolled from UNITY to INTEGRITY will be no sooner than October 1, 2016.

EOHHS will send notices to enrollees who are eligible to be passively enrolled into INTEGRITY 60 days and 30 days before the effective enrollment date. Enrollees may choose to "opt out" or cancel this enrollment at any point before it takes effect, and retain their current coverage.

Enrollees who are passively enrolled into Neighborhood INTEGRITY can also choose to disenroll from Neighborhood INTEGRITY at any point after their enrollment has taken effect. Disenrollments will take effect on the first day of the month after they were received. For example, a disenrollment request received on October 11, 2016 would be effective on November 1, 2016.

Is enrollment into the Medicare-Medicaid Plan mandatory for dually eligible beneficiaries in Rhode Island?

Individuals can opt-out of the ICI Demonstration at any time, before or after enrollment, to keep their Medicare and Medicaid the same as it is today. Eligible beneficiaries who opt-out or disenroll from the ICI Demonstration will continue to receive Medicaid services through either the Rhody Health Options program (Neighborhood UNITY) or Medicaid fee-for-service, and they will continue to have a choice of Original Fee-for-service Medicare and a prescription drug plan or a Medicare Advantage (MA) plan.

Where should providers refer consumers for answers to questions about the Medicare-Medicaid Plan?

This information can be found on the plan's website https://www.nhpri.org/Medicare-MedicaidPlan.aspx You can also reach Neighborhood by phone Monday through Friday, 8 a.m. to 8 p.m. and Saturday 8:00 am to 12 noon at 1-844-812-6896 (TDD/TTY 711). EOHHS is also in the process of contracting with an independent organization to act as an ombudsman, or consumer advocate, for people eligible for the Medicare-Medicaid plan. The ombudsman program is expected to be operational in summer 2016. Contact information will be posted online at:
http://www.eohhs.ri.gov/Initiatives/IntegratedCareInitiative/OmbudsmanProgram.aspx once available.

For unusual or extreme situations like a high cost medication or medical device, who should we contact to discuss items or services that require prior authorization?

> The member's care manager is happy to discuss and assist in the process of obtaining necessary medication and devices. You can reach INTEGRITY Utilization Management at 401-459-6060.

Who should we contact in order to assist enrollees to coordinate or obtain out of plan services?

> The member's care manager is happy to discuss and assist in the process of coordinating out-of-plan services. The member can contact their care manager directly. If they lost their care manager's number or forgot his/her name they should call Neighborhood Member Services.

Have benefits changed compared to Rhody Health Options (i.e., Neighborhood UNITY), or fee-for-service Medicare and Medicaid? Can we provide different or expanded services?

> The plan may be offering expanded services or benefits as compared to fee-for-service Medicare and/or Medicaid. For more information, please see the Plan Benefit Manual. For example, in 2016, INTEGRITY is offering zero cost sharing for Part D drugs, however the plan may update its benefit package annually and expanded benefits can change on a yearly basis.

How do we and/or a consumer learn about other health care coverage options, in addition to the Neighborhood INTEGRITY Medicare-Medicaid Plan? For example, PACE, Medicare Advantage, or fee-for-service Medicare and Medicaid?

> Rhode Island State Health Insurance Program (SHIP) counselors are good resources to help consumers and providers with questions about coverage options. For more information, call the POINT at (401) 462-4444 (TTY 711). Consumers can also call the POINT to set up an appointment with a Medicare-Medicaid Counselor in-person for more info on the Medicare-Medicaid Plan.

Will there be a closed network and, if so, how will providers be selected? If a provider is "out-of-network" (i.e. not contracted with Neighborhood INTEGRITY) can the provider still serve current patients who enroll in INTEGRITY as well as new patients that are members of INTEGRITY?

> Neighborhood INTEGRITY enrollees can continue to see their out-of-network providers during the continuity of care period (please see below) during which time the plan should reach out to the providers to attempt to contract with them either to bring them in-network or for a single case agreement. Providers are also encouraged reach out to

the plan directly about contracting with NHPRI to join the Neighborhood INTEGRITY network.

What is the continuity of care period?

