GIS 16 MA/08

TO: Local District Commissioners, Medicaid Directors

FROM: Jonathan Bick, Director
Division of Health Plan Contracting and Oversight

SUBJECT: Voluntary Managed Care Enrollment for Nursing Home Recipients

EFFECTIVE DATE: October 1, 2015

CONTACT PERSON: Local District Support Unit
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This General Information System (GIS) message informs local departments of social services (LDSS) that voluntary enrollment in managed care for adults age 21 and older in permanent placement in a Nursing Home (NH) is effective October 1, 2015. This applies to consumers who were in permanent placement in a Nursing Home prior to the applicable transition date for the county, now wishing to enroll in a Managed Long Term Care (MLTC) plan, Fully Integrated Dual Advantage (FIDA), or a Medicaid Managed Care (MMC) plan, including HIV Special Needs Plans (SNP). PACE, or Program of All-Inclusive Care for the Elderly, is not an enrollment option available to consumers in permanent placement in a NH, unless the Plan of Care actively supports the consumer's return to the community.

Prior to the transition of the Long Term Nursing Home benefit and population, the nursing home population in permanent placement was excluded from managed care enrollment. After the transition date for the county, this population became either mandatory or voluntary for managed care enrollment, based upon the date of permanence. Those with a date of permanence prior to the transition date are voluntary and, if enrolling in a managed care plan, may later elect to disenroll to Fee for Service Medicaid. Those with a date of permanence on or after the transition date are mandatory for managed care enrollment. See 15 OHIP/ADM – 01, "Transition of Long Term Nursing Home Benefit into Medicaid Managed Care," for additional information.

Medicaid eligible consumers in permanent placement in a NH who wish to enroll in a Managed Long Term Care or Medicaid Managed Care plan must contact New York's Enrollment Broker, New York Medicaid Choice (NYMC). NYMC will conduct outreach to the consumer to provide education and assist with plan selection, based upon the plans contracting with the NH in which the consumer resides. NYMC will also process enrollments for this population. Districts should refer any enrollment requests received from consumers or plans to NYMC.

NYMC will manage each voluntary enrollment request on a case by case basis, including notification to the local districts. LDSS staff may be requested to temporarily enter Restriction/Exemption (R/E) code N7 on the Medicaid case in WMS to allow the enrollment line to be processed. NYMC will also direct the LDSS when to remove the N7 once the enrollment line is accepted by the system. Removal of the N7 will prevent the case from entering the mandatory and auto assignment processes. This will also allow the consumer to return to Fee for Service Medicaid if he or she so desires, since this is a voluntary population. The LDSS is responsible for all appropriate data entry for cases returning to Fee for Service Medicaid, such as changes to Principal Provider screens and entering appropriate card codes.

Counties not utilizing the services of the Enrollment Broker are responsible for consumer outreach, education, enrollment processing, and any auto assignment functions for all MMC enrollments. These districts must also work with existing systems to distinguish voluntary enrollment cases from mandatory, and to ensure these cases receive appropriate treatment following all applicable Medicaid policies and regulations. The Enrollment Broker will be responsible for these functions for all MLTC enrollments regardless of county of fiscal responsibility.

Once the enrollment is in place, the LDSS is responsible for reviewing the monthly Enrollment Report and updating the Medicaid case as appropriate to reflect plan enrollment. The LDSS must enter the appropriate N1-N6 R/E code, with a Begin Date equal to the first date of plan enrollment:

- N1-N5: MMC enrollments only, based upon bed or facility type;
- N6: all MLTC enrollments, regardless of product or bed type.

It is imperative that the LDSS use the correct R/E N code for this process. See the chart below for N codes.

Medicaid Managed Care R/E Codes:

N1	MMC Enrollee	Regular NH
N2	MMC Enrollee	AIDS NH
N3	MMC Enrollee	Neuro-Behavioral NH
N4	MMC Enrollee	TBI NH
N5	MMC Enrollee	Ventilator Dependent

Managed Long Term Care R/E Code (MLTC/FIDA):

N6	MLTC Enrollee	NH – any type

MMC and MLTC R/E Code:

N7	Not Enrolled	Chronic Care Budgeting Approved

Once the enrollment is effective, the enrollment will appear on the plan's monthly roster and Nursing Home report, along with any monthly NAMI contribution. The NAMI amount is derived from the Medicaid budget stored in Medicaid Budget Logic (MBL). Once the enrollment is effective, the LDSS is also responsible for transmitting any eligibility notices containing NAMI information to the plan, in place of the Nursing Home.

The LDSS must send any changes in NAMI to the managed care plan through the roster system, utilizing the Associated Name fields. The LDSS must also notify directly the managed care plan of any changes in NAMI amount not reflected in the budget. The LDSS must issue a notice to the plan and enrollee for NAMI amounts that may be different from the amount appearing on the roster, including retroactive changes.

For all consumers enrolled in a managed care plan, the LDSS is responsible for transmitting notification of NAMI information as follows:

- Any changes in NAMI must be sent to the managed care plan through the roster system, utilizing the Associated Name fields.
- The LDSS must also send notices directly to the managed care plan with any changes in NAMI amount not reflected in the budget or on the roster.
- The LDSS must issue a notice to the plan and enrollee for NAMI amounts that may be different from the amount appearing on the roster, including retroactive changes.