- If a doctor or other health care provider is already in Neighborhood INTEGRITY's provider network, members may continue to see that provider indefinitely. If a provider is not in Neighborhood INTEGRITY's provider network, and the member has seen the provider within the previous six months before joining the Medicare-Medicaid Plan, the member may continue to see the provider for another six months after enrollment.
- Permanent residents of nursing facilities or assisted living facilities may stay in their current residence, regardless of whether the residence is in Neighborhood INTEGRITY's provider network.
- For all items and services other than nursing facility services and non-Part D prescription drugs, enrollees maintain current health care providers and service levels at the time of enrollment for at least six months after enrollment.
- Enrollees will retain their current LTSS service authorization levels for all LTSS services (including personal care, waiver nursing, home care, respite care, community living, adult day health, social work, counseling, and independent living assistance) during the six month transition period, unless a significant change occurs and is documented through the assessment process.
- During the first 90 days of enrollment in Neighborhood INTEGRITY, a member can request a temporary supply of prescription drugs that are not on Neighborhood INTEGRITY's formulary but are covered by Medicare Part D or Medicaid. The member will continue to receive all non-Part D drugs, therapies, or services for which he/she had received a prior approval at the time of enrollment for up to 60 days after the member's transition period begins.

How can Neighborhood INTEGRITY enrollees or prospective enrollees check to see if a certain provider is in-network?

Enrollees can view the provider directory online on the Neighborhood INTEGRITY website https://www.nhpri.org/Medicare-MedicaidPlan.aspx or request a paper copy from the plan by calling 1-800-459-6019 (TDD/TTY 711).

What are the timely filing requirements for Neighborhood INTEGRITY?

As under Medicare Advantage, Medicare-Medicaid Plans like Neighborhood INTEGRITY can establish their own timely filing requirements in the plan-provider contracts. Providers should discuss questions with the plan directly. You can reach Neighborhood by phone at 1-800-459-6019 (TDD/TTY 711).

Do we follow consolidated billing guidelines?

> In general, Medicare-Medicaid Plans like Neighborhood INTEGRITY follow the same requirements as Medicare Advantage plans. SNF billing requirements for Medicare Advantage enrollees is addressed in Section 90 of Chapter 6 of the Medicare Claims Processing Manual; SNFs are generally instructed to follow the requirements of the agreement they have with the plan. For more information see: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf.

How will SNF providers track a resident's remaining skilled nursing facility benefit days and whether those days are during a co-insurance period? Will providers be required to report this to Medicare for Neighborhood INTEGRITY MMP enrollees?

> The Neighborhood INTEGRITY MMP must provide coverage no less generous than Medicare and Medicaid. Providers should follow the requirements of their agreement with the MMP to determine what benefits are available, as they would with a Medicare Advantage enrollee. MMPs and providers may follow the Medicare rules regarding days of SNF coverage, or they are free to negotiate alternatives.

> Regarding tracking, SNFs serving demonstration enrollees are expected to follow the MA/CMS tracking rules (sections 90.1 and 90.2, Chapter 6 of the Medicare Claims Processing Manual at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf, "When a Medicare beneficiary is in a skilled stay in a SNF and has coverage under [a Medicare Advantage (MA)] Plan, the SNF is required to submit MA plan no-pay claims to Medicare which results in the beneficiary's benefit days being deducted from their current benefit period").

What happens if a patient moves from the Neighborhood INTEGRITY MMP service area to a non-MMP service area?
> In a scenario where a beneficiary leaves the MMP service area and is disenrolled from the MMP, the procedure for Medicare Advantage beneficiaries in Medicare Claims Processing Manual Chapter 6, Section 90.1 applies: If a beneficiary voluntarily or involuntarily disenrolls from a risk MA plan while an inpatient of an SNF and converts to original Medicare (i.e., fee for service) … The beneficiary will then be eligible for the number of days that remain out of the 100 day SNF benefit for that particular SNF stay minus those days that would have been covered by the program under original Medicare while the beneficiary was enrolled in the risk MA plan."

Under the ICI Demonstration, the Neighborhood INTEGRITY MMP may enter into provider contracts that do not require a three-day hospital stay (i.e. that does not require an enrollee to have a qualifying three-day hospital stay for SNF coverage). What happens if an enrollee

who is receiving skilled care without a hospitalizations decides to disenroll and return to Original Fee-for-service Medicare? How will Medicare FFS treat that stay?

> Chapter 4 of the Medicare Managed Care Manual (section 10.2.1) addresses the 3-day stay issue from a Medicare Advantage perspective: "If the enrollee is in a SNF in December in an MA plan that does not require a prior qualifying 3-day hospital stay and then joined Original Medicare on January 1, the stay continues to be considered a covered stay (if medically required)." The same guidance applies for the Integrated Care Initiative Demonstration under the capitated financial alignment model.

Will the Neighborhood INTEGRITY MMP's reimbursement schedule coincide with the RUG Schedule with Medicare?

> Nothing in the Demonstration dictates the payment structure to in-network providers for any covered services. Payments levels for in-network providers are dictated by the terms of the contracts that providers establish with health plans.

What about MDS requirements, will they change?

> No, nothing about the Demonstration changes requirements on the nursing facilities to comply with any prevailing assessment requirements as part of their Medicare SNF conditions of participation. Under the Demonstration, Neighborhood INTEGRITY will be required to conduct either a discharge opportunity assessment or a wellness assessment for all facility-based enrollees. The discharge opportunity assessment will be conducted within 30 days of enrollee identification or referral for discharge to the community. The wellness assessment for those not returning to the community will be conducted within 120 days of enrollment. The assessment may consider results of a previous MDS assessment for enrollees residing in a nursing facility.

How often can NFs submit claims under the ICI Demonstration?

> For billing to the Neighborhood INTEGRITY MMP, SNFs follow the requirements of the agreement they have with the plan.

Will Neighborhood INTEGRITY MMP enrollees be subject to the Physician's Quality Reporting System (PQRS)?

> MMPs, including Neighborhood INTEGRITY, are managed care plans, similar to Medicare Advantage. PQRS reporting only applies to the provider's Medicare FFS beneficiaries, so if a person enrolls in an MMP, their provider doesn't report PQRS for that individual any more. Basically it works for the provider just like if their beneficiary joined an MA plan. Generally, instead of CMS saying what to report and how to bill, the MMP will tell them.

How will providers know when their patient is enrolled in the Neighborhood INTEGRITY MMP if the beneficiary doesn't know which plan he or she is in/forgets their ID card?

Providers can look up the individual's Medicare eligibility and enrollment just as they do today. The HIPAA Eligibility Transaction System (HETS) (270/271) is the system providers and suppliers can access for Medicare eligibility and plan enrollment (including MMP) information. HETS 270/271 is formerly known as the Common Working File, it's just a new name. Here is the CMS link: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html?redirect=/hetshelp.

All inquiries and comments regarding Trading Partner registration, connection set-up, transaction testing, and the submission of 270/271 transactions and interpretation of their data should be directed to MCARE, which is the helpdesk for HETS 270/271. MCARE is available at 1-866-324-7315 or at MCARE@cms.hhs.gov, Monday-Friday, from 7:00 AM to 7:00 PM ET.

The state also has a portal for providers to look up Medicaid eligibility. Providers should contact their HPE provider representative for information on how to get access to the system.

What happens if the provider bills the wrong plan/entity (e.g. if they bill Medicare rather than the Neighborhood INTEGRITY MMP)?

They'll get a denial notice, and they'll need to resubmit the bill to Neighborhood INTEGRITY.

What happens if someone enrolls in Neighborhood Integrity in the middle of therapy or skilled stay?

Section 90 of Chapter 6 of the Medicare Claims Processing Manual (referred to above) indicates that "SNFs follow the requirements of the agreement they have with the plans. In cases where the patient may have enrolled or disenrolled from the plans during the billing period, the SNF will split the bill and send the plan's portion to it and the remaining portion to the FI."

What if a provider doesn't contract with Neighborhood INTEGRITY, will they still get paid?

As a managed care plan, Neighborhood INTEGRITY will require prior authorizations for services provided by an out-of-network provider. Approved services will be reimbursed, in the aggregate, essentially the same as what would have been paid absent the Demonstration (e.g., the combined prevailing Medicare and/ or Medicaid rate, as applicable).

Additionally, the Demonstration includes a 6-month continuity of care period, wherein the enrollee may continue to access services from an out-of-network provider for 6 months after enrollment into the Demonstration without a prior- authorization. During the applicable continuity of care period, Neighborhood INTEGRITY will provide or arrange for all medically necessary services. If the enrollee chooses to remain in the plan, the enrollee's care manager will assist in finding the enrollee a suitable in-network provider by the end of the 6-month continuity of care period. Neighborhood may also continue to authorize out-of-network services if medically necessary and a suitable in-network provider is not available